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Original Research

Exploring the causes of health inequalities in disadvantaged areas of Sunderland: A grounded theory approach

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ABSTRACT

Objectives: This study explores how residents in disadvantaged areas of the City of Sunderland understand, construct, and navigate the drivers of poor health and health inequalities, with particular focus on lived experience and on how social, structural, and relational forces shape everyday experiences and health outcomes.

Study design: Interpretivist study via the adoption of qualitative methodology.

Methods: Fifty-two participants from the City of Sunderland's most demographically disadvantaged wards were recruited using purposive, snowballing and theoretical sampling mechanisms. Data were collected through semi-structured interviews and focus groups (September 2024–January 2025). Transcripts were analysed iteratively using Situational Analysis map-making and Straussian coding techniques, supported by processes of constant comparative analysis and memo writing. Analytical rigour was enhanced through reflexivity, peer debriefing, and the integration of recognised approaches to the establishment of data which is authentic and trustworthy.

Results: Instability emerged as a central unifying mechanism influencing health experiences. Both objective (e.g. housing, income, access to services) and subjective (e.g. stress, uncertainty, loss of control) forms of instability were identified, often interacting and consolidating the negative impact of one another. Four interrelated categories were developed: (1) housing and neighbourhood conditions as foundations of stability; (2) income insecurity and precarious employment as ongoing stressors; (3) systemic instability across health, welfare, and digital systems undermining trust and access; and (4) social isolation, harmful networks, and stigma shaping wellbeing and help-seeking.

Conclusions: Health inequalities in the City of Sunderland's demographically disadvantaged wards appear to be shaped by interconnected experiences of instability across multiple life domains. Addressing both material conditions and subjective experiences of instability may be critical for reducing inequalities. Findings highlight the importance of trust, system reliability, and community-informed approaches in the context of applied public health policy and practice.

1. Introduction

In the United Kingdom (UK), improvements in life expectancy have been stymied since the early 2010s, with declines observed during the COVID-19 pandemic, and only partial recovery thereafter.^{1,2} Evidence consistently shows those residing in the most deprived areas of England to experience significantly poorer health outcomes, reflected in national data in the inferential prediction of average healthy life expectancy.³

Sunderland, located within the North East of England, is a post-industrial coastal city ranked within the 20% most deprived local authority areas nationally.⁴ The city experiences some of the poorest health outcomes both nationally and regionally, including high rates of smoking during pregnancy, depression in adults, and premature mortality from cardiovascular disease.⁵ Healthy life expectancy in Sunderland for both men (55.0 years) and women (55.6 years) falls below regional and national averages (Sunderland City Council, 2025). Within

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the city itself, substantial inequalities also exist; men residing in the most disadvantaged wards live on average more than 11.5 years fewer than those in the most affluent areas, with similar figures reflected for women.⁶

The social determinants of health (SDH), which are the conditions in which people are born, grow, age, and work, also referred to as “the building blocks of health” in more recent policy documents, are widely recognised as shaping health and lifestyle trajectories.^{7–9} Psychosocial factors, including stress, stigma, discrimination, and social isolation have also been identified to play crucial roles in producing unequal health outcomes.^{10–12}

However, such identified causes are frequently conceptualised at a population level rather than grounded in the lived experiences of those most affected by health inequalities.¹³ Without this perspective, explanations of health inequalities risk remaining incomplete, as they could underplay how individuals interpret, negotiate, and respond to structural conditions in ways that shape health behaviours and service engagement.¹⁴

This study addresses this gap within the context of the City of Sunderland, by focusing on how residents residing in disadvantaged areas of the city construct and make sense of the underlying drivers of poor health and inequalities impacting on their lives. Using a grounded, context specific analytical approach, the research foregrounds lived experience as central to understanding how health inequalities are produced and sustained, by examining how social, structural, and relational forces shape everyday experiences and health outcomes.¹⁵

2. Methods

2.1. Study design

A qualitative design was selected, employing a Situational Analysis Grounded Theory (SA) approach, incorporating Straussian Grounded Theory's (SGT) coding techniques. SA, with its emphasis on complexity, context, and relationality, is well suited to examine multifaceted public health issues, while Straussian coding provides an epistemologically compatible systematic structure for the interpretivist analysis of data.¹⁵ Reporting followed the Consolidated Criteria for Reporting Research (COREQ) checklist.

