Short outline for:

**PhD project on social inequity and patient perspectives on life with heart disease**

*This document is only a first and brief outline of the project and it is open to changes. The project will be further developed by the PhD student, and we would therefore like to hear the ideas and thoughts on the project from applicants.*

People with a short education or low income can expect more disease and a shorter life than people with a long education or a high income (1). These social inequalities in health have furthermore been widening both in Europe and Denmark (2). This also holds for cardiovascular diseases (CVD), where ischaemic heart disease, acute myocardial infarction, heart failure and stroke show large differences across educational groups (3).

The causes of social inequalities in CVD are only partly known, differences in lifestyle factors do play a role (4), but from the national Danish health surveys this increased risk is apparent even when adjusting for known risk factors (5). The focus on lifestyle factors tend to remove focus from the fact that the apparent choice of lifestyle is a reflection of underlying more distant causes of disease linked to social and cultural factors including possibilities, knowledge and resources (4).

Also the healthcare service system seems to be involved in maintaining socioeconomic differences in relation to prescribed medication (6), clinical investigation (7) and outcome (8). It might suggest that both the individual's ability to make use of health information and the conduct of staff and the system itself is significant in maintaining unwanted health inequalities related to socioeconomic status.

Although the existence of a social gradient in CVD is well recognized, causes and mediating factors are not well known, and it has been speculated whether both social and psychological factors interact in the ability of gaining and maintaining health. This might be related to both traditional SES factors as education, resources (economy) and status, but also to personal attributes as the ability to understand health information (health literacy) (9), the conviction of being able to handle the surrounding (sense of coherence (10)) and having relations with others (social support or social capital (11)). These factors probably develop in a life course perspective, inherited from parents, established during childhood relation with surrounding, and further developed during life.

Research shows that low health literacy leads to poor health outcomes and widens health inequality (12). In relation to CVD, a study of patients with heart failure in an integrated managed care organization demonstrated that low health literacy was significantly associated with higher all-cause mortality (13). However, even though this points towards heighten the health literacy of patients, it is important to map causes in a broader sense in order to understand the interplay between determinants, as it appears unlikely that more simplistic efforts will change the causes for instance in relation to behavior to improve health.

The objective of this study is to develop new in-depth knowledge on important underlying factors and complex mechanisms that drive inequity in health and health behavior and can aid
new way of intervention that are contextualized and sensitive to patient needs and perspectives.

The specific aim is to explore the underlying and fundamental, social, psychological and cultural factors determining of social inequity of cardiovascular health and obtain indepth information and understanding of lay/patient perspective on these phenomena’s as well as on individual needs and wishes for support and intervention.

Recuiting among participants in an adjunct study, a large survey on e.g. the level of health literacy among patients with heart disease, a purposeful sample will be invited to participate in three substudies, roughly outlined below:

**Substudy 1) Qualitative interviews with patients with low level of health literacy**
This substudy will include patients with established CVD and healthy individuals, all with low health literacy but different age, gender and levels of SES.

The aim of the study is to gain further understanding of the concept of health literacy and the significance of low health literacy for CVD for different social groups and the challenges they meet, and to develop new understanding of how health literacy may be improved.

**Substudy 2) Qualitative interviews with patients with limited social, psychological and cultural resources**
This substudy will include patients with established CVD and limited social, psychological and cultural resources (as judged by survey answers with focus on especially social capital and sense of coherence.

The aim of the study is to obtain in-depht insight in the perspectives on illness and health of patients with limited social, psychological and cultural resources, how this relate to SES. We will study to how low ressources may form barriers for equity in cardiovascular health in order to develop new approaches to overcome these barriers.

Furthermore, the analyses will focus on the development of new knowledge on how these different, fundamental social, cultural and psychological factors are interrelated and interact.

**Substudy 3) Qualitative interviews with patients with premature cardiovascular disease**
This substudy will include patients with low SES who have survived a myocardial infarction and who are less than 60 years old to indicate premature cardiac disease.

The aim of the study is to examine how social, cultural and psychological factors influences the perspectives and everyday life of patients with CVD and how these factors related to their knowledge, experiences, attitudes, actions related to health behavior and achievement of healthy change.

On basis of the study results and international literature, recommendations for interventions to diminish the social inequality that are appropriate, timely and tailored to the target group will be presented.
References:


