A HANDBOOK FOR

TRAINEE NURSING ASSOCIATES

EDITED BY
Neil Davison and David Matthews

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ISBN: 9781914962042

Lantern Publishing Ltd, The Old Hayloft, Vantage Business Park, Bloxham Rd, Banbury, OX16 9UX, UK
www.lanternpublishing.com

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Cover design by AM Graphic Design Ltd

Typeset by PageMajik Pvt Ltd, India

Printed in the UK

Last digit is the print number: 10 9 8 7 6 5 4 3 2 1

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PREFACE

Registered nursing associates are important members of the modern healthcare team. The *Handbook for Trainee Nursing Associates* provides relevant theory to support trainees on their level 5 educational programme and towards registration with the Nursing and Midwifery Council (NMC). It will also be the foundation for their future practice as nursing associates. Each chapter is linked to the outcomes of the NMC's *Standards of Proficiency for Registered Nursing Associates* (2018) and uses activities and examples to apply theory to contemporary practice.

Neil Davison
David Matthews

Acknowledgements

Our thanks must go to Lynne Bedson, a colleague and lecturer with considerable experience of teaching healthcare students. Lynne raised the idea of a book like this and its value to trainee nursing associates over coffee and informal chats.

ABOUT THE AUTHORS

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Neil worked in trauma and orthopaedics after the completion of his state registration and orthopaedic nursing qualifications in the 1970s and early 1980s. He lectured at Bangor University for two decades where he was made a Teaching Fellow in 1999. He has presented papers nationally, published in journals and has written a book on clinical calculations and numeracy, now in its second edition.

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Josh is a Senior Lecturer in Learning Disabilities at Teesside University. A second-generation nurse, he's been working in the field for around 15 years and has been a Registered Nurse in Learning Disabilities (RNLD) for just over 10 years. Josh has worked predominantly in the private sector across a range of services including learning disabilities, mental health, end of life care, clinical assessment and management. He is currently studying towards his doctorate and is examining perceptions of the field of learning disability nursing with a view to uncovering people's experiences and increasing understanding.

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Anneyce Knight

The late Anneyce Knight, who died in 2021, had retired earlier that year from her role as Associate Dean for Global Engagement and Senior Lecturer in Adult Nursing at Bournemouth University, where she was also the Programme Leader for the Return to Nursing Practice course. She qualified as a registered nurse in 1982 and worked in orthopaedics and oncology, then trained as a midwife. She continued to practise in a variety of nursing and midwifery clinical settings before moving into Higher Education in 2000. Prior to taking up her role at Bournemouth University in 2015, Anneyce was the Course Lead for the innovative Foundation Degree in Health and Social Care (clinical) for Associate Practitioners, a joint NHS and Southampton Solent University collaboration. Previously she was at the University of Greenwich, where she held a number of positions. She was passionate about the need for compassionate care, thereby enhancing the quality of patient care, particularly at the end of life. Her primary research interests focused on public health and wellbeing, areas in which she published and presented nationally and internationally.

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David is a Lecturer in health and social care at Bangor University, and is programme leader for its BA Health and Social Care, where he teaches issues and subjects relating to the social determinants of health and health policy, as well as supervising undergraduate and postgraduate dissertations. His research interests and publications focus on critical and materialist understandings of the welfare state and social policy, with a particular emphasis on the impact of neoliberalism and capitalism for physical and mental health. In addition, he has an interest in the development and evolution of Welsh health policy during the era of devolution.

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4 SOCIETY AND ITS IMPACT ON HEALTH

David Matthews

This chapter relates to outcomes 1.11, 2.4, 2.5, 2.6, 3.1 and 3.2 within the *Standards of Proficiency for Nursing Associates* (NMC, 2018).

LEARNING OUTCOMES

When you have completed this chapter you should be able to:

- Understand that the concept of health is not fixed, but that there exist competing models.
- Recognise that the experience of health and wellbeing is not just a biological issue, but is greatly determined by society.
- Have an awareness of key social determinants of health and wellbeing.
- Understand how good and bad health, alongside wellbeing more generally, is unequally distributed among social groups as a result of their social circumstances.

4.1 Introduction

The purpose of this chapter is to provide an overview of how society influences the health of individuals. It will be demonstrated that health is unequally distributed throughout society as a result of varying social circumstances people experience. Biology dominates our knowledge of health. Differences in health between individuals are frequently assumed to initially be a result of biological variation. However, as significant as biology is, social experiences are also greatly influential. As Marmot (2016) argues, health cannot be left to doctors alone. Rather it must be accepted that the social conditions within which individuals are born, develop as children, work and age, have significant consequences for health (Marmot, 2016). There is indeed little evidence to suggest that poor health is caused purely by biological phenomena operating in isolation from social factors (White, 2017).

