



Should health inequalities be addressed with healthy lifestyle promotion policies? An intersectional approach during and after crisis time

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Abstract: Health inequalities caused by socioeconomic factors violate social justice principle. Therefore, policies in Public Health should try to eliminate them. Two main strategies aim to reduce health inequalities: the promotion of healthy lifestyles appealing to individuals (i) and the increasing of life standards for all the population (ii). Here I present why the former, broadly extended in West Europe under the lifestyle drift phenomenon, has severe limitations. In order to do so I will explore how socioeconomic determinants of health shape individual's ability to adhere to healthy behaviours specially in the specific context that we are currently living (COVID-19 crisis) taking as a reference the Great Recession crisis of 2008.

Keyword: Health Inequalities, Social Determinants of Health, Lifestyle Drift, Social Justice, COVID-19 Crisis

Resum: Les desigualtats en salut causades per factors socioeconòmics violen el principi de justícia social. Per aquest motiu, les polítiques de salut pública haurien de dissenyar-se amb l'objectiu d'eliminar-les. Les principals estratègies que intenten reduir-les son: la promoció d'estils de vida saludables a nivell individual (i) i l'augment del nivell de vida de tota la població (ii). En aquest article, exposo les limitacions de la

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primera estratègia àmpliament estesa als països occidentals europeus. Per fer-ho, analitzo com els determinants socioeconòmics de la salut determinen l'estat de salut de les persones així com la seva capacitat d'adherència a un estil de vida saludable en l'actual crisi sanitària tenint com a referència la recessió econòmica del 2008.

Paraules clau: Desigualtats en salut, determinants socials de la salut, el gir de l'estil de vida, justiciar social, crisi de la COVID-19.

Health inequalities can be defined as differences in health status between different population groups caused by biological variations or social and environmental factors (World Health Organization [WHO], 2020). This last kind of health inequalities are considered to go against the principles of social justice because they are determined by social and economic circumstances beyond individuals' choices and control (Public Health Scotland, 2020). In England, social injustice caused by health inequalities supposed the loss of 2.6 million years of life across all social groups in 2010, according to the English Marmot review (Popay, Whitehead & Hunter, 2010).

Since their existence is avoidable, Public Health policies and interventions are designed aiming their elimination or, at least, their reduction. In order to do that, many strategies and approaches have been proposed and adopted by different governments and countries as well as a considerable effort and resources that have gone into research in these areas. Nevertheless, inequalities in health have not disappeared at all and, in some cases as in England, they have even widened (Popay, Whitehead & Hunter, 2010).

It is necessary, therefore, (i) to define those policies and understand their limitations, (ii) to analyse in depth the real causes of health inequalities locally and (iii) to try to eliminate them through redesigned policies and actions that address the real causes of health inequalities.

One of the latest and well extended strategies in West Europe to reduce health inequalities has been the promotion of a healthy lifestyle. This Public Health tendency, named in the literature as lifestyle drift (Marmot & Allen, 2014), focuses on individual behaviours such as diet, alcohol and other drugs, diet and sedentarism – which are well-known causes of health inequalities –, but ignores the origin and the drivers of these risky behaviours (the causes of the causes) (Marmot & Allen, 2014; Williams & Fullagar,

2018). Healthy behaviours have come to the core of Public Health policies during the last decades in the Western countries and, even though this approach is necessary, it tends to undermine the importance of structural factors, social conditions and local settings that determine people's health and also their capacity to accept and perform these healthy lifestyles (Williams & Fullagar, 2018).

This paper addresses the political debate between the two main strategies of Public Health interventions that aim to reduce health inequalities: the promotion of healthy lifestyles and individual behaviour change (downstream approaches) and the one that tries to increase standards of living for all the population through economic, social and politic interventions (upstream approaches). In order to do that, I will analyse the lifestyle drift limitations by exploring how social determinants of health shape individual's health status and their ability to adhere to healthy behaviours in the specific context that we are currently living (COVID-19 crisis and its consequences) taking as a reference the Great Recession crisis of 2008.

