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Revisiting the 'gap'

Intersections of health inequality, poverty, and psychological well-being

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Introduction

Delivery of global health may be a laudable goal but has been traditionally marked by an uneven distribution of quality and access to resources due to a number of reasons. Mental health problems constitute one of the most significant public health challenges of all times, in terms of access, burden, and impact. Inequalities in societies and mental health care intersect with each of these domains and present as potent barriers for health professionals and policymakers alike, perhaps more so in the low- and middle-income countries (LMICs). Nearly one-third of the population worldwide are affected by a mental disorder, and more than 60% of them are deprived of adequate care (Chisholm et al., 2007; Kessler et al., 2005). Neuropsychiatric disorders (substance use, depression, and all forms of psychoses) contribute to nearly 14% of the global disease burden (Prince et al., 2007). Thus, the number of people worldwide suffering from any form of untreated mental illness is in the millions. These untreated diseases affect not only their quality of life, but also that of their carers and families. In addition, 1.5% of global deaths are due to suicide (Fazel and Runeson, 2020): every year nearly 12 in 100,000 people are victims of suicide (Värnik, 2012). Untreated psychiatric disorders are a well-recognized risk factor in cases of suicide and attempted suicide (Vijayakumar et al., 2011). Further, the increase in the mental health gap, as described by the World Health Organization (WHO), disproportionately affects developing and war-stricken nations—countries with high-income inequality and specific vulnerable populations (Ngui & Flores, 2007; Kataoka et al., 2002; World Health Organization, 2008b). With the burden of mental illness projected to double in the next five years, it is vital to explore and understand the inequalities in mental health.

Psychiatric disorders, as one of the major non-communicable illnesses, are strongly influenced by 'social determinants'. Although Engel's biopsychosocial model revamped the conceptualization of mental disorders, the shift towards 'biological psychiatry' marked by the 'decade of the brain' (1990–99) highlighted genetic, molecular, and neuroimaging correlates that have often tended to overshadow the social determinants of mental health. This neurobiological focus had several optimistic outcomes in understanding pathogenesis and neurocircuitry, and popularized the explanatory 'medical model' in the community. Over the last few decades, targeted psychopharmacological interventions, and genetic insights into mental disorders and physiology of the brain have certainly improved our understanding of brain structures and functioning. However, similar to the clouding of social causation theories in the nineteenth century by 'biological psychiatry', this continued 'medicalization' has gradually distanced mental health from its social and environmental correlates, which are substantial in explaining its global inequality. In the words of Thomas Insel, past director of the National Institute of Mental Health, 'imaging/genetic studies have not yet impacted the diagnosis and treatment of 45 million Americans with serious or moderate mental illness each year' (Insel, 2009). The 'population-based public health approach' in managing mental disorders focuses on the social determinants to understand their prevalence, causation, and impact within the community, not particularly the 'individual' (DHSS 1999). Frieden's health impact pyramid (Frieden, 2010) further focused on this 'population approach', highlighting the need to reduce the unequal distribution of psychiatric disorders. Interventions that changed the individual's social context, enabling them to develop healthier choices and deal with the related socioeconomic factors, were shown to bear a maximum impact and improve outcomes. The social determinants (environmental conditions and social circumstances in which we are born, brought up, work, live, and age) influence and diversify all health outcomes—physical or psychological (see Chapter 20). However, these connotations are often ignored, which also resonate with the 'unequal' importance given to mental health. In this way, the traditional diagnostic systems fail to capture the widely prevalent social inequality of mental health. These inequalities can be experienced at various individual, social and ecological levels.

