The nature scale and causes of health inequalities sociology essay

The black report on Inequalities in health care was introduced by the Department of health in the UK by Health Minister, David Ennals in 1977. It wanted to point out why the NHS had failed to reduce social inequalities in health and to investigate the problems. He would do this by analysing people's lifestyles and their health records from different social class backgrounds. It found that the overall health of the nation had improved but the improvement was not equal across all the social classes, and the gap in inequalities in health between the lower and higher social classes is widening. It seemed that some of the main causes of this were class and ethnicity.

Class

The black report was based mainly around social class and that middle and upper class people have better standards of living, better quality of life and health than the working class and the lower class people. The report stated that there were four types of explanations for the differences of life expectancy and illness within different social classes and they were:

The substantial artefact explanation: your age, your profession, and whether you are upper, middle, working or lower class.

Natural or social expectations: lower social class and lower wages, poverty and poor housing do not cause illness – it is in fact on the contrary. A lack of energy why they are placed in deprived circumstances.

Cultural or behavioural explanations: focuses on behaviour and lifestyle choices of people in lower classes. Poor nutrition and exercise, smoking and alcohol seemed to be connected to working class people. This is also related

to illnesses such as cancer, bronchitis, and diabetes and heart disease. Difficult circumstances lead to this lifestyle choice. Not the other way around.

Material or structural explanations: Poor diet, poor housing, low income, poor environments and unsafe and insecure employment are more common in working class families. Studies in these areas confirm that social factors are the main causes which contribute towards ill health.

Ethnicity

There is evidence that there is a higher frequency of rickets in children from Asian families due to a lack of vitamin D in their diet. Most ethnic minority groups have shorter life expectancy and have higher infant mortality rates. This could be associated to the social economic situations face by migrant workers.

Cultural and language barriers can limit the use of health services. For example Asian women do not feel comfortable going to see male doctors. Translation is another language complication. This is because it is not easy to capture the same meaning when translating between two completely different languages.

There are regional differences in patterns of health and illness. Morbidity and mortality rates are different in other areas of the UK. For example within England, lung cancer is above average in North West, Northern, and Yorkshire regions and below average in the South Western, Southern and Eastern regions. This shows that the mortality rates and morbidity rates are higher in different areas in the country.

Chances of becoming ill and even dying are linked to several factors which include social class, gender, age and ethnicity. The two social groups that are being compared are social class and ethnicity. These social groups affect health issues and explain the sociological perspectives and the patterns and trends.

Social class and patterns of health and illness

Social class is the classification of people based on their education, occupation, income and manners. It is said that the healthier you are the higher your social class. Poverty and inequality in society have consequences on the social, physical and mental well-being of a human being. These two factors are closely linked.

The infant mortality rate – IMR – for children born to underprivileged parents are higher than that of a child born to wealthy parents. People from a higher social class are much less likely to die of illnesses such as cancer, heart diseases and strokes and would be likely to live longer compared to others.

The Black Report – which was introduced in 1980 – studied the health differences of people by dividing the population into five social classes and offers information on how social and environmental issues of health and illness and life expectancy are related to one another.

“ There is overwhelming evidence that standards of health, the incidence of ill health or morbidity and life expectancy vary according to social groups in our society especially to social class”. (Stretch, B, 2007, Pg361).

One of the explanations for this is that the higher social classes can afford to pay for private healthcare. Their level of earnings is also much higher which then also results in a better lifestyle and housing. People who were in inadequately paid jobs meant they had poor housing and a reduced amount of money to provide nutritious food and heating.

In 2009 the main cause of infant mortality in Great Britain was ‘ certain conditions originating in the perinatal period, accounting for around a quarter of all infant deaths among males (27 per cent) and females (25 per cent) (ONS, 2010c; NRS, 2010a). 4

Life expectancy data for 2009 are period life expectancies from the 2008-based principal projections. Source: Office for National Statistics; National Records of Scotland; Northern Ireland Statistics and Research Agency

Between 1930 and 2009 period life expectancy at birth in the UK increased by around 20 years for both sexes (Figure 2). In 1930 life expectancy at birth was 58. 7 years for males and 63. 0 years for females, increasing 33 per cent among males to 78. 1 years and 30 per cent among females to 82. 1 years in 2009.

At age 65 period life expectancy increased by more than 50 per cent for both sexes: from 11. 7 years for males and 13. 5 years for females in 1930, to 18. 0 years and 20. 5 years respectively in 2009.

In 2007-09 the UK period life expectancy at birth was highest in England at 78. 0 years for males and 82. 1 years for females and lowest in Scotland at 75. 3 years and 80. 1 years respectively (ONS, 2010b).