4.2 Social determinants of health

When discussing how society contributes to the experience of health, and how social factors shape and organise both good and poor health, reference is frequently made to the social determinants of health. These are those social, political and economic factors that influence the health of individuals, communities and populations (Humber, 2019). Accepting them as significant, the World Health Organization (WHO) defined the social determinants of health as "the conditions in which people are born, grow, work, live and age, and people's access to power, money and resources. The social determinants are the major drivers of health inequities" (WHO, 2021a). For the WHO, the social determinants of health greatly determine the opportunity for all individuals to achieve good physical and mental health. In response to Covid-19, the distribution of which, the WHO argued, was greatly influenced by the social determinants of health, the WHO argued that individuals with enhanced living and working conditions, higher levels of education, and good access to health and welfare services, had a better opportunity of protecting themselves from Covid-19 (WHO, 2021a).

ACTIVITY 4.1

Why do you think enhanced access to, and a good experience of, the following factors might have provided added protection from Covid-19?

- Living conditions
- Working environment
- Education
- Health and welfare services

For Dahlgren and Whitehead (1991), there exist varying social determinants of health, ranging from those considered to be related more to lifestyle and behavioural issues (more about which can be found in the chapter on public health and health promotion), to others which are largely the result of the way society operates and is organised (*Figure 4.1*). Given their breadth, it is not possible in a single chapter to cover them all. Consequently, three of the most significant social determinants will be examined here, these being determinants which all nursing associates are likely to experience, in varying ways, as impacting upon the health of their service users. These determinants are:

1. Social class
2. Gender
3. Ethnicity.

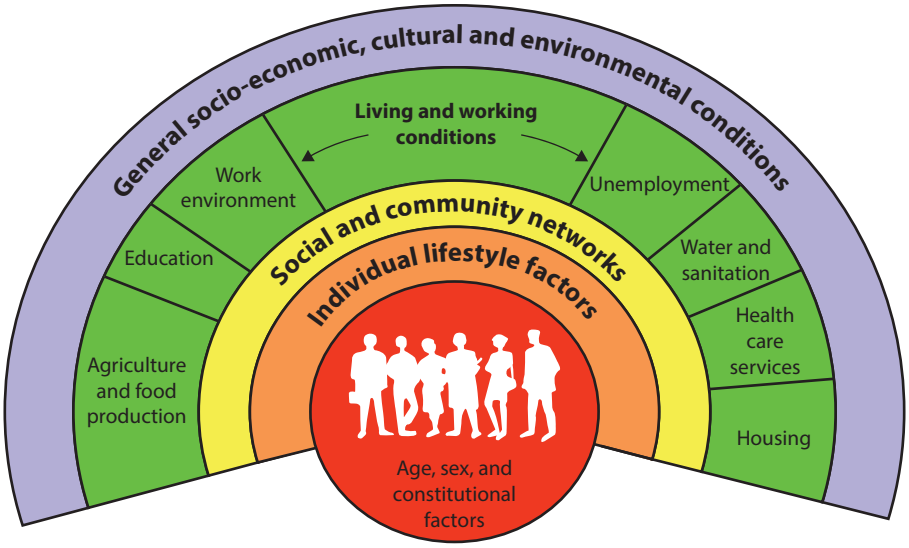

Figure 4.1: *The Dahlgren–Whitehead rainbow. Reproduced with permission from Institute for Futures Studies.*

Before examining how society influences the distribution of health, however, an argument will be made exemplifying why, as nursing associates, it is important for you to have an understanding of how society influences health.

4.3 Why society? Understanding your service users

Few would argue against the claim that fundamental to the provision of good quality care is ensuring that all service users are understood as individuals, having specific personality characteristics and needs which must be met. As such, an understanding of service users is essential if, as a nursing associate, you are to deliver the best service. An awareness of how society works is essential for this. Significant aspects of an individual's personality, identity and character, including their health, are influenced by social factors and the individual's place in society. Awareness of how social factors subsequently influence the distribution of health within the population is crucial for nursing associates, in order to understand how particular health issues are distributed among social groups, and broadly associated with individuals from different social backgrounds. The benefits of this awareness are particularly evident for nursing associates when considering the locality in which you work.

» **Understanding your service users and how social factors influence their health is essential to deliver the best service.**

All localities have social characteristics. For example, it is commonly identified that some areas are affluent and some seen as deprived, while others can be considered as populated by members of different ethnic groups

and characterised by different cultures. With this being so, all localities are dominated by particular social groups and social issues. By way of illustration, a hospital in a deprived area can expect a higher proportion of service users from lower social classes, potentially single parents, and possibly ethnic minorities.

Drug and alcohol abuse may also be more prevalent than in more affluent areas, along with the effects of poverty such as poor diet and substandard housing. As a nursing associate it is important to develop an understanding of the social characteristics of the locality in which you work, as this will allow you to become more familiar with and develop an awareness of the types of individuals you are more likely to be caring for, the specific social determinants of health your service users may experience, and the subsequent potential health issues service users may experience as a consequence of the social determinants they are exposed to. In effect, it is important to realise that being a nursing associate may very well be different, despite doing the same job, depending upon the locality where you work, as a consequence of the social characteristics of the locality and the impact of those characteristics on service users.

ACTIVITY 4.2

Think about the locality in which you are training. What are some of its social characteristics? Think about such things as wealth and poverty, the ethnic backgrounds of the people living there, their age profile, and so on.

RECAP

- The social determinants of health are those social, political and economic factors that influence the health of individuals, communities and populations.
- It is important to develop an understanding of your service users as individuals.
- An awareness of the social characteristics of the locality in which you work and the impact of those characteristics on service users is also important in delivering the best service to your users.

4.4 Biomedical model

While it might be thought that health is straightforward to understand, especially if it is considered a biological phenomenon, there is in fact no fixed understanding of it. Instead there are competing definitions and models of health which professionals draw upon to frame their perspectives and actions.

Two of the most dominant definitions of health are that of the biomedical model and social model, with the latter being the model adopted in this chapter.

The biomedical model, Barry and Yuill (2016) argue, is the primary way of understanding health. At the centre of this model is the human body and its biological composition, with poor health having its aetiological cause in the biological dysfunction of the body. All diseases, this model contends, have a biological cause which impacts upon the body in a universal and predictable manner. As a consequence, Germov (2012) asserts that, theoretically at least, there exist universal remedies, with the same 'cure' applied to everyone who experiences the same disease. With the cause of poor health being considered biological, it is subsequently the body which is the focus of attention in efforts to alleviate symptoms and correct problems. Medical professionals intervene, often with the use of medicines, drugs and operative procedures, directing their attention towards those aspects of the body which are thought to need correction. As a consequence, the biomedical model embraces and promotes the use of medical technology to treat poor health and encourage good health.

The biomedical model is commonly considered reductionist, reducing the cause of poor health to one single determinant, that of biology (White, 2017). As medical science has advanced, there has been an ever greater focus on increasingly smaller aspects of the human body, such as cells, molecules and genes as the causes of poor health, focusing more and more on these biological aspects at the expense of psychological and social causes.

ACTIVITY 4.3

Why do you think the biomedical model is the dominant way of understanding health in society?

4.5 Social model

In contrast to the biomedical model is the social model of health. Within the social science disciplines of sociology and social policy, as well as for many individuals in the fields of public health, health promotion and epidemiology, this model provides an alternative framework for understanding health, with the origins of poor health seen as something greatly influenced by society.

Over the last few decades, the causes of morbidity and mortality, globally, have increasingly been identified as the result of individuals acquiring chronic illnesses (Barry and Yuill, 2016). As of 2021, according to WHO, such diseases accounted for 71% of all global deaths, with cardiovascular disease, cancer, diabetes and respiratory issues amounting to 80% of all premature deaths

caused by chronic illnesses (see *Table 4.1*). Such illnesses, however, do not largely originate from biological processes located within the body, but are the result of social conditions, circumstances and behaviour (White, 2017). They are therefore social in origin. Subsequently, we can talk of social pathology.

Table 4.1 *The main causes of death as a result of non-communicable disease in 2021 globally (WHO, 2021b)*

Non-communicable disease	Number of deaths
Cardiovascular disease	17.9 million
Cancers	9.3 million
Respiratory disease	4.1 million
Diabetes	1.5 million

Although not ignoring biology, the social model of health does not start with biological phenomena as the cause of poor health. It places health within a social context. The social model understands health to be influenced by social factors. They include, among other social causes, social class, working conditions, housing, the urban landscape, gender, ethnicity, and access to public services (see *Figure 4.2*). The social model contends that health is the result of the interaction between the individual and their social environment. With individuals experiencing various social conditions which are either conducive or detrimental to their health, it is the case that both good and poor health are unevenly distributed throughout society, with society being characterised by health inequalities where some groups in society are exposed to more negative social factors than other groups.