The Millennium Development Goals (World Health Organization, 2018) have been criticized for neglecting these mental health inequalities (Miranda & Patel, 2005; Thornicroft & Patel, 2014) (see

Chapter 69). The WHO emphasized that the social determinants of health do not 'operate in a vacuum', but are influenced by the global distribution of power, finance, and resources (World Health Organization, 2008a). Thus, discussion about social inequalities in mental health cannot be isolated from socio-economic and political scenarios. Health equity can be achieved only through the appropriate homeostasis of these social determinants (Whitehead, 1991). These differences can be multifactorial (e.g. ethnic, racial, socio-economic, geopolitical, etc.). Over the years, the bidirectional linear relationship between financial impoverishment or poverty and mental illness has evolved into a more complex interplay of income inequality, social gradient, and social injustice. The 'social gradient' is not purely an economic term, but is affected by cultural, environmental, and relational influences (Wilkinson & Pickett, 2006). Higher rates of depressive and anxiety disorders have been reported with greater social inequality (Ribeiro et al., 2017), as well as an increase in rates of drug abuse, teenage pregnancies, violence, imprisonment, and quality of life—all of which influence population well-being (Wilkinson & Pickett, 2011). The consequences of these mental health inequalities have also been amplified and politicized as a reductionistic approach to 'blame' poor mental health outcomes solely on poverty and worse living conditions (Read, 2010). Nevertheless, the consequences of such an unequal distribution of mental illness and health care access can be devastating and prolonged. This chapter attempts to provide a synthesized view of the globally prevalent social inequalities of mental health and the impact of urbanization, to critically assess the intersections between poverty and psychiatric disorders, and, finally to highlight possible strategies for mental health care professionals and administrators to preserve and target mental health equity as an integral part of service delivery.

Health inequality

In March 1966, at a convention of the Medical Committee for Human Rights in Chicago, Dr Martin Luther King Jr voiced a concern that remains real even half a century later: 'Of all the forms of inequality, injustice in health care is the most shocking and inhumane' (as cited in Zabel & Stevens, 2006). The contemporary public health challenges of the twenty-first century have been taking place within the context of a rapidly changing political and institutional landscape globally and very recently in the times of a raging pandemic. The COVID-19 pandemic has shown itself to be a 'great equalizer', in that the virus has affected everyone, regardless of their age, socio-economic status, gender, or ethnicity (Kantamneni, 2020). However, the pandemic has shown clear proof—as if proof were needed—that gaps exist in health care services and that access to resources is unequally distributed within and among nations.

Levy and Sidel (2013, p. 5) define health equality as 'the absence of systematic inequalities in health, or in the major social determinants of health, among groups at different levels in the social hierarchy in terms of wealth, power, and/or prestige'. The causes of public ill health are often a complex interplay of myriad factors, many of which occur because of socio-economic and socio-political inequalities, and other injustices, including poverty, inadequate access to and inadequate education, inadequate health care services, and inaccessibility to many essential resources. Those facing social injustice and inequalities are at a greater risk of suffering ill health. This unequal distribution of health risk is conceptualized as health inequality.

The 2010 Global Burden of Disease Study indicated that a given population's health would improve if the prevention and treatment of mental ill health and substance abuse prevention are public health priorities (Gopikumar et al., 2015). However, there are great variations and disparities among individuals and populations, even when they can access mental health services. These persistent factors also influence health outcomes (Gopikumar et al., 2015). Of the persistent factors that maintain socio-economic inequalities and injustice globally, and contribute to physical and mental ill health, 'poverty' has been of particular interest to stakeholders. For decades, poverty has been consistently associated with poor mental health that forms a vicious loop over the life course (Lund, 2012; Murali & Oyebode, 2004; Patel et al., 2018) (see also Chapter 28).

In the next section, the nexus of poverty and mental health are discussed. However, before that, we will provide an overview of poverty as a contributor to socio-economic inequality globally.

Poverty

In the first world health report 'Bridging the Gap', the WHO defined poverty as 'the world's deadliest disease' (WHO, 1995). It wields its destructive influence at every stage of human life, and for most of its victims the only escape is an early grave. Poverty provides that too: while life expectancy is increasing in the most developed countries, it is actually shrinking in some of the poorest. For many millions of people for whom survival is a daily battle, the prospect of a longer life may seem more like a punishment than a prize. The report also highlighted the widening gaps between the rich and the poor, between the poor and the poorer, and between those with and without access to health care worldwide.