The research was underpinned by an interpretivist paradigm, with a relativist ontology and constructivist epistemology, reflecting the view that multiple socially constructed realities exist, and knowledge to be co-constructed.¹⁶ Symbolic interactionism further informed the analysis, by providing a theoretical lens for understanding how meaning is created through processes of social interaction.¹⁷

2.2. Sampling and participant recruitment

Participants were recruited from Sunderland's most disadvantaged wards, identified using Index of Multiple Deprivation data (IMD). Recruitment took place between June 2024 and January 2025. Recruitment techniques were diverse, and facilitated through community organisations, Sunderland City Council networks, and snowball techniques. Purposive sampling ensured inclusion of residents with lived experience of disadvantage. Theoretical sampling was used during later stages to explore emerging concepts more deeply.

2.3. Data collection

Data were collected through semi-structured interviews and focus groups between September 2024 and January 2025. Semi-structured interviews enabled in-depth exploration of individual experiences, while focus groups captured the collective dynamics of the wards through participant interaction. Data collection was guided by a topic guide informed by existing relevant literature. Open ended questions explored daily life, barriers to health, experiences with services,

perceptions of health and illness, and sources of support. Interviews lasted 20–90 min, were audio-recorded with consent, and transcribed verbatim. All transcripts were pseudonymized to protect participant confidentiality. Field notes were recorded following data collection sessions to capture contextual observations and reflections. Transcripts were offered to participants for comment; no participants requested their transcripts or commented on these.

2.4. Data analysis

SGT's coding steps and SA's map-making occurred iteratively during data analysis, supported by extensive memo writing (see Fig. 1). The constant comparative method was used throughout, which led to the identification of core concepts and categories. This process finalised once no new conceptual insights emerged during data collection, indicating the achievement of theoretical saturation. Coding and map-making were conducted by RJ, with ongoing discussion and refinement of codes and categories through supervisory review to enhance analytical rigour.

Initial open coding generated numerous descriptive codes including housing insecurity, poor housing quality, financial worry, insecure employment, barriers in the access to healthcare, digital exclusion, loneliness, stigma, and mistrust. Through constant comparison, these codes were grouped into higher-order conceptual categories. Continued axial coding explored the relationships between these, leading to the identification of various forms of instability to operate across life domains. Selective coding subsequently identified instability as the central mechanism which acted as a unifying mechanism integrating all four categories identified.

2.5. Reflexivity and trustworthiness

To enhance rigour, reflexive practices were adopted throughout the research process.¹⁸ Extensive memo writing documenting methodological decisions and the discussion of how the researcher's background, assumptions, and positionality may have influenced data interpretation took place throughout the research. Techniques outlined within Lincoln and Guba's framework to establish trustworthiness of qualitative enquiry, including peer debriefing, member-checking and the code-recode strategy were also employed.¹⁹

2.6. Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki. Ethical approval was obtained from the University of Sunderland Ethics Committee (reference number 025589). All participants provided informed consent. Interviews were conducted with sensitivity to stigma, and trauma. Confidentiality was maintained throughout the research; however, in focus groups, anonymity among participants could not be fully guaranteed, which was clearly explained during the consent process.

The study presented here forms part of a doctoral thesis, which involved the use of Patient and Public Involvement (PPI) and professional co-production to shape and refine the study's design. The study design was also piloted with a smaller participant sample prior to this main study. These processes were undertaken to enhance the ethical rigour and overall suitability of the research approach, which was subsequently deemed appropriate for the larger-scale study reported here.