» **The social model of health places health within a social context.**

From the perspective of the social model, methods to promote good health cannot rely upon biomedical interventions alone. Instead, they must focus upon the social circumstances of individuals, as well as wider social factors which are beyond the immediate influence of the individual, such as the availability of, and access to, public services and welfare support, reducing income inequality, provision of affordable housing, and greater access to educational opportunities, among many others.

ACTIVITY 4.4

Which health services in the UK do you think are influenced by the biomedical model of health and which services are influenced by the social model of health?

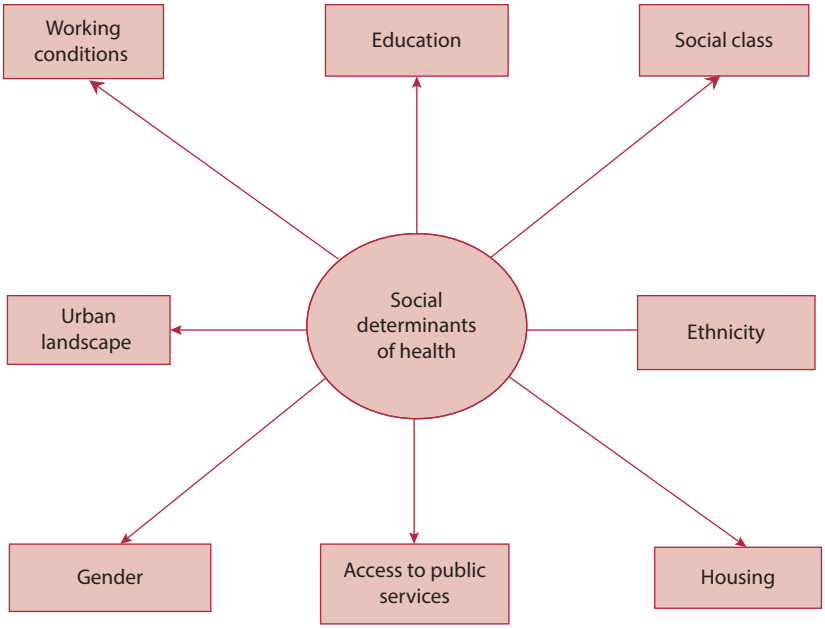

Figure 4.2 *Key social determinants of health.*

Accepting that social determinants play a role in influencing health is to accept the importance of the social model of health. Having discussed what is meant by the social determinants of health and the social model, we now need to examine in more detail how social class, gender and ethnicity can impact upon the health of individuals.

4.6 Social class, money and wealth

» **Low income and poor working conditions have a detrimental impact on an individual's health.**

Various and often contested measurements of and efforts to define an individual's social class exist. Arguably one of the more common is that based upon the indicators of occupation and income. How income impacts upon health is significant, with a strong established relationship between low income and poor health (Marmot *et al.*, 2020). Further, there exists a definitive correlation between health and occupation, with insecure poorly paid employment and poor working conditions having a detrimental impact upon health and wellbeing, both physically and mentally (Marmot *et al.*, 2020). Overall, on average, in a country such as the UK, the less income an individual has, the poorer their health will be. This is known as the social gradient of health.

ACTIVITY 4.5

In what ways can insecure, poorly paid employment impact negatively upon someone's physical and mental health?

In the UK, a country which has high levels of income inequality, health inequalities can be dramatic. Between 2017 and 2019, in England, life expectancy (LE) for males living in the 10% most deprived neighbourhoods was an average of 74.1 years, compared to 83.5 years for males living in the wealthiest 10%. Similarly, for women in the most deprived neighbourhoods, LE was 78.7 years in comparison to 86.4 years for those living in the wealthiest neighbourhoods (ONS, 2021). Additionally, there exist significant variations in healthy life expectancy (HLE), which is the number of years an individual can expect to live in good health. In the most deprived localities in England, between 2017 and 2019, male and female HLE was 52.3 years and 51.4 years respectively, compared to 70.7 for males and 71.2 for females in the most affluent localities (ONS, 2021). The wealthiest men and women in the UK can expect to experience nearly two decades more of healthy life compared to the poorest. Statistically there exists a strong correlation between wealth and health, yet statistics tell us very little about the social circumstances which contribute to this pattern.

4.6.1 Materialism and the conditions of life

The manner in which social class and income influence the distribution of health can be illustrated with what are referred to as materialist factors. A materialist understanding of health focuses on those factors which influence the conditions in which individuals live and work (White, 2017). While materialist influences are plenty, of particular significance are occupation and working conditions, the physical organisation of the urban landscape, availability of and access to public services, educational opportunities, housing, exposure to pollution and environmental decline, and diet. More often, the unequal distribution of income influences the relationship between individuals and all these factors, with those on low incomes tending to be exposed to unhealthier material conditions.

