

HEALTH INEQUALITIES — A NEGLECTED AREA OF PHARMACY POLICY AND PRACTICE

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In this article, we argue for much greater engagement by pharmacists with the emerging health policy focus on public health and inequalities in health. In particular, we highlight recent epidemiological and sociological research in this area, describe the scope of pharmacy's response to the health inequalities agenda and discuss some barriers to pharmacy's sustained engagement in the health inequalities arena.

We conclude that although important work is currently being carried out in pharmacy practice, it is important for pharmacy to seize the opportunity presented by current Government policy and devote more attention to addressing the root causes of inequalities in health in society

Given the plethora of changes to the National Health Service enacted by the present government, pharmacists might be forgiven for overlooking the significance of the recent policy focus on reducing health inequalities. As many readers will be aware, targets have been set for reducing inequalities in health in several areas: infant mortality, life expectancy, smoking and teenage pregnancy (see www.doh.gov.uk/healthinequalities). The setting of such targets is an entirely new development in United Kingdom health policy, and is one that all health and social care professionals need to consider. However, while public health and health development are increasingly referred to within pharmacy practice,¹⁻³ there is less debate about health inequalities. (In a recent literature search of pharmacy databases we found only three relevant papers.) In this article, we argue for much greater engagement by pharmacists with health inequalities. In particular, we review some of the evidence on the causes of health inequalities and discuss the obstacles to developing a practice-based culture which places health inequalities at the heart of pharmacy's professional mission.

THE HEALTH INEQUALITIES DEBATE

One of the last (and perhaps one of the most radical) acts of the previous Labour government was the decision to commission Douglas Black and others to conduct research into health inequalities in the UK. The Black report, as it became known, assembled extensive evidence on the scale of health inequalities in the UK and highlighted possible explanations. Black and his colleagues argued that inequality in health stems from structural and behavioural factors in society, that "inequalities in health had been widening since the 1950s, and that a programme of higher social security benefits and more equal distribution of income, as well as action on housing and services, was required".⁴ Promptly disowned by the incoming Tory government, the Black report nonetheless remained the intellectual foundation on which 20 years of subsequent

research into health inequalities in the UK was built. This was despite a distinctly hostile political culture whereby researchers and public health workers in the field were required to adopt the politically correct term "variations" rather than "inequalities" in health.

An early decision of the Labour government elected in 1997 was to commission the Acheson inquiry⁵ into the scale of contemporary health inequalities in the UK. Acheson's findings eerily echo those of Black, except that the inequalities gap has consolidated and widened even further over the past two decades. To take some simple examples: among both men and women aged 35-64 years, overall mortality rates fell within each occupational class group (according to the Registrars General Classification I to V) between 1975-81 and 1986-92. However, the gap in mortality between those in the highest socioeconomic group (RG I and II) and those in the lowest socioeconomic group (RG IV and V) actually increased. In the late 1970s, mortality rates were 53 per cent higher among men in RG IV/V compared with those in I/II; by the late 1980s, they were 68 per cent higher. Among women, differences increased over the same period from 50 to 55 per cent. In relation to morbidity, the data are equally stark. In 1996, among those aged 45-65 years, 17 per cent of professional men reported a limiting long-standing illness, compared with 48 per cent of unskilled men (the figures for women were 25 and 45 per cent).⁶ This "social gradient" in life expectancy between those in the highest socioeconomic groups and those in the lowest is now well documented.⁷

Like his predecessor, Acheson identifies material and socioeconomic factors as the most likely explanation for these inequalities in life chances. He argues: "The weight

of scientific evidence supports a socio-economic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as to the material environment and lifestyle. It follows that our recommendations have implications across a broad front and reach far beyond the remit of the Department of Health."⁵