3. Results

Fifty-two participants took part in the study (see Table 1). Analysis identified instability as a central analytical category, acting as a unifying dynamic process underlying participants' experience. Participants described instability to arise through the interaction of multiple structural and interpersonal determinants, including housing insecurity,

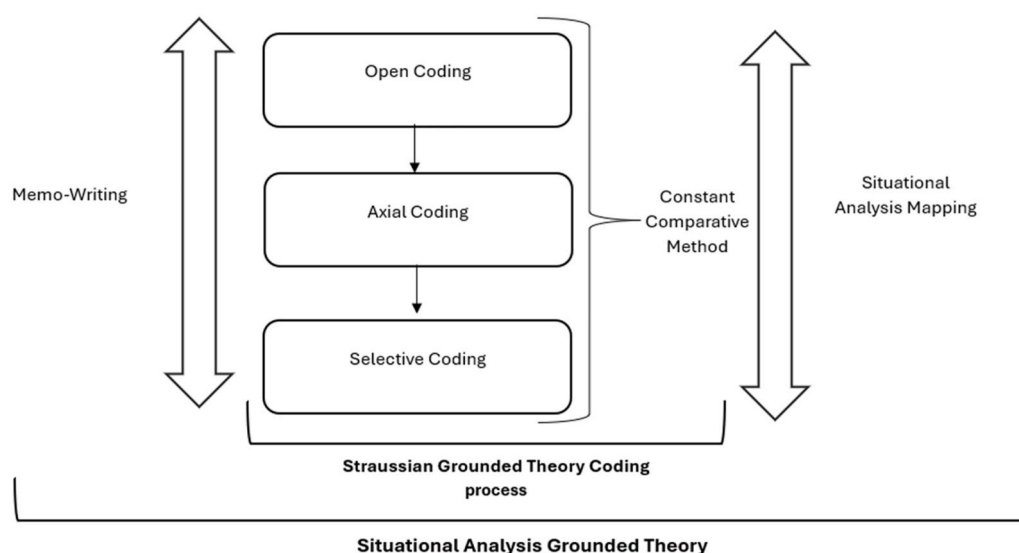


Fig. 1. Data analysis process of the study.

Table 1

Participant demographics and data collection format ($n = 52$).

Characteristic	n
Age (years)	
18 to 24	2
25 to 34	9
35 to 44	12
45 to 54	6
55 to 64	11
65 or over	12
Ethnicity	
White British	52
Gender	
Male	21
Female	31
Employment status	
Full-time employment	9
Part-time employment	6
Unemployed	26
Retired	11
Area of residence (by electoral ward)	
Castle	3
Hendon	1
Hetton	1
Pallion	7
Redhill	3
Sandhill	2
Southwick	18
St. Anne's	1
Washington North	6
Experiencing homelessness at the time of data collection	10
Data collection format	
Face-to-face individual interviews	20
Microsoft Teams individual interviews	7
Focus groups	5

financial hardship, employment precarity, and limited access to support. Experiences of instability in one domain frequently intensified others, shaping participants' daily lives, decision-making, access to opportunities and support, and ultimately, their health and wellbeing.

The analysis also revealed important differences between objective and subjective forms of instability. Participants' accounts highlighted objective disruption often triggered heightened subjective feelings of uncertainty, stress, and diminished control. However, even when objective conditions were relatively stable, subjective instability could persist when individuals lacked trust in systems, felt unsupported, or anticipated future disruptions.

"Lots of things aren't stable ... yes ... so then they are keeping you from ... it is like a domino effect, one little, small thing can be unstable in your life, and then everything, you're moving forward, and where you want to be, can deteriorate ... which can cause other things to occur, which then can get you more down ..."

Participant AWI59L

Four interrelated categories were identified, with instability serving as the central analytical category underpinning each of them. Rather than representing independent categories, each captures a distinct but interconnected dimension of instability experienced by participants. Category 1 explores how housing and living environments enhance or undermine stability; Category 2 explores the influence of income security, welfare benefits, and employment on participants' perceptions of stability; Category 3 considers how interactions with health, welfare, and digital systems can reinforce or reduce instability; and Category 4 focuses on the role of social networks and stigma in shaping experiences of stability and wellbeing. Collectively, these categories illustrate how instability operates across multiple, interacting domains of everyday life. Each category is discussed below, illustrated by pseudonymized participant quotations. A Situational map and positional map are also presented to further illustrate the findings (Figs. 2 and 3).