Three perspectives are often used to understand poverty: (i) the amount of money required by a person to maintain or support oneself at a minimal level; (ii) the life below a minimum subsistence level and living standard prevalent at a given time in a given place; and (iii) the state of well-being of a few in comparison to the state of deprivation and destitution of the majority in society (Ahuja, 1997). Whereas the first two concepts refer to the economic understanding of *absolute poverty*, the last approach conceptualizes poverty in terms of *relativity and inequality*. It is this last approach that we will focus on, exploring the concerns of the WHO in terms of the importance of poverty as a variable that adversely influences health by disrupting social equality.

Poverty, social inequality and health: the nexus

During a public lecture at Ohio State in 2017, Noble laureate economist Amartya Sen stated that 'There is empirical evidence that living in unequal societies with some people being much worse off, economically and socially, tends to produce deprivations in the absolute quality of life that people enjoy' (Panandiker, 2017). For decades, evidence has been emerging of a strong association between poverty and its direct or indirect effects on the physical, mental, and social well-being of individuals and communities (Murali & Oyebode,

2004; Wilkinson, 1997). While one could equate socio-economic inequality and disadvantage with poverty and poverty with low income and lack of money, socio-economic inequality goes beyond that. One cannot simply understand the relationship between socio-economic inequality and health by focusing solely on money or material disadvantage. Other disadvantages associated with socio-economic positions are also critical for health. Poverty is not the only factor that enables social disadvantage (Marmot, 2015).

Amartya Sen, a pioneer in the concept of capabilities, argues that it is not so much what one has that is important, but instead what one can do with what one has. Marmot et al. (2013a) observed that social inequalities in health might be a consequence of inequalities in capabilities. They propose that any inequalities in these capabilities might be conceptualized as a direct consequence of the social stratification which then promotes and maintains an unequal distribution and access to resources, and this can contribute to a more negatively skewed distribution of empowerment. Such a disempowerment deprives individuals of a number of factors: they may lose control of their life, their well-being, and their health. The WHO linked 'health inequalities within and between countries to inequities in the distribution of power, money, and resources and to the inequities in conditions of daily life to which they give rise' (as cited in Marmot, 2015). There is no doubt that all societies worldwide have socio-economic inequalities, but the magnitude of such variance in inequalities across and within the same society varies. The capability of meeting the essential and critical human needs like health and its determinants, autonomy or control over one's life, self-empowerment, and so on, is likely to adversely affect individual and population health.

It has been shown that poor health correlates positively to low income (Deaton, 2003; Wilkinson & Pickett, 2006). It might also be hypothesized that increasing income inequalities may maintain increasing social divisions and inequality in access to resources.

The Figure 21.1 explains how low income and social inequality reduces access to critical resources like nutrition, sanitation, housing, and education, thus contributing to poor health conditions. This, in turn, leads to out-of-pocket expenditure, adding further to the existing burden of low income and social inequality, and exacerbates the deterioration of the quality of life and well-being.

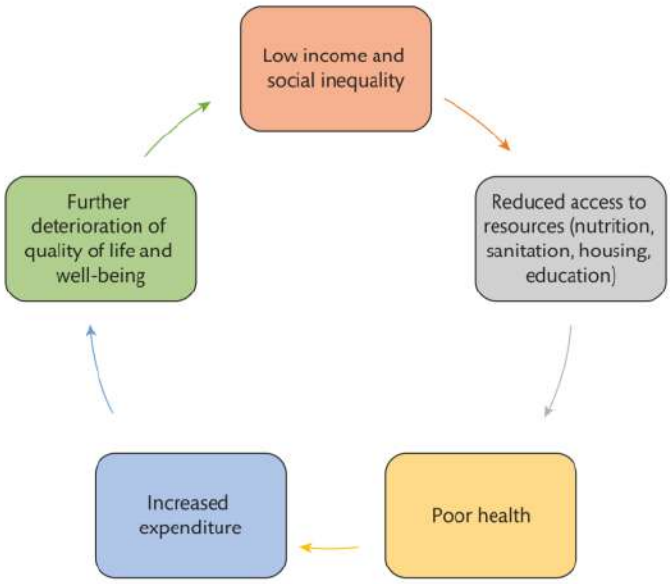

Figure 21.1 Poverty/social inequality, poor health and well-being: the vicious cycle.