Our modern understanding of a materialist approach to health originates from the investigations of Friedrich Engels (1845). Investigating the health conditions of the working class in England during the mid-nineteenth century, he argued that ill health was significantly influenced by the pursuit of profit; the majority of working class individuals in this time worked in dangerous circumstances, resulting in disability and sometimes death, and lived in overcrowded conditions spreading disease because of poverty.

Occupation can greatly impact an individual's health. Where people work in manual occupations, such as in heavy industry, in factories, or in construction, risks of injury and accidents are inevitably greater, despite the existence and growth of health and safety regulations over the last century in countries such as the UK. However, while many incidents of occupational mortality and morbidity are often associated with manual occupations positioned at the lower end of the social class spectrum, occupations thought to be middle class can also have negative consequences for an individual's health. White-collar occupations expose workers to increased risk of problems such as repetitive strain injury and the potential consequences of sedentary working conditions. Moreover, aside from the physical aspects, many individuals in a variety of jobs, be they manual or white-collar, may also feel a lack of control or autonomy at work, resulting in a sense of alienation which impacts upon their mental wellbeing (Matthews, 2019). On the other hand, more senior white-collar roles may potentially inflict great levels of stress on individuals, which, while having negative consequences for mental wellbeing, can also impact upon physical health such as increasing the risk of cardiovascular disease.

ACTIVITY 4.6

Which occupations and professions do you think have potentially negative consequences for an individual's health?

Alongside occupation, housing, which is one of the most important materialist factors for anyone, can have severe consequences for health. This is overwhelmingly determined by an individual's level of income. Poorer housing increases the risk of experiencing accidents as a result of overcrowding and unsafe conditions, while individuals have a greater chance of developing respiratory problems as a consequence of damp and poor air quality (White, 2017).

Related to housing, the impact of the wider built environment can have significant consequences for ill health. A locality's affluence impacts upon physical features, local resources and the socio-cultural environment (Annandale, 2014). The affluence or poverty of the urban environment influences the development of, and is illustrated by, the availability of public services, housing conditions, levels of pollution, rates of crime, and the quality of private sector enterprises in terms of the goods and services provided, such as takeaways, tanning salons and pawnbroking outlets, as well as access to green space such as parks. The affluence and poverty of space and place can have serious consequences for health.

ACTIVITY 4.7

If an individual lived in an area of a city where there existed high crime rates and increased levels of pollution, how might this impact upon their physical and mental health?

The impact of the urban landscape upon health has been illustrated by the Royal Society for Public Health (RSPH) (2018) in its identification of what constitutes a healthy town. To promote good health, healthy towns require high streets free from excess noise and pollution, architecturally designed to support activities such as walking and cycling, to be planned and provide services to facilitate social interaction and improve social cohesion and to encourage the establishment of businesses providing healthier services and goods. Crucially, the research identified a link between healthy high streets and local deprivation, with the localities of the ten unhealthiest exhibiting greater levels of deprivation than the ten healthiest (RSPH, 2018).

ACTIVITY 4.8

How important is social interaction for an individual's health?

4.7 Gender: men, women and health

It is observed that women have lower mortality rates than men (Annandale, 2014), but suffer greater morbidity (White, 2017). Moreover, certain health and wellbeing issues are commonly claimed to be associated with one gender more than another, with women experiencing greater levels of dementia, depression and arthritis, while men are more prone to lung cancer, cardiovascular disease and suicide (Broom, 2012).

» **Biological differences may influence the different health status of men and women but they do not determine health differences.**

Attempts to explain gender variations commonly draw upon biological differences, with efforts to account for the health status of men and women illustrating supposed inherent biological differences. Consequently, biomedical interpretations often dominate efforts to explain gender health inequalities. This has given rise to the growth of gender-specific medicine utilising scientific analysis to explain variations in the physiological differences between the genders. Scientific analyses, however, can be criticised for overemphasising differences associated with gender. Biologically the division between men and women is far less than is popularly understood. It would, however, be unwise

to dismiss the *influence* of biology on the health of men and women, but biology does not *determine* health differences (Annandale, 2014).

4.7.1 Women as caregivers

The extent to which society determines gender health inequalities is considerable. One influential argument is with regard to gender-specific roles men and women have within society. In relation to women, their role as a carer is identified as having great consequences for their health. Despite increasing involvement by men over the last three to four decades, it is the case that women remain the primary caregivers in society, having the responsibility for the majority of informal care of family members including children, disabled adults and the elderly. As Public Health England (now the UK Health Security Agency since October 2021) argued, a typical carer is likely to be female and in her 50s and 60s. The impact of this often difficult, challenging and time-consuming role on women can include reduced sleep, less leisure time, and increased risk of poverty, should a woman be a full-time carer. All three can have significant direct and indirect consequences for a woman's physical and mental health. Focusing on those who provide care for elderly individuals, Public Health England identified that the consequences of being a carer can include stress, anxiety and depression. Moreover, carers of all individuals who require care are at greater risk of cardiovascular disease, musculoskeletal conditions and cognitive decline (Public Health England, 2021).