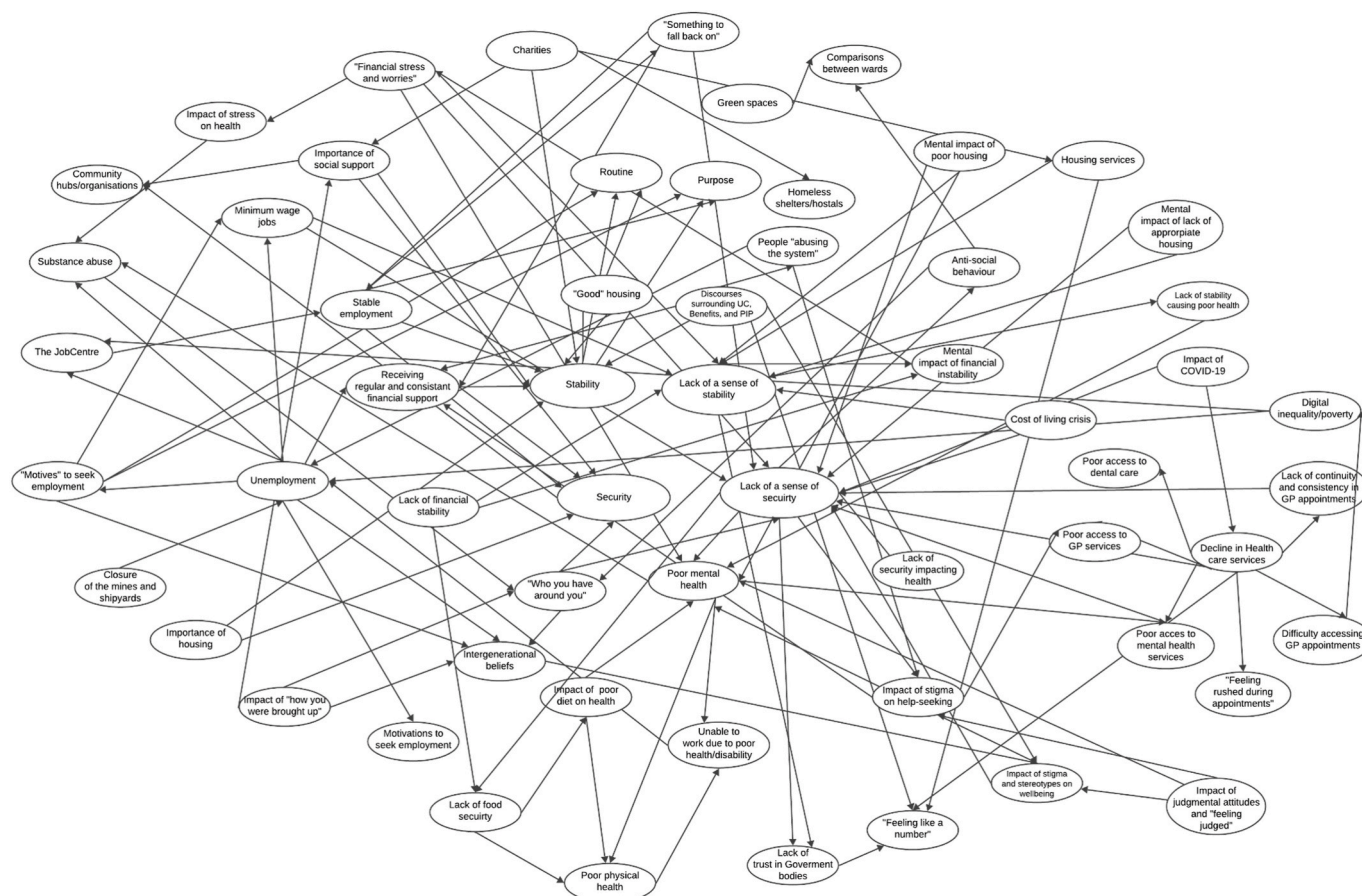
Fig. 2 presents the situational map developed during analysis. Rather than representing causal relationships, it illustrates the complex interconnections between the topics and codes identified across the dataset and participants' experiences of both objective and subjective instability. The map highlighted the interconnected nature of these experiences, supporting the identification of instability as the central analytical category.