An important reason for the increase in life expectancy is the fall in infant mortality rates (deaths under one year old), which decreased by 93 per cent from a rate of 63. 1 per 1, 000 live births in 1930 to 4. 5 per 1, 000 in 2010, the lowest on record. Similarly, neonatal mortality rates (deaths under 28 days old) have fallen by 90 per cent to their lowest recorded level, from 31. 5 per 1, 000 live births in 1930 to 3. 1 per 1, 000 in 2010.

There are also differences in health between the ethnic groups. In April 2001 Pakistani and Bangladeshi men and women in England and Wales reported the highest rates of both poor health and limiting long-term illness, while Chinese men and women reported the lowest rates.

http://www. publications. parliament. uk/pa/cm200809/cmselect/cmhealth/286/28608. gif

Age-standardised limiting long-term illness: by ethnic group and sex, April 2001, England and Wales

South Asian people are reported to have high rates of heart disease and of hypertension;

Black Caribbean people are reported to have high rates of hypertension, but not of heart disease;

All ethnic minority groups are reported to have high rates of diabetes, but low rates of respiratory illness;

Black Caribbean people, particularly young men, have high rates of admission to hospital with severe mental disorders (psychosis).

According to the January 2007 report by the Parliamentary Office of Science and Technology, Why are some ethnic minority groups at more risk of ill health than others?

Black and Minority Ethnic (BME) groups commonly have worse health than the general population, although some BME groups are much worse than others, and patterns differ from one health condition to the next.

Evidence proposes that the poorer socio-economic position of BME groups is the main reason which is motivating ethnic health inequalities. A number of strategies have aimed to challenge health inequalities in recent years, although to date, ethnicity has not been a continuous focus.

Ethnicity results from various aspects of variation, which are socially and politically fundamental in the UK. These comprise race; culture; religion and nationality, which influence on a person’s identity and how other individuals see them. Identification with ethnic

groups is at many different levels. They may see themselves to be: British, Asian, Indian, Punjabi and Glaswegian at different times and in different circumstances.

Health Survey for England exhibit showed that Black and Minority Ethnic groups (BME) as a whole are expected to account ill health. Amongst the BME this begins at a younger age than the White British. There is more deviation in the rates of some illnesses by ethnicity than other socio-economic factors.

On the other hand, patterns of ethnic variation in health are particularly diverse, and inter-link with a lot of overlapping factors:

Some BME groups experience worse health than others. For example, surveys commonly show that Pakistani, Bangladeshi, and Black-Caribbean people report the poorest health, with Indian, East African Asian and Black African people reporting the same health as White British, and Chinese people reporting better health.

Patterns of ethnic inequalities in health vary from one health condition to the next. For instance, BME groups tend to have higher rates of cardio-vascular disease than White British people do, but lower rates of many cancers.

Ethnic differences in health vary across age groups, so that the greatest variation by ethnicity is seen among the elderly.

Ethnic differences in health vary between men and women, as well as between geographic areas.

Ethnic differences in health may vary between generations. For example, in some BME groups, rates of ill health are worse among those born in the UK than in first generation migrants.

Sociologists try to describe how society ranks itself but there are many different philosophies for this, which often clash with one another. Some of these common theories include Marxism, Functionalism, and Interactionism. There are also more modern or current theories such as Feminism. Each sociological perspective has different views.

Marxists are concerned with the distribution of economic power and wealth. They believe that society is in conflict between two classes. Those classes are the Bourgeoisie; who own the means of production, i. e. land and the Proletariat; who sell labour to these owners for wages. The Proletariat are being exploited in order for the Bourgeoisie to gain economic and cultural power over them; Marxists believe this leads to antagonism, arguments and conflict between the two classes.

Functionalists argue that society is organised much like the Human Body. Everything must function correctly in order for society to work as a whole, just like every organ in the body must function correctly in order for the body to work as a whole.

Another classic view is Interactionism. We can liken Interactionism to a play; everyone must play their respective roles in order to create a successful performance – in society everyone must do their jobs in order to create a successful society. This approach is much like the functionalism viewpoint.

The biomedical model of health looks at individual physical functioning and describes bad health and illness as the presence of disease and symptoms of illness as a result of physical causes such as injury or infections and doesn’t look at the social and psychological factors. E. g. biomedical models assume that the complexity of individual can be reduced so that by accumulating facts about the parts that make up their body a decision about how to fix that part will result in health

The social model of health looks at how society and our environment affect our everyday health and well-being, including factor such as social class,

occupation, education, income and poverty, poor diet and pollution. E. g. poor housing and poverty are causes to respiratory problems and in response to these causes and origins of ill health. The socio-model aimed to encourage society to include better housing and introduce programmes to tackle poverty as a solution.