SOCIAL DETERMINANTS OF HEALTH AND HEALTH INEQUALITIES: A GENDER-BASED EXAMPLE

Social determinants of health are the economic, material, social, political and cultural factors and circumstances that shape the conditions in which people live, grow, work, age and, therefore, behave (Marmot & Allen, 2014; Islam, 2019). Some of the most well-studied social determinants of health are: income and its distribution in society, social exclusion, social support, stress, work and unemployment, addiction, food and diet, transport and early life conditions (Islam, 2019; Wilkinson & Marmot, 2003). Many other determinants of health have been added in recent research; these new social determinants of health include gender, sexual orientation, race, colonialism, religion and even time (Islam, 2019). Due to the big number of social determinants of health not all of them will be addressed and analysed in this paper – I will focus on income distribution in society, work and unemployment and gender. The link between social determinants and health is big enough to understand health inequalities as an indicator of how social and economic inequalities impact on people's lives (Marmot & Allen, 2014) and, thus, to reduce health inequalities requires action and policies to reduce socioeconomic and other inequalities such as gender inequalities.

Examples of how this link exists and may be addressed by applying policies that aim to reduce socioeconomic and gender inequalities can be found in previous studies. Regarding health inequalities between genders, it has been found that, despite having a longer life expectancy, women are expected to live fewer years in good health (Palència et al., 2016). While men shorter lives result from both biological and gendered patterns of health-related behaviours and risk taking, women have higher prevalence of a large amount of non-fatal, disabling physical and mental illnesses (Palència et al., 2016). Furthermore, it has been proved that women with a higher burden of household unpaid work have worse health outcomes than men, who have more time than women, since they bear with less (or any) burden of unpaid work (Borrell et al., 2013).

This exemplifies how socioeconomic inequalities and different distribution of wealth between men and women (since women have, in general, less access to paid work and, even when they have access to it, they usually have lower salaries than men for the same job) lead to inequalities in health outcomes, self-perceived health and life quality. The poorer health status of women has been interpreted as a consequence of the systematic domination of women by men which limits women's access to paid work and economic resources and the allocation of those lower economic resources to domestic and family responsibilities (Malmusi et al., 2012), which leads to a higher prevalence of chronic and mental conditions.

After analysing different policies intended to explicitly support women and families and, thus, to reduce the socioeconomic differences and inequality between men and women, the study performed by Borrell et al concluded that an improvement on health outcomes for women and a decrease on health inequalities can be achieved (Borrell et al., 2013). This shows that claiming individual responsibility for one's own health and, therefore, addressing health inequalities only with a change on one's lifestyle may not always be viable and arises many ethical concerns that should be considered. One of them is social justice: the lifestyle drift approach may not only be useless to reduce health inequalities, but it may exacerbate them due to the fact that not everyone in a population has the same opportunities and possibilities to change their lifestyle. In fact, the distribution of healthy behaviour in a society follows the same gradient as wealth distribution does (Williams & Fullagar, 2018) . This makes easy to predict that the gap between the most vulnerable subpopulations and the most privileged ones won't diminish by promoting Public Health policies and discourses of individual empowerment and

personal health responsibility. However, collective action and structural reforms, might be a more viable alternative.

ECONOMIC CRISIS: AN ANALYSIS OF HEALTH INEQUALITIES DURING NEOLIBERAL PERIOD

Socioeconomic inequalities and, therefore, inequalities in health tend to increase even more during economic and financial crisis periods. The Great Recession of 2008 coincided with the rage of neoliberalism ideology, characterised by the deregulation of the market which resulted on the circumstances that preceded the 2008 global financial crisis (De Vogli, 2014). Austerity policies were implemented in several countries, which not only exacerbated the financial debt crisis and the wealth gap between social groups, but also introduced neoliberalism as the solution in the design of Public Health policies (De Vogli, 2014). Lifestyle drift approach emerged at the same time in which neoliberal ideology was ascending and becoming the dominant political and economic influence in Western countries. With this new political context based on market-oriented logics and individual responsibility, Public Health has also been entangled in processes of marketisation (Williams & Fullagar, 2018) and it has been hard to ensure socially-oriented policies that have significant influence to change social distribution of health and, therefore, to reduce inequalities.

In the specific context after a crisis, such as the Great Recession, the lifestyle draft made even harder to address socioeconomic inequalities and their resulting health inequalities because they are not seen as a social problem but as an individual one, which leads to the victim-blaming problem (De Vogli, 2014).

