Nursing sociology : how class affects health

Health & Medicine, Nursing

Inequalities inhealthbetween social groups have long been a dominant feature of British Society. Evidence suggests that people in the lower social scale suffer from ill health more than the middle and upper classes. This essay aims to address the reasons for this trend by primarily looking at evidence found in the Black Report, Acheson Report and the Marmot Review and by evaluating the explanations given to support the evidence. The concept of social class is wide ranging – people can move between classes or have character/ occupational traits that cross more than one class.

(Giddens, 2001: p282) described Social Class as ‘ A large scale grouping of people who share common resources which strongly influence the type of lifestyle they are able to lead. ’ Government statisticians have measured Social Class using the ‘ Registrar General’s Social Class’ (RGSC) scale. First used in Britain in 1911, the census divided people into six social classes based on the occupation of the head of household; Men were allocated on basis of their occupation, Married/cohabiting women on basis of their partner’s occupation, Children on basis of their father’s occupation and Single women on basis of their own occupation. Following the 2001 census the scale used to measure class changed to the ‘ National Statistics Socioeconomic Classification (NS-SEC)’. The change of scale reflected the changing nature of occupations, the growth of middle class professions, the levels of social esteem that these jobs attracted and it ranked the occupations according to the level ofresponsibilitythat the job entailed. The Black Report published in 1980 was a report commissioned by the Labour Government. It used the Registrar General scale as follows; I) Professional II) Managerial/Technical III (NM) Skilled (non-manual) III(M) Skilled (manual) IV)

Partly Skilled V) Unskilled VI) OtherTo show the health inequalities of people in Social Class V compared to those in Social Class I.

It demonstrated that although the health of the nation had improved since the introduction of the Welfare state, there were still large divides between the social classes, with the people in social class V suffering more from poor health. It is evident from the life expectancy rates that people in Social Class V live shorter lives than that of people higher social classes. The Black Report revealed that class differences are found at birth, childhood, adolescence and in adult life. Average life expectancy is a useful summary of the impact of disadvantages and advantages on a person's life due to their class. In 1980 a child born to parents in social classes I – II will live on average five years longer than a child born into social classes IV – V. The risk of death during birth and the first month of life in class V was double the risk in class I. In 1977 Babies born into class III(M) had one and a half times more risk of mortality than babies born from parents in social class I and for every one male infant death in class I there were almost two deaths in class III(M) and four deaths in class V (Table 2).

There were more cases of children dying with diseases of the respiratory system and infective parasitic diseases in the lower social classes. See Graph 3 . Adult males and females in class V had one and a half to two times the risk of death than those of the same age group in social class I. From the sample range of 15-64 years from when the Black report was compiled, people in the earlier ages had the greatest mortality rate within the different classes as Table 4 indicates. The premature deaths in Britain was

systematically linked to socio-economic class, it was a trend that was not new or unusual when the report was commissioned and is still a factor in today's society. The Independent Inquiry into Inequalities in Health Report (also known as the Acheson Report), was a report published in 1998 by the Labour Government. The Acheson Report reiterated the evidence found in its predecessor the Black Report, that there are considerable disparities between health and the social classes.

The Acheson report also used the Registrar General Scale to support its findings, although the report did take note of the level ofeducation, the residential area and the ability to own assets as a factor of defining social class. The Acheson report found that death rates had fallen between the years 1978-1998, but the differences among the top and bottom scale had widened. For People in the lower social classes, mortality rates were three times higher in 1990's than they were in the 1970's. See table 5. This is due to a significant decline in the higher social classes mortality rate than in the lower classes. Premature Mortality (death before the age of 65) was considerably higher for those in social class V, Heart Disease was the prominent reason for premature death. See table 6.