While such inequalities are not inevitable, they are a direct consequence of systemic hegemony (the socio-economic dominance over the poor by the oppressive state, society, and system). Social inequalities damage social cohesion, affecting not only socio-economically disadvantaged and marginalized populations, but society at large. A more socially cohesive society is likely to be a healthier society that helps pursue holistic well-being (Marmot et al., 2013b; Putnam, 2000).

Poverty and mental health

There is no argument that poverty and ill health are positively correlated. However, it took a while for researchers and policymakers to reach a consensus about whether poverty contributed to the causation and perpetuation of mental ill health. One of the explanations for this put forward is the so-called dominance of a rather over-simplistic, pessimistic, and reductionist medical model (Read, 2010). Other explanations include the conceptual and methodological complexities around research on poverty (Burns, 2015; Lund, 2012). It has been debated that the diagnostic-based definitions of mental health and heterogeneity in the concept of poverty are the major concerns in this field of research (Cooper et al., 2012). In fact, gross domestic product per capita is one of the most common measures of economic growth and poverty in the population. However, it fails to gauge the distribution of wealth and the extent of poverty, which are the main concerns in various LMICs (Burns, 2015). The disproportionate share of the total wealth in the hands of few forms the concept of 'relative poverty', which is the main driver of mental health, but is, unfortunately, not estimated or researched. Some of the critical challenges in these discussions and observations are as follows.

The first challenge in establishing a causal relationship between poverty and mental health and illness is primarily due to the diverse measures of poverty. Inconsistent and imprecise measures to describe poverty and define psychiatric disorders affect research findings (Cooper et al., 2012). As mentioned earlier, the concept of the absolute measure of poverty is likely to provide a less accurate portrayal of the problem than the relative measure of poverty. Other challenges include a pressing need to examine the relationship at different levels of poverty/wealth, as the effect may vary (Lund, 2014).

There is a need for more theory-driven research in addressing this relationship (Lund, 2014; Burns, 2015). The capabilities framework highlighted by Amartya Sen (discussed previously) and others, for example, is one such 'powerful construct in disability discourse related to the social and economic isolation experienced by people with mental illness' (Ware et al., 2007; Baumgartner & Burns, 2014, as cited in Burns, 2015). There needs to be a more comprehensive approach to measure and understand mental health outcomes, including the severity of the illness (elaborated on later in the 'social drift approach').

There is a strong and significant epidemiological association between mental disorders and low socio-economic status (Kessler et al., 2005; Patel & Kleinman, 2003). Many studies indicate an association between poverty and mental illness (Weich & Lewis, 1998; Jenkins et al., 2008; Butterworth et al., 2009), including depression

(Ridley et al., 2020; World Health Organization, 2007) and schizophrenia, which have twice and eight times more risk in people experiencing poverty, respectively (Holzer et al., 1986). Furthermore, Funk et al. (2012) observed that four of every 10 people with mental disorders are from LMICs.

However, bearing in mind the various challenges noted above, Lund (2012) observes that there have been contradictory data on the interrelationship between mental health and poverty, noting that whereas some research in LMICs (Patel et al., 1999, 2003) indicates 'strong associations between common mental disorders (CMD) and violence, insecurity, lower socio-economic status, lower education levels and rapid social change, particularly among women', others have found weak associations (Das et al., 2007).

Interestingly, in a systematic review on CMD and poverty in LMICs, Lund et al. (2010) found significant, consistent associations between CMD and restricted access to education, food, housing, low social class, low socio-economic status, and financial stress. Nevertheless, these associations were not consistent with 'reduced income and consumption'. This finding is consistent with the World Mental Health Survey conducted in high-income countries that had also reported a 'statistically significant monotonic association between severity of mental disorder and days out of role' (World Health Organization, 2004).

Thus, there appears to be a role of poverty in mental ill health. The debate has now moved on to what aspects of poverty and social inequality may be the strongest drivers (Burns, 2015).

In the next section we explore some of these determining factors.

How might poverty drive mental illness in the poor?