Let us consider other research in this area before returning to pharmacy. Richard Wilkinson has explored the mechanisms which produce health inequalities, and his work has galvanised interest in the whole field. His focus has been on the issue of relative income and health status. A social epidemiologist, Wilkinson⁸ argues that we should not focus exclusively on poverty as a factor, but on the relative distribution of income within a country. So, even if the extent of poverty is reduced it is how people perceive themselves in relation to others within their society that is important. He suggests that once certain levels of gross national product per capita have been attained (about \$5,000 per annum), the principal determinant of health status in a nation is the degree of income inequality. He asks why, if health inequalities were due to poverty, have they got bigger in countries such as Britain during the past 50 years, despite huge rises in the standard of living. The evidence suggests that what matters within societies is not so much the direct health effects of absolute material standards so much as the effect of social relativities.

Moreover, just increasing national wealth does not improve health, beyond a fixed income level. He argues that "regardless of the fact that health differences within societies remain so closely related to socioeconomic status, once a country has passed through the epidemiological transition, its whole population can be more than twice as rich as any other country without being any healthier".⁸

Indeed, Wilkinson argues that a difference of around 7 per cent in the share of income going to the bottom 50 per cent of the population would result in a two-year increase in life expectancy. Drawing on the work of Robert Putnam,⁹ Wilkinson argues

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that this is because social cohesion/social trust is the main mechanism linking a nation state's degree of income inequality with health. He contends that income inequality involves "not only the effects of changes in the burden of low social status but, perhaps, less obviously, also the effects of poor social affiliations".

Essentially, Putnam argues that greater social integration, cohesion and trust derived through active civic engagement (what he refers to as social capital) impacts on health; Wilkinson, that relative income is the key factor underpinning social activity and health. Other writers see the concept of social capital as a highly contestable ideological device, a diversion from policy to reduce absolute poverty and improve the public environment.¹⁰ Wilkinson argues that "although we used to assume that the direct effects of poorer material circumstances accounted for the social gradient in health, it now looks as if a major part of the association between low social status and poorer health springs from the experience of low social status or subordination itself".¹¹ There is now, a vibrant debate about the role of relative income and social capital as key determinants of health inequalities within social epidemiology and the sociology of health and illness.¹²

THE HEALTH INEQUALITIES DEBATE AND PHARMACY

Wilkinson goes on to speculate how this association works in practice and we refer interested readers to his numerous publications. The political and economic implications of his arguments are, of course, enormous and we recognise that these are controversial and contested issues. Notwithstanding that, we see little critical engagement within pharmacy in relation to the central questions that Black, Acheson, Wilkinson and Putnam (and others) raise. Indeed, with a few honourable exceptions, we have noted an absence of pharmacy delegates at public health conferences we have attended over the last year, such as UK Public Health Association Forum and Health Development Agency conferences, and a virtual vacuum at the intellectual and discursive level more generally. This is a glaring omission, and does not bode well for the emergence of pharmacy into the sub-field of pharmaceutical public health.

On the other hand, we acknowledge that in terms of reducing inequalities in access to health services, some health action zones have drawn on the skills of pharmacists in setting up schemes to provide emergency hormonal contraception¹³ and that specialist smoking cessation programmes have been instituted in several areas.¹⁴ Furthermore, there have been important and timely reviews of the national and international literature on pharmacy's role in public health and health development funded by the Pharmacy Healthcare Scheme.³ A leading pharmacy multiple group has been active in the area of developing social capital through the institution of their CHAT centres and in the social pharmacy network

meetings.¹⁵ All of these are welcome initiatives. However, we must remember that most of these developments relate to specific services, and will only have an impact on inequalities in access to services, rather than on the underlying causes for health inequalities. What we seek to do in the rest of this paper (and our work more generally), is not only to encourage pharmacists to explore ways by which inequalities in access to services can be reduced, but more importantly, foster a climate in which the work of pharmacists is focused on addressing the root causes of inequalities in health.