A link to such a large percentage of people dying due to heart disease could be linked to the problem ofobesitywithin the lower classes. Although life expectancy had risen and people were living longer, they were not necessarily living healthier lives. In 2010 the Government ordered ' Fair Society, Healthy Lives' (The Marmot Review) The report used the NS-SEC method of gauging social class. In England the report discovered that people

living in the poorest areas were on average more likely to die seven years younger than those living in the wealthier neighbourhoods. See graph seven. More worryingly the report found that there is still a problem that was addressed in the Acheson report 13 years previously - that people in the lower social classes and living in poor areas have a greater level of living a life with a disability, some 17 years more than in the wealthier classes and regions. To summarise, people not only die sooner in the lower classes, they also spend their shorter life with a disability.

The Marmot Review explained the disparity as ‘ Differences in health do not arise by chance, and they cannot be attributed simply to genetic makeup, ‘ bad’ behaviour, or difficulties in access to medical care, important as these factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society. The Commission on Social Determinants of Health (CSDH), set up by the World Health Organisation, concluded that social inequalities in health arise because of inequalities in the conditions of daily life – the conditions in which people are born, grow, live, work and age – and the fundamental drivers that give rise to them: inequities in power, moneyand resources. There are four main explanations as to why socio economic status affects health so greatly. One reason is Measuring Artefact (Townsend and Davidson, 1982: 154) both class and health are artefacts of the measuring process, and ny observed relationship must also be an artefact. Variations in diagnosis, certification, classification and coding processes have been identified as contributing to observed health relationships (Bloor et al. , 1987).

Class related health differences are merely the result of the biases involved in the measurement and recording of the data obtained in the reports. Further reports such as the Acheson Report have rejected this explanation as the evidence was deemed to be consistent and used long ranging data to back up the claims made. Another explanation is the Natural / Social Selection. This perspective argues that health status can influence social position. It is suggested that those who are healthy are more likely to be upwardly mobile and those who are unhealthy are more likely to drift into the lower social classes (Nettleton 2006, p182) In other words it’s ill health that causes people to lead a life ofpoverty- people cannot hold down a full time job if they have a chronic medical condition that leads to them needing to take time off work sick, therefore it’s not poverty itself that’s the cause of a person’s ill health, rather ill health causing poverty. However, most health problems emerge when people enter adulthood often after commencing full time education andcareerchoices have been made making this hypothesis less likely. Cultural explanations suggest that the lower social classes prefer a less healthy lifestyle.

(Nettleton 2006, p 183)They eat more foods that are high in fat, smoke more and take less exercise than the upper and middle classes. (Our Healthier nation, 1998) commented that a sense of control over life and having optimism for the future is good for health. However people in the lower classes may have an underdeveloped locus of self control; their fate starts and ends with the life chances they were born with. ‘ Those who are more deprived in society will, because of their position relative to others, experience moredepressionandanxietywhich, in turn, may be associated with

lower levels of well being and poorer health (Graham. E, et al 2000, p 177). Leading to a feeling of hopelessness at the hand they were dealt with in life, low income, deprivation and social exclusion all influencesmokinglevels. It’s harder to stop smoking when worrying about making ends meet (Our Healthier Nation, 1998, p 16) this creates a self fulfilling prophecy which in turns leads to a life of deprivation and ill health.

The Materialistic explanation blames living in poverty as the reason for ill health. ‘ Those on low incomes, live in poorer housing conditions, in more polluted areas with fewer facilities, can afford less of many of the more palatable forms of healthyfoodand are often employed in the most heavy and hazardous industries (Blane et al. 998). Poor housing conditions, lack of resources, higher risk occupations, limited access to transport links all impact negatively on health. Although this reason isn’t the answer for all the ill health in society (some conditions are more prevalent in the upper classes, such as prostate cancer) there is little dispute that the poorest regions of Britain have the worst cases of ill health and mortality. It is evident that Social class is made up of variables, such as; occupation, education, social status, background and wealth. Each person in society has their own history and it would be naive and stereotypical to say that every person in a lower social class smokes, eats badly and doesn’t take any exercise.

Similarly, not every person in the upper classes lives a life without becoming ill at any time. All of these factors can influence a person’s health and lifestyle choices. It is hard to over look the evidence, coupled with the

material explanation, that people will have a shorter life, more prone to ill health than that of the wealthier, elevated social classes.