The effects of the crisis were mostly felt by low-income workers, small employers and the poorest subgroups of the entire population whose health outcomes were significantly worrying. During the first years of the crisis (2008 - 2010) there were 290 suicides attributable to the financial crisis consequences (such as unemployment) in Italy. Meanwhile, in Spain there was a positive correlation between unemployment and suicide rates (De Vogli, 2014). Socioeconomic inequalities widened between extreme groups of population which lead to differential health effects in different socioeconomic groups: the 2008 crisis in Spain increased inequalities regarding mental health, infectious diseases such as HIV and AIDS and healthy lifestyle such as diet and sedentarism in adults over

50. In addition, there is also evidence on how these health inequalities are gender biased: women over 50 were the most affected group in the Catalan population after the Great Recession. A possible explanation to this might be the relation between their economic resources and own health with their home living conditions (presence of gender violence) and their job access (or lack thereof) (Spijker & Zueras, 2018).

Despite those years after the beginning of the 2008 crisis both socioeconomic and health inequalities decreased. However, the highest and wealthiest subgroups of society are still much better informed about the importance of healthy lifestyle than the lowest and less privileged ones (Spijker & Zueras, 2018) which makes evident the inefficiency that the lifestyle drift will suppose in a post-crisis scenario. When policies are already being focused on population lifestyle, neoliberal governance is able to shift responsibility to individual citizens, making them guilty not only of their risky and non-healthy behaviour but also of the difficulties they find while trying to adopt healthy lifestyles (Williams & Fullagar, 2018). After all, it would seem rational to think that governments in Europe made efforts to design redistributive policies, invested in social protection and, after that, promoted sustainable health in order to prevent future financial and economic crisis and safeguard Public Health. This was not the case and, in fact, policies became even more neoliberal increasing marketisation and individualisation of health during last years (Williams & Fullagar, 2018; De Vogli, 2014).

Even though the causes of the current crisis that Western societies are living are very different from the Great Recession, it may lead to similar consequences regarding health inequalities. Many governments have claimed that COVID-19 virus makes no distinctions between social classes and that it affects equally to all the population. It might be biologically true but, even though it is too soon to observe the health outcomes distributions after COVID-19, it is already possible to observe how the potential exposure to the virus has a clear social gradient. In Barcelona, the geographic distribution of infected people reveals that those neighbourhoods with a highest number of infections are also the lowest income neighbourhoods (Roquetes with 0,53% of the population infected and Sant Andreu with 0,49% of the population infected), while the lowest number of infections are found in the wealthiest neighbourhoods (Sant Gervasi-Galbany with 0,07% of the population infected) (AQuAS, 2020) . This may be due to the fact that in Spain, where the lockdown measures are one of the strictest in Europe, manufacturing workers have been the only non-essential workers that have been obliged to go to work in order

to maintain their job. Manufacturing jobs are well-known to be the lowest income jobs in Spain, which means that the potential exposure to the virus is higher for lower income workers.

Furthermore, in Spain, 53,3% of the single-parent families are in high risk of entering the extreme poverty level and have no access to internet. Thus, children belonging to these families will have no option to finish the scholar course which means that the educational gap between subpopulation groups will be wider at the end of the year if no solution is given (Tena, 2020).

CONCLUSIONS

Although it is still too soon to know which will be the health outcomes of this current crisis and how it will affect health status of different subgroups of the population, it can already be observed that socioeconomic inequalities are shaping how COVID-19 is affecting people's health following a socioeconomic gradient. Taking as a reference the Great Recession crisis of 2008 (and being aware of the existing differences) it can be predicted that there will be a need for Public Health interventions. In order to reduce the widening of health inequalities it will be essential to understand social determinants of health as the underlying cause of health inequalities. If not, health inequalities will be addressed only with a lifestyle drift approach which may even increase inequalities on health.

Reducing health inequalities and improving health is a duty and should be considered a priority for any government which aims to promote and support social justice. If governments do believe in the principle of social justice it may be the moment to address not only health inequalities through healthy lifestyle promotion, but also to reduce socioeconomic inequalities through, for instance, wealth redistribution among population or by the establishment of clearer limits to the market's free regulation. Without a clear effort and commitment on these lines of action it will become almost impossible to achieve the transformation needed to eliminate health inequalities. Public Health policies and actions should address the social determinants of health to build bridges to a healthier life and stop promoting self-responsibility to learn how to swim to arrive at the other side of the river.

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