Despite the inadequacy of longitudinal research evidence, two causal pathways have been hypothesized from the existing literature in LMIC and high-income countries (Lund, 2012; Read, 2010; Saraceno et al., 2005). The first is the 'social causation pathway'. It is clear that poverty and socio-economic inequality deny equity and equal access to resources in almost every aspect of life. People in poverty are at increased risk of being a victim of violence and trauma and/or commit a crime; stressful life events; health-related complications due to malnutrition; and unemployment due to adequate education, to name a few. They are also less equipped financially to protect themselves from the adverse consequences of such risks. Cumulatively, all these factors heighten the risk for mental illness among the poor.

The other causal pathway is the 'social drift' hypothesis. It suggests that people who have mental illness are more likely to drift into, or remain in, poverty owing to increased out-of-pocket expenditure, compromised productivity, and job loss associated with social stigma leading to further exclusion and marginalization. This is more likely to be the case in countries where health care systems are private. It has been argued that the social causation hypothesis explains how poverty is a significant cause of mental illness (both common and severe mental illnesses), and the social drift hypothesis explains how poverty is involved in its maintenance (Read, 2010). Thus, the causal mechanism is likely to move in both directions for most mental disorders. This bidirectional relationship is best conceptualized as a vicious cycle (Patel, 2001) (**Figure 21.2**).

Medicalization of poverty: re-evaluating the vicious cycle of poverty and mental illness

In her paper on the politics of 'psychiatrization' of a socio-economic crisis like poverty, Mills (2015) reflects upon the radical changes needed in the field to understand the relationship between poverty and 'distress'. Thus, lived experience of poverty are likely to be related to despair, pain, and loss of the desire to live, and Mills (2015, p. 213) questions whether this distress is mental illness or a normal human experience. As mentioned earlier, much of the existing literature and explanations revolve around the vicious cycle construct of 'poverty–mental illness'. The historical, social, political, economic, and cultural trajectories that construct poverty and mental illnesses are often overlooked in literature.

An individual-centric, psychopathology-oriented focus of the existing system limits the understanding through the disability lens. Medicalization of the lived experience is to see persons living in poverty in clinical and therapeutic terms. Therefore, the problem is often seen as residing in the individuals; the solution is to live in treatment and clinical case management following the medical model. It unnecessarily bounds the range of vulnerabilities we are willing to consider when thinking about factors that make some marginalized groups more vulnerable than other marginalized populations. Thus, the medical model tends to adopt the language of disability. It limits our understanding of the population, creating a bidirectional but linear relationship between poverty and mental illness. By doing so, we tend to focus on explanations and interventions at the level of the individual responsibilities as per 'neoliberal trends', rather than on the structural and systemic landscapes that produce and sustain poverty. Similarly, the capability of being healthy is to be seen at societal/cultural/political, as well as individual, levels. It further assumes the universality of the Western diagnostic categories and treatment without considering the social, cultural, and historical contexts, and that the alleviation of distress might also be possible without medical interventions (Bracken et al., 2012; Mills, 2015; Morrow & Weisser, 2012; Summerfield, 2012). Using diagnostic categories to explore the relationship between social determinants like poverty with mental health may be problematic at an individual level as it imposes particular world views universally. However, these categories may well locate the cause of a sociogenic problem like poverty within individuals. It is essential and critical for research to refocus the 'need' to understand the lived experiences of individuals in poverty (Leavy & Howard, 2013). As mentioned earlier, it begs the question of whether their experiences of 'pain', 'distress', and 'sadness' because of their poverty and socially unequal positioning qualify as 'mental illness'. It does, when one imposes upon them the Western classificatory system of diagnosis without paying attention to the fact that 'symptoms' are not symptoms of such disorders rather 'normal' reactions to their long-standing conditions of poverty or inequality and deprivations (Horwitz & Wakefield, 2006, p. 22). An individualized and medicalized approach to poverty exacerbate the exclusion, alienation, and marginalization of low-income persons and communities to the 'expert' discourse (Schram, 2000, p. 98). Consequently, people living in poverty and those diagnosed as 'mentally ill' (or both) are 'assumed' to be 'incompetent and reliant' on the experts acting in their best interest (Mills, 2015). Furthermore, due to the medicalization of poverty, many antipoverty campaigns have shifted their focus to tending to the 'mental illness symptoms' of those living