

# Socio-economic status and health inequalities relationship



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In this essay I will discuss the relationship between underlying social structures and health outcomes. the debates about the casual pathways between socio-economic status and health inequalities. Inequality in health is the worst inequality of all. There is no more serious inequality than knowing that you'll die sooner because you are badly off (Frank Dobson / DoH, 1997a).

The term health inequalities refer to the difference in health opportunities and outcomes between individuals or group of people within society. From a literature review and many studies there is information which suggests that there are inequalities in health, and that the inequality between rich and poor, termed the ' health gap', is continuing to grow (Smith *et al.* , cited in Davidson, Hunt & Kitzinger 2003)

The National Health Service was first implemented after World War II with ideological motto " from birth to grave". The National Health Service (NHS) was established as a result of the 1944 White Paper, The National Health Service was based on recommendations in the 1942 Beveridge Report which called for a state welfare system. According to William Beveridge, a national welfare state is the only way for Britain to beat five giants Want, Ignorance, Disease, squalor and Idleness.

The National Health Service was set up in 1948 to provide health care for all citizens, based on need, rather than ability to pay ; providing a compressive service funded only by taxation. Initially, and mistakenly, it was predicted that demand and the cost of service would decline as illnesses were cured. In fact, the opposite happened: An ageing population a expensive new

technology and drugs created new financial pressure. Despite NHS improvement and the expansion of bio medicine, facts and statistic showed that that health of nation had improved generally but the improvement had not been equal across all social classes .

The most widely accepted recent study of health inequalities and social class was the Black Report of 1980, which gathered information relating to the Standardised Mortality Rates (SMR) for different social classes in Britain, based on the Registrar General's categorization according to occupation. In 1971 the death rate for adult men in social class V was nearly twice that of adult men in social class I.

The purpose of The Black Report (1980) was to investigate the problem of health inequalities in the UK. The report analysed the lifestyles and health records of people from all social classes. It suggested that the causes of health inequalities were so deep rooted that only major public expenditure would be capable of altering the pattern (Jenkin 1980).

This report showed that the gap in equalities of health between lower and higher social classes was widening. The problem had to be investigated outside NHS. The key causes of inequalities in health were linked with social economic factors such as low income, unemployment, poor environment, poor education and sub standard housing. The report looked at four explanations patterns in inequality.

The artifact explanation which suggests health inequalities don't really exist, but only appear to because of the way class is constructed. the black report found evidence to support the view that the higher a persons social class, <https://assignbuster.com/socio-economic-status-and-health-inequalities-relationship/>

the more likely it would be to find them in 'good' health. The report used infant mortality rates, life expectancy, mental illness and causes of death of people in different social classes. But critics such as Illsley (1986) argue that the statistical connection between social class and illness exaggerates the situation.

Social selection explanations suggest that it is health that determines social class rather than class determining health, as those who are healthy will 'experience upwards social mobility' (p36) which raises the death rates and levels of illnesses and disability within the lower classes as the unhealthy are pushed down the social scale (Naidoo and Wills, 1994). On the basis of data from a National of Health and Development, Wadsworth (1986) found that seriously ill boys were more likely to suffer a fall in social class than others. Social selection did not explain the disadvantages that occur at all stages of individual's life cycle, also it did not account for the social class differences in health found in childhood, when there is not much social mobility but differences in mortality. (Marsh and Keating, 2006) Shaw et al (1999) argues that those from poorer backgrounds are faced with different economic, social and employment factor which can cause ill health. This shows that class position shapes health, not vice versa. (Giddens, 2006)

The behavioural / cultural approach, suggests that poorer health in classes IV and V is a consequence of less healthy behaviour associated with the lower classes, for example smoking and excessive drinking. The cultural / behavioural explanations stresses that differences in health are best understood as being the result of cultural choices made by individuals or groups in the population. In other words , inequalities are rooted in the <https://assignbuster.com/socio-economic-status-and-health-inequalities-relationship/>

behaviour and lifestyles of the individual, and those suffering from poor health have different attitudes, values and beliefs which mean that they do not look after themselves. The behavioural / cultural approach, suggests that poorer health in classes IV and V is a consequence of less healthy behaviour associated with the lower classes, for example smoking and excessive drinking.

The structural/material approach is that the material situation of the lower class is the most important factor in determining their poorer health.. It claims that poor health is the result of ' hazards to which some people have no choice but to be exposed given the present distribution of income and opportunity' (Shaw et al, 1999). Poverty is the key factor that links a range of health risks. It is a known fact that poorer people have worse diets and worse housing condition and are more likely to be unemployed and generally have a more stressed life which may lead to increase smoking and drinking habits, potentially dangerous for long term health. This approach put emphasis in the circumstances which people make their choices are strongly affected by the extent of inequality existing in our society. Poverty limit choices, satisfying immediate gratification; it is about being denied the expectation of decent health, education, shelter, a social life and a sense of self esteem (Marsh (2000). Poverty and health are definitely linked and not only are the ' poor more likely to suffer from ill health and premature death, but poor health and disability are themselves recognised as causes of poverty' (Blackburn 1991, p7.

Marmot and Wilkinson try to explain that social hierarchy and income/wealth inequalities causes stress and ill health, operating through mind/emotional

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pathways affecting people's well being (lecture notes ). Health improvements have been made synonymous with income equality, as Wilkinson argues is ' to improve social cohesion and reduce the social divisions' Richard Wilkinson (1997) argues that mortality, which is influenced by health, is affected more by the relative living standards of that country. He argues that ' mortality is related more closely to relative income within countries than in differences in absolute income between them. Statistics show that mortality rates have a trend of being lower in countries, which have less income inequality. He thinks that long-term economic growth rates seem to have no relation to any long-term rise in life expectancy

Acheson Report (1998) was another important study into health inequality which was commissioned by the New Labour government in 1997. The main purpose of Acheson report was to update the findings of the Black Report and particularly to advice on priorities for policy development (Ham, 2004). It was a comprehensive survey of the disadvantaged. The findings mirrored those of the Black Report that the root cause of inequalities was poverty. Over the last 20 years death rates have fallen among both men and women and across all social groups. However, the difference in rates between those at the top and bottom of the social class has widened. The conclusion of the report was that the gap between richest and poorest had to be reduced.

Davies (2001) explains that:

' The Labour government came into power in 1997 with a commitment to tackle health inequalities, and offered a ' third way' with regard to policies on health' (p183). The major health strategy published after the Acheson Report

was the White Paper 'Saving Lives: Our healthier Nation' (DoH 1999a) in July 1999. It endorsed the Acheson Report by emphasising the need to reduce inequalities in health. At the same time as the White Paper, 'Reducing Health Inequalities: an action report' was published. It referred to policies for a fairer society, building healthy communities, education, employment, housing, transport, crime and healthcare (DