Health Inequalities of Addiction

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Author Note

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The presence of health inequality exists as a mediating factor in nearly all causes of mortality and morbidity. In the case of behavioral addictions such as tobacco, drugs, gambling, or alcohol addictions, a clear social patterning is observable in its prevalence among less affluent neighborhoods and lower socio-economic groups. One of the key aims of recent public health policy in the U.S. has been to remove these socio-spatial health inequalities, especially in the case of addictions. The paper will further analyze the causes of addiction-related health inequalities, examine current challenges and propose suitable interventions and changes in this respect.

The current understanding of addiction inequalities points to a complex interrelationship between psychosocial, material, cultural, and behavioral factors that are collectively and individually experienced and which are further influenced by macro-level economic and political arrangements (Bambra, 2018). One of the key areas of health inequality research is intervention-generated inequalities that result from an unequal provision of health services in comparison to the actual needs of the people. The Inverse Care Law illustrates why addiction inequalities exist in less affluent areas in the U.S. Privatization and marketization of healthcare services tend to create a higher likelihood of addiction-related prevention and treatment services being available in areas that can better afford these services and have generally lower health needs (Dickman, Himmelstein, & Woolhandler, 2017). Furthermore, mass health promotion campaigns that rely on media coverage have also been found by multiple studies to exacerbate behavioral addictions, in particular, tobacco and food addiction (Sniehotta, et al., 2017).

Several intervention strategies have been proposed in research to reduce health inequalities especially with respect to addictions. In particular, prevention strategies that focus more on the social aspect of addictions have been found to be particularly effective among lower income groups, instead of solely concentrating on the behavioral aspects, or on fiscal and regulatory approaches such as tobacco pricing, marketing restrictions, standardized packaging, and age restrictions (Sniehotta, et al., 2017). Further changes that could reduce addiction-related health inequalities include combining downstream and upstream approaches by addiction researchers, wherein individual-level cessation interventions are combined to work in tandem with national tobacco and drug control strategies. Addiction researchers and health practitioners should work closely with policymakers to advocate policies that address the social causes of health inequities alongside the behavioral aspects (Bambra, 2018). Additionally, welfare and education policies that promote social protection, prevent housing, labor, and social exclusion, and provide early parenting and childhood education support are important primary interventions that will promote health equities (Bruce & Hawkins, 2019). In addition, health policies must focus on removing social and economic barriers such as inaccessible addiction support services and reducing stigmatization to minimize health inequalities.

The use of systematic health data is particularly helpful in improving health inequalities among addicted populations. An accurate identification of health disparities requires comprehensive data on the individual determinants of health at the state, local, and community levels. Moreover, large scale sample sizes are needed to illustrate these disparities due to a substantially high tendency of the overall population to engage in some form of behavioral addiction. In this regard, measurements should specifically include granular ethnicity, language and race data to provide more accurate estimations of the existing ethnic, racial, or socio-economic disparities among this population group (Bilheimer & Klein, 2010). Furthermore, systematic and standardized health data would bring about granularity, specificity, and consistency in the collected information relevant to ethnicity, race, disability, sex, language, or income based health disparities (Dorsey, et al., 2014). In turn, this would enhance addiction researchers and health practitioner’s ability to track reform and intervention efforts on various subpopulations of addicts facing health inequalities, and advocate policies better suited to target the underlying causes.

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