Although an assertion which is contestable, women's status as dominant care providers has often been justified as a result of their reproductive function, which in itself has been medicalised. The days immediately prior to menstruation, for instance, are no longer viewed as a time of hormonal imbalance in the form of premenstrual tension (PMT), but a medical syndrome in the form of premenstrual syndrome (PMS) (Morrall, 2009). Over time, women's bodies have increasingly been exposed to the clinical gaze. Over the last half century, or more, women's bodies have been constructed as a medical issue more so than men's, meaning they are scrutinised and regulated more by medical professionals. An increasing medicalisation of women's bodies has meant women consult doctors more regularly and attend hospital more frequently than men (White, 2017).

ACTIVITY 4.9

Think: is more attention given by the medical profession to women's bodies than those of men?

Along with women's role as the main providers of care, medicalisation is a significant reason for women coming into contact more often with medical

professionals and using the health system more than men. Outside childbearing age women have a tendency to attend hospital at the same rate as men (Broom, 2012), and when men and women are exposed to the same stressful non-gender-specific situations they have broadly the same rates of depression (Nazroo *et al.*, 1997). Therefore when these variables are no longer a factor or are controlled, gendered health inequalities are reduced.

4.7.2 Masculinity and femininity

How men and women are expected to behave is greatly determined by society's expectations, with this being influenced by the concepts of femininity and masculinity. Both of these concepts are social constructs, as what it means to be a man or woman is culturally and historically specific, and both concepts have consequences for health. The emphasis society places upon women, more than men, as the main providers of care is a construction of femininity by society. Further, societal pressures regarding femininity in terms of appearance can be identified as contributing to the greater prevalence of eating disorders amongst young women.

Constructions of masculinity can have just as negative consequences for men. In an effort to 'prove' themselves, young males have a tendency to be less risk-averse, taking part in such activities as contact sports, excessive alcohol consumption and dangerous driving. As a result males exhibit higher rates of both accidental and non-accidental injuries (Broom, 2012). Further, while it is claimed that women exhibit greater levels of mental health issues, men have a tendency to internalise anger, turning to substance and alcohol abuse as a source of relief, while women are more likely to express their feelings and seek support. For some men, especially teenage boys and young men, such pressures can be too much during the transition from adolescence to adulthood, potentially resulting in drug abuse or even suicide (White, 2017).

4.8 Ethnicity and health inequalities

The impact of social class upon the distribution of health has been recognised widely for well over a century, even if there have been at times, among some, a reluctance to acknowledge it. The relationship between gender and health has also long been accepted. However, conceding that ethnicity is also a determinant is a relatively recent phenomenon. Only since the 1970s has there been any serious attempt to both recognise and analyse its impact upon the social distribution of health (Karlsen and Nazroo, 2000).

Efforts to understand the extent to which ethnicity contributes to health are at times hampered and made more complex by the fact that ethnicity can prove difficult to determine. Broadly, ethnicity refers to the identification of population groups based upon social, cultural and historical variations. Ethnic groups are

characterised by organised cultural boundaries such as language, religion and country of origin, which differentiate groups. Ethnicity is a subjective concept, consisting both of self-identification and categorisation by others. Individuals can recognise themselves as belonging to a particular group, with the way they subsequently act and think influencing the perception they have of their ethnicity. Thus ethnicity can be considered as an active construction of its members. At the same time individuals can be categorised as belonging to an ethnic group by others; they are therefore labelled as belonging to an ethnicity based upon others' interpretations. Ethnicity is consequently an arbitrary concept, with this presenting a challenge to health researchers.

ACTIVITY 4.10

What ethnicity do you consider yourself to be, and what are you drawing upon to differentiate yourself from people who you think are from different ethnic backgrounds from yourself?