We have to ask whether there is a role for pharmacy in the health inequalities agenda, and if there is, what is it? How can it be developed if the root causes of health inequalities are material? We recognise immediately that this is likely to be no easy task, and in the rest of this article we suggest why this is so.

CHANGING THE CULTURE OF PHARMACY PRACTICE

The pharmacy health education/promotion/prevention role is well established, for tackling individual behaviour, and there is a plethora of research into this area of practice. However, this work focuses solely on changing individual behaviour and there is now growing evidence that there are clear limits to the degree to which "lifestyles" or behaviours can be modified through health promotion activities.¹⁶ Moreover, there are clear limits to the provision of advice and the supply of products at the community pharmacy level. From a public health perspective there is little empirical evidence to show that health promotion energies are targeting those population groups seen to be most at risk, rather, the driver is the personal enthusiasm of individual pharmacists. We believe it is important for pharmacists to have a greater appreciation of how health behaviours are linked to wider social structures since in the future many more pharmacists will be working at strategic level within primary care groups, within the new strategic health authorities and as directors of public health the UK. They will have a key role to play in partnership and commissioning services from health organisations and local government, from statutory and voluntary sectors to deliver the health improvement programme, the community plan and local strategic partnerships. This will require a social scientific understanding of health and health behaviours as well as an awareness of clinical issues.

What currently mitigates against a broader understanding is the professional training, socialisation and practice of pharmacists themselves. Why is this?

One important issue is the focus on the orthodox biomedical model within pharmacy schools. A common sociological critique of the orthodox biomedical model of health and illness (ie, that which is taught in pharmacy and medical schools) is that it places little emphasis on the ways in which health and illness are shaped by an individual's location within their social, psycholog-

ical and environmental context – in short, the factors which Black, Acheson and Wilkinson have identified as producing health inequalities. Learning and teaching about the ways in which mortality and morbidity are socially patterned according to variables such as socioeconomic status, race, age and gender is typically only a relatively minor or, in the past, a non-existent part of pharmacists' overall training. Although this is now being addressed in many schools of pharmacy through the input of social science, public health and social epidemiology modules, these tend to be only small components in the overall course, which privileges learning base science and clinical skills. Furthermore, these areas of teaching are still considered contentious.¹⁷ For example, in a "Broad Spectrum" paper in *The Pharmaceutical Journal* Armstrong¹⁸ noted "unease at the current preoccupation with social aspects of health" and that "a dramatic reduction in mortality over the past century [was] due largely to a medical approach, underpinned by pure science". Those familiar with the work of McKeown¹⁹ would suggest something rather different: that reductions in mortality are largely the result of social and economic development. With honourable exceptions, our experience is that these issues are rarely acknowledged as being of central importance to pharmacists' training. There should be an introduction to the new public health at undergraduate level; the more specialised knowledge will be required in postgraduate practice.

We also see the current culture of everyday pharmacy practice, described by Walker as a "uniprofessional culture"²⁰ as one which accentuates this bias towards the medical model. Many pharmacists have limited levels of contact with patients as compared to other health professionals, such as doctors and nurses, because of the traditional focus within the practice of pharmacy on dispensing and the sale of over-the-counter medicines. These activities typically do not require much in-depth patient contact. Unlike in the nursing or medical professions it can be more difficult to make the link between the social determinants of health at group level and the individual material and social circumstances of the patients lives, especially in the absence of a thorough grounding in these issues at undergraduate level. Awareness of their impact on health outcomes and health behaviours is more limited among pharmacists, simply because they do not have routine, in-depth consultations with patients where these issues might be revealed.

Now, as sociologists "within pharmacy", it is our role to be objectively critical of what we see. In the pharmacy profession we note that it is the structure of pharmacists' occupational activities which (largely) determines their destiny. We do know that some pharmacists do maintain an active interest in how the material and structural aspects of patients' lives impacts on their health. However, many are divorced from a wider social understanding of their position and we believe that these factors strongly mitigate against a greater acknowledgement and

understanding of the social and material basis of health and consequently the lack of focus on public health inequalities.