3.1. Category 1: Housing, neighbourhood environment, and the foundations of instability

Adequate housing was recognised to be a central element of healthy living. Poor housing conditions left many feeling unsafe within the place that should provide security. Experiences of homelessness further emphasized the importance of stable housing for good health, where their experiences were characterised by living in "survival mode" daily.

"Well, if you are just sitting there, breathing in spores, you're just sitting looking at that black patch, and you're seeing it getting bigger and bigger in your mind ... maybe it is more the mental health of the stressor of knowing".

Participant DCCFG71N



Both contextual and compositional factors of area of residence could have important health implications. Neighbourhood decline, involving the loss of local shops, green spaces, and healthcare services were described. There was also an overall shared perception of rising crime and antisocial behaviour within their areas of residence.

Participant HCI60D

Participants framed financial security as foundational to health, autonomy, and stability. Economic conditions were viewed as active, destabilising forces restricting choice and wellbeing. Participants described financial hardship as a primary source of stress, shaping their physical and mental health. The cost-of-living crisis was recognised to further intensify such difficult circumstances.

Participant HCI38A

conditions, involving zero-hour contracts, unpredictable shift patterns, and low wages, as a constant source of tension. For many, employment failed to provide the routine, structure, and purpose traditionally associated with good work.

A recurring dilemma concerned the perceived stability of welfare benefits in comparison to precarious employment. Participants generally described benefits to provide a more predictable income, as well as an enhanced level of support in comparison to employment, suggesting benefits to be perceived as more stable and secure than employment.

Participant KRLFG60G

These accounts suggested that stability was not inherently associated with employment, but rather with the predictability and security of income. Participants occupied different positions regarding whether employment or welfare benefits offered greater stability, reflecting the varied realities of precarious work and financial security. Fig. 3 presents the positional map developed during analysis, illustrating the range of participant positions in relation to perceived stability concerning employment and welfare. Rather than portraying employment as uniformly beneficial, the map demonstrates how participants negotiated competing understandings of work, welfare, and stability, challenging conventional assumptions that employment is invariably the more stable and health-promoting option.