4.8.1 Ethnicity as a health inequality

» **There is a lack of evidence to support the assertion that biological and genetic variation among different ethnic groups accounts for health disparities, and many professionals and academic disciplines reject this argument.**

Historically, discussions relating to how ethnicity impacts upon health often focused on the role of biology and genetics, with it broadly argued that health differences between ethnic groups could be largely accounted for by biological and genetic variation among different ethnic groups (Barry and Yuill, 2016). Contemporary debates, however, dismiss this position. While the reasons for health variations between ethnic groups are contested, many professionals and academic disciplines reject emphatically biological and genetic interpretations due to the lack of evidence. Various global population groups may be characterised as possessing certain genes, but these predominantly influence hair, eye and skin colour and are of little importance with regard to the body's susceptibility to disease (Bartley, 2016). Global populations have far more biological and genetic commonalities than differences, and any variations which do exist are no greater than those that exist within one population group (White, 2017). Attempts to focus upon, and identify, biological and genetic causes for the ill health experienced by ethnic groups conjure up the real danger of falling into racist assertions.

Not uncommonly, as Barry and Yuill (2016) argue, certain health concerns have been associated with particular ethnic groups, with such claims often predicated upon assumptions of biological and genetic dispositions towards

various health problems. Sickle cell disease (SCD) is one such issue. Originating from a genetic mutation which historically developed as a form of protection against malaria, SCD is a blood disorder which can cause pain, tiredness and fatigue, and has commonly been associated with individuals from African and Afro-Caribbean backgrounds. Yet it does not exclusively affect these groups. Individuals from Middle Eastern, southern European and Hispanic backgrounds have the potential to develop it. Overall, Barry and Yuill (2016) argue, those who are at risk are primarily individuals whose ancestry lies within a country where malaria was commonplace at one point. Although its origins lie within the genetic structure of an individual, from the evidence available it can be concluded that the actual distribution of SCD is, in fact, far more widespread among individuals from different ethnic backgrounds than has been commonly thought. It is inaccurate to suggest that it can be identified with one or only a handful of ethnic groups, as its prevalence cuts across a varying number of different peoples.

With SCD having been commonly associated with African and Afro-Caribbean individuals, this is an illustration of what Carter and Dyson (2011) describe as the ethnoisation of disease. This, they assert, refers to the popular association of a specific disease with one particular ethnicity, while conversely assuming that it does not impact upon others. As there is limited evidence that biology and genetics account for much of the variation in health status among ethnic groups, there exists little reason to believe that there are certain ethnic minority groups who are more prone to experience certain diseases simply as a result of their ethnicity.

4.8.2 Ethnicity and health: a complex picture

Efforts to understand the relationship between ethnicity and health are invariably complex. Nonetheless, it is possible to identify a broad picture. Evidence produced by Raleigh and Holmes (2021) illustrated the complexity of ethnic health inequalities; they argued that, in the UK, health inequalities exist between ethnic minorities and the ethnic majority population, as well as between ethnic minorities themselves. Drawing upon evidence from self-reported perceptions of their own health, Raleigh and Holmes (2021) argued that ethnic minority groups, in particular Pakistani and Bangladeshi individuals, are more likely to report long-term illness and poor health than White British population groups. Moreover, White Gypsy and Irish Traveller individuals reported the poorest health of all ethnic groups.

Focusing on specific aspects of health, Raleigh and Holmes (2021) identified some notable inequalities. In relation to maternal mortality, although the absolute numbers are relatively low, compared to white mothers, women from Black ethnic backgrounds were more than four times as likely to die during

childbirth, with women from Asian backgrounds twice as likely. Additionally, Raleigh and Holmes (2021) found rates of infant mortality were greater among ethnic minorities. In examining why this was so varied among ethnic groups, however, poverty and deprivation were identified as significant, with a higher proportion of mothers from ethnic minority backgrounds living in poverty compared to white mothers. Deprivation, it was argued, could also account for the higher rates of childhood obesity among Black and Asian children. Among adults, it has been identified that those from South Asian groups consistently exhibit higher rates of cardiovascular disease compared with individuals from white backgrounds, as well as the national average. On the other hand, individuals from Black backgrounds have lower rates than the national average.

When examining the determinants of ethnic minority health, Raleigh and Holmes (2021) largely disregard smoking and alcohol, with levels of use largely lower among ethnic minorities compared to the white population. Furthermore, rates of physical activity vary among ethnic minorities, while, on average, ethnic minority individuals are less likely to eat the recommended portions of fruit and vegetables per day.

That health issues can disproportionately impact upon ethnic minorities was significantly illustrated during the Covid-19 pandemic of 2020–21. Among other studies illustrating similar evidence, Sze *et al.* (2020) argued that there was a clear correlation between ethnicity and Covid-19, with higher infection rates among Asian and Black ethnic minority communities in both the UK and the USA. Similarly, Khanijahani's (2021) analysis identified both higher infection rates and mortality levels as a consequence of Covid-19 among communities with large black ethnic minority populations in the USA. Moreover, Raleigh and Holmes (2021) argued that in the UK, during the first wave of Covid-19, ethic minority groups had higher rates of mortality than the white British population. A knee-jerk reaction to such evidence would be to try to identify the causes of increased ethnic minority susceptibility within biological and genetic explanations. However, the evidence for this has been, at best, negligible. In an effort to understand why ethnic minorities have a tendency to display poorer rates of health and wellbeing, we must look to social and economic factors.