Other factors are relevant here. For example, community practice operates within a commercial environment; the terms of reference of pharmacists' work is shaped by the dictates of the market — whether large corporations, or small independent owner — and the prime aim of these companies is economic survival and growth, not a philosophical consideration on the social and material causes of ill health. However, the profit motive clearly does play a part in what public health activities pharmacy will be involved. Companies are sensitive to public opinion and pressure group lobbying, and can react to please shareholders rather than serve a public health objective.²⁰

Moreover, we are aware that at the level of professional practice and policy, there are of course a superabundance of other issues that pharmacists must act on — governance, quality, indicators and objectives as well as developing and maintaining a distinctive niche for pharmacy in the NHS itself. It is perhaps not surprising therefore, that developing strategies and strategic alliances to

reduce public health inequalities have not occupied centre stage in pharmacy policy.

And yet, to return to the inequalities targets set by the Government, it is apparent that innovative thinking on the part of pharmacists has been and is an important factor in the development of smoking cessation, emergency hormonal contraception patient group directions and illegal drug misuse services in pharmacy. The commitment of the Pharmacy Healthcare Scheme to public health concerns and the recently commissioned review of pharmacists involvement in health development are also notable developments. At the British Pharmaceutical Conference (2002) in Manchester, in the session on public health and pharmacy, at least one contributor (Roger Walker) preceded his talk with a detailed commentary on the social and material determinants of health status. It is clear that there has been positive change in some areas.

What we would argue, is that a prerequisite to developing strategies which contribute to reducing the causes of health inequalities is the need to raise awareness of the importance of inequalities in health, and moreover, to raise awareness of the social and material causes of inequalities in health.

Then we will be able to tap more innovative and creative policy suggestions coming from grass roots pharmacists who are actively involved in the community. For example, Ghalamkari and Jenkins²¹ have recently related the social capital concept to social entrepreneurship, seeing the pharmacy as part of the physical and social infrastructure (albeit privately owned) of a community. They note that the pharmacists human capital adds to community well being and suggest that this is largely unmeasured and undocumented outside historical narratives and nostalgia for a distant past. We would strongly encourage such debate.

SEIZE THE OPPORTUNITY!

Arguing for such an approach is all very well. But as sociologists working and teaching within pharmacy, an all too depressing experience has been the propensity of pharmacists to focus on the behavioural arguments for health inequalities (smoking, drinking, salt, sugar, fat in diet, etc) without seeing the link with wider structural and material factors, and even where they do so, to see these as beyond the remit of pharmacy. Changing this mind-set and encouraging pharmacists to think outside the narrow confines of the traditional biomedical model is a fundamental challenge if the public health role is to be placed at the heart of pharmacy's professional mission. We would like to see much greater input within all pharmacy schools of social science based courses which address these new public health issues at an undergraduate level, something that is referred to in the indicative syllabus produced by the Royal Pharmaceutical Society. At the same time, we also call for a research agenda, which places health inequalities at the centre stage of pharmacy practice and policy.

Some might question our passion about health inequalities given the profusion of other issues that need attending to. We would argue that having watched for 20 years, and waited for a government prepared to tackle health inequalities, we want to see everyone involved, and to tap the undoubted skills of all pharmacists. However, we are frustrated by pharmacy's hesitancy, and all too aware of the barriers to greater involvement. Our interest in this area is motivated by our awareness that access to resources, income, wealth, education, health and social services are a basic right in a civilised and democratic country. That access to these resources is profoundly unequal, and contributes to major differences in mortality and morbidity across different groups in the population, is one of the most central social problems to be addressed today. A greater awareness of, and commitment to these issues, allows us to judge the value of our health and social policy objectives. We expect all pharmacists to have a similar awareness, knowledge and commitment to doing something about these public health issues.

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