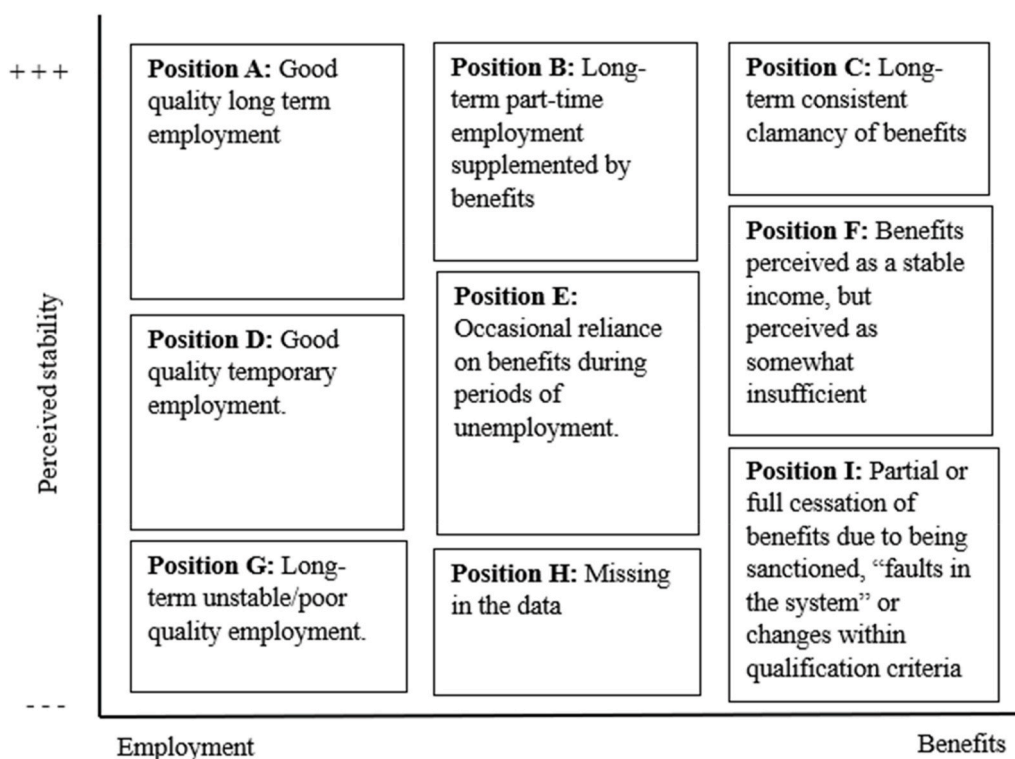


Fig. 3. Situational Analysis "Positional map" visually representing the positionalities identified within the data of the perceived stability of employment and financial welfare benefits.

3.3. Category 3: Systemic and institutional instability across health, welfare, and digital systems

Participants emphasized widespread instability across health and welfare systems, characterised by long General Practice (GP) waits, difficulties securing appointments, and inconsistent continuity of care. Experiences of dismissiveness or judgment from staff were also frequent, further eroding trust and discouraging help-seeking. Collectively, participants largely perceived systems to be fragmented and unreliable. Rather than functioning as safety nets, they appeared to contribute to the instability felt by participants.

When speaking of healthcare systems, participants frequently perceived there to have been a decline in the quality of care received. They commonly expressed there to be a lack of a "doctor-patient relationship" which once existed, to "feel rushed during appointments" and feelings of "not being listened to".

"Then, you can only say one thing. If you've got two things wrong with you, you can't mention two, you can only mention one. You get allocated 10 minutes and that's all you get, and that's it, and they just look at the screen the whole time, no communication between yourself and the GP".

Participant KRLFG58T

Welfare systems were described as bureaucratic, emotionally taxing, and difficult to navigate. Various barriers to accessing support were described, including a lack of knowledge of support pathways, and feeling as though they were made to "ask for help".

"They're just like robots, no sympathy, no empathy, there's nothing, because you're claiming money, you're claiming benefits, that's all you are basically".

Participant AHFG26S

The rapid digitalisation of health and welfare services, accelerated during the COVID-19 pandemic, introduced additional barriers. Digitally excluded participants, including older adults, low-income

residents, and people experiencing homelessness, reported online-only systems to have amplified feelings of confusion, mistrust, and frustration.

3.4. Category 4: Social isolation, harmful networks, and the impact of stigma

Participants consistently framed social connection, supportive networks, and optimal quality support as essential foundations for restoring stability and improving health. Social isolation emerged as a pervasive challenge, with many participants describing loneliness, loss of community ties, and limited emotional support as detrimental to health. Declines in neighbourhood cohesion and reduced access to shared spaces further limited opportunities to build meaningful connections.

"At one time, you could depend on your neighbours. Gone are the days where you could just leave your door open. You don't know who lives next to you, you don't know who's within that community, you don't know where you can go for help, and it just, it does, it makes you guarded and defensive".

Participant KRLFG60A

The quality of support provided was also an important factor considered. Several participants described involvement in harmful or risky networks which reinforced addiction, coercion, or exploitation. Stigma related to area of residence, poverty, welfare use, homelessness, and unemployment, were frequently described. Acts of stigma and discrimination had powerful impacts on self-esteem, identity, and help-seeking behaviours. Experiences of judgment within health and welfare services further discouraged engagement, sometimes resulting in complete withdrawal from support systems.

"When you go in, they're looking at us like, scumbags, or leeches, or whatever. They shouldn't tar everyone with the same brush ... they have an attitude towards us".