4.8.3 Social and economic inequality and ethnicity

It has been common to try to explain health disparities among ethnic groups by reducing them to cultural factors, arguing that the origins of ethnic minority ill health are located within the cultural norms and values of the ethnic minority group, with any disadvantage being the result of their own practices and attitudes. This perspective, however, has been labelled as a 'blaming' approach, as it is the culture of the ethnic minority group which is considered at fault

(Nazroo, 2004). As with biological and genetic arguments, this approach ignores social and economic inequalities which contribute to health disparities.

In wealthy nations, including the UK, it is not uncommon for many ethnic minorities to live in conditions of social deprivation, experiencing poverty, low income and unemployment on a scale greater than the ethnic majority population. Recognising the relationship between socioeconomic status and health, Raleigh and Holmes (2021) argued that Asian and Black groups are more likely to live in a low income household than members of the white British population, overcrowding is higher among ethnic minority households, while unemployment in Pakistani, Bangladeshi and Black communities is roughly double the national average. From research conducted during the 1990s, Nazroo (2004) concluded that there was a strong relationship between socioeconomic status and the health of all ethnic minorities, as once the impact of socioeconomic status was removed, the risk of poor health was reduced. Evidence from the USA supported this, with both high income white and black populations displaying greater health than their lower income counterparts (Williams, 2012). Overall, the last quarter of a century has demonstrated that socioeconomic inequality is one of the principal reasons for health disparities experienced by ethnic minorities (Nazroo, 2010).

The consequence of economic inequality for ethnic minority health was illustrated with regard to Covid-19. In their analysis, Sze *et al*. (2020) asserted that a higher proportion of ethnic minorities in the USA were more likely to experience lower socioeconomic status, resulting in an increased chance of living within overcrowded households and sharing communal facilities, thus exacerbating the risk of contact with others who may potentially have had Covid-19. This was supported by Iacobucci (2020) in the UK, who argued that living conditions and occupation influenced rates of Covid-19 among ethnic minorities.

4.8.4 Discrimination and prejudice

Socioeconomic status undoubtedly has a significant impact on health; yet, when factors accounting for its impact are adjusted, there remain disparities of health between ethnic minorities and the ethnic majority populations. When the health status of ethnic minority and ethnic majority individuals within the same socioeconomic position are compared, ethnic minority individuals still display poorer health. As Nazroo (2004) argues, there exists another component of ethnicity which increases ethnic minorities' susceptibility to poor health; namely, discrimination and prejudice.

Racial prejudice in the UK towards ethnic minorities is very difficult to quantify, primarily due to reservations by individuals with regard to admitting to being

prejudiced. One attempt illustrated in 2017 that 36% of the UK population described themselves as racially prejudiced to varying degrees (Kelley, Khan and Sharrock, 2017). Racial prejudice, both in terms of being a victim and the awareness that such attitudes exist, can have significant negative consequences for an individual's health, in particular their mental health (Annandale, 2014; Barry and Yuill, 2016).

Similarly, racially prejudiced attitudes can be embedded within the way society operates, with its social structures and institutions functioning in a racist manner. Thus, rather than just focusing on the actions of individuals, attention also needs to be drawn to social structures and institutions which operate in a discriminatory manner and which subsequently influence the actions and attitudes of those located within them. Institutional and structural discrimination can, at times, characterise both health and other governmental services which collaborate with the health sector. This can be exemplified in relation to mental health, where the institutional attitudes and practices of mental health services and the criminal justice system have been argued as contributing to some of the ethnic disparities identified in relation to mental illness.

ACTIVITY 4.11

In what ways do you think racism and discrimination can impact negatively upon an individual's health?

CHAPTER SUMMARY

- Health is not just a biological phenomenon, caused by the malfunctioning of the body and its biological system. Rather, health is as much a social phenomenon.
- Not everyone in society has an equal chance of experiencing good and poor health. The experience of good health is unevenly distributed in society. The result is a society characterised by health inequalities.
- There exist various social determinants of health which contribute to its uneven distribution among the population.
- As well as focusing upon medical interventions in order to promote positive health, it is important to understand that a fundamental component of a healthy population is a healthy society, one in which efforts are made to mitigate against those aspects of society which contribute to poor health.

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