The focus of these models is principally to explain why health inequalities exist and persist. The key cultural explanation places emphasis upon pathological (i. e. personal/individual) consequences of behaviour such as poor diet, excessive alcohol consumption, smoking, drug addiction, sexual practices or lack of exercise. On this argument, inequalities in health will be reduced when people make healthier personal behavioural decisions.

The health selection explanation argues that people in ill health will inevitably fall to the bottom of society and that therefore inequality is inevitable and will persist. People in this group are also least likely to alter unhealthy lifestyles. The structural explanation sees factors outside the individual’s control affecting life and health chances. Issues relating to the form and nature of employment and unemployment are critical; as is the individual’s position in society relating to, for example, home ownership, education, income, quality of life, living conditions and poverty (where few people have any real choice). Knowledge of health issues and of how poor health can be avoided or treated is equally critical

Socio- model of health is one where:

The state of health is socially constructed resulting historical, social and cultural influences that have shaped perceptions of health and ill health.

The root causes for diseases and ill health are to be found in social factors, such as the way society is organised and structured.

Root causes are identified through beliefs and interpretation for example, from a feminist perspective, root causes relate to patriarchy and oppression.

Knowledge is not exclusive but has a historical, social and cultural context as it is shaped by these involved.

The biomedical of health is where:

The state of health is a biological fact and the norm.

The body is a machine and ill health results from dysfunction of that machine.

Ill health is a deviation from the norm.

Ill health is caused by biological factors such as viruses, bacteria, genetic characteristics or trauma.

The cause of ill health is identified through the process of diagnosis, considering the signs and symptoms.

Individuals play little or no part in the interventions to restore the body to health.

There is no consideration of the individual’s interpretation of health and ill health or social factor that may contribute to ill health. Finding a cure is a greater concern than preventing ill health.

Culture plays an incredibly important role in the cause and reasoning of mental health. Cultural beliefs can shape the way people identify stress and the way in which they seek help. Indeed, in some cultures, people suffering from depression and anxiety disorders can also present with physical/psychosomatic symptoms.

As Britain becomes more culturally-enriched, striving for a melting pot of nations and ethnicities as opposed to a salad bowl of clearly defined ethnic groups, our society is slowly adapting.

Cultures differ in what is considered normal and what is considered abnormal. Therefore, the conception of mental illness is tied into whether or not members of a culture will seek help, what kind of help these individuals will seek and from whom. It should be remembered that traditional psychotherapy evolved from both the existential and psychoanalytic framework imported from Europe. Sigmund Freud has become a household word, and it was his approach to psychoanalysis that influenced much of the psychodynamic approach that is used today. The humanistic approach associated with Carl Rogers is an offshoot of the European existential theories which were evaluated by American psychologists as being too morbid. Many of these European theorists believed much of the individual's problems are related to death anxiety. The humanistic approach puts emphasis on a more optimistic view of the individual. The therapist focuses on responding to the client with empathy, warmth and positive regard. Irrespective of the approach to treatment, it is important that mental health providers have some concept of what for the client constitutes mental illness (Hall, 2005).

The term ‘ mental health’ was popularised in the early 1900s by physicians, social reformers and former asylum patients. They wanted to reduce the stigma surrounding mental illness, and said ‘ illness’ reinforced prejudices against asylum patients because it implied segregation between the sick and the well. Focusing on health countered a persistent misconception that only some people are prone to psychiatric problems.

The label ‘ mental illness’ is highly stigmatising to many given it encourages people to think of ‘ the mentally ill’ as an entirely separate group from ‘ people like us’, rather than as ordinary people who have, for whatever reason, more severe emotional difficulties to cope with. Popular misconceptions, fuelled by the media, depict ‘ the mentally ill’ as violent and dangerous. These stereotypes are contradicted by ordinary people’s experiences of mental health problems affecting themselves, their family, friends or work colleagues.

Mental illness is a narrow meaning often used by psychological and psychiatric services. By placing an emphasis on the word illness we acknowledge the need for medical treatment. But there are certain difficulties with describing someone as mentally ill as there is no universally agreed cut-off point between normal behaviour and that described as mental illness. (Reader, David L Rosenham p p70-78) What is considered abnormal behaviour? An abnormal reaction to circumstances differs between cultures, social groups within the same culture and even different social situations.

The use of the term mental illness may be misleading if it is taken to mean that all mental health problems are solely caused by medical or biological

factors. In fact, most mental health problems result from a complex interaction of biological, social and personal factors. For example, some people may be biologically vulnerable to experiencing depression, yet strong social support during difficult times can reduce their risk of becoming severely depressed. Similarly, in people with a higher than average genetic risk of schizophrenia, a particular psychotic experience may be triggered by stressful life events and circumstances. And for many people the existing systems of categorising illnesses do not relate closely enough to their experiences.