Participant KRLFG47D

4. Discussion

The findings propose instability to act as a central mechanism, consisting of interconnected and mutually reinforcing domains, which contribute to the production and perpetuation of health inequalities in disadvantaged areas of Sunderland. Conceptualising instability in this way offers a potentially useful integrative lens through which to understand the causes of health inequalities. Although related concepts such as precarity, insecurity, and lack of autonomy are well established within the literature, instability captures both the objective conditions of unpredictability and lack of security, and the subjective experience of uncertainty, loss of control, and anticipatory stress.^{20,21}

Stability is characterized by consistency, predictability and security, whereas instability is characterized by uncertainty, vulnerability and increased stress.²² The findings align with distinctions in the literature between objective and subjective stability, where objective stability refers to the presence of consistent and predictable living conditions, while subjective stability reflects an internal sense of confidence, predictability, and structure.²³ The experiences of instability identified within the findings could undermine both objective and subjective forms of stability, reinforcing feelings of vulnerability, and limiting the capacity to focus on longer-term goals.

Participants' accounts could not only reflect the impact of multiple forms of instability, but also the ways in which these interact to shape health. Instability in one domain often triggered instability in others, supporting the evidence of domains of stability to tend to exacerbate one another, leading to multidimensional forms of instability.²⁴ The findings' recognition of the relational and cumulative nature of instability across life domains aligns with previous research suggesting disadvantage to operate through compounding and intersecting mechanisms.^{25,26}

However, objective and subjective forms of stability could not always be mutually exclusive. Participants' experiences could resonate with Abraham Maslow's conceptualisation of "safety needs" within his Hierarchy of Needs. Maslow argued that individuals may become "wholly dominated" by safety needs when stability is threatened, where safety becomes "the almost exclusive organizer of behaviours".²⁷ The importance participants placed on predictability and the desire for stability could reflect this dynamic. This emphasis could be further understood through Anthony Giddens' concept of "ontological security", referring to the importance of trust in the continuity and reliability of one's environment.²⁸ Ontological security could be understood to be pivotal for a sense of subjective stability, as it highlights the need for stability and security to be subjectively "felt", rather than solely objectively perceived; a perspective which was recently reinforced by Marmot et al., who applied the concept of ontological security to the importance of housing stability.²⁹

The findings also provide an insight into the role of institutions and systems as sources of instability, rather than as mechanisms of support. Participants frequently described health and welfare systems as fragmented, difficult to navigate, and at times actively destabilising. These findings support existing critiques of institutional processes that inadvertently exacerbate inequalities, particularly for disadvantaged populations.^{30,31}

4.1. Limitations

As an interpretivist qualitative study, findings are context-specific and cannot be generalised to all populations or regions. The sample reflects the demographic composition of Sunderland's most disadvantaged wards who voluntarily took part in the research, and therefore some inclusion-health groups and ethnic minorities were underrepresented in the participant sample. Furthermore, recruitment heavily relied on the assistance of voluntary and community organisations, and the use of pre-existing networks, which could have unintentionally excluded individuals with minimal service contact.

4.2. Conclusion

Health inequalities in Sunderland are progressively and iteratively shaped by experiences of instability embedded across domains of life. Although prior research highlights the role of material deprivation, neighbourhood context, and social relations in the creation of health inequalities, limited research has identified the experience of instability itself to function as a unifying mechanism central to the process through which inequalities are produced, experienced, and reproduced.²⁴

The findings could also have practical implications for local public health policy. For local authorities such as Sunderland City Council, addressing systemic instability requires community-informed approaches that move beyond consultation or "tokenistic attempts", towards genuine co-production with residents experiencing disadvantage. Practical strategies could include the involvement of residents in the development and redesign of health and welfare services, embedding peer navigators within communities, strengthening partnerships with trusted voluntary organisations, improving existing neighbourhood-based digital inclusion initiatives, and ensuring service pathways prioritise continuity, predictability, and relationship-building. Such approaches could potentially improve both the objective accessibility of services and the subjective sense of trust, security, and stability identified throughout this grounded theory as fundamental to reducing health inequalities.

Ethical approval

Ethical approval was obtained from the University of Sunderland Ethics Committee (reference number 025589).

Data availability statement

The data that support the findings of this study are available from the corresponding author [RJ], upon reasonable request.

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Declaration of competing interest

No competing interests to declare.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.puhe.2026.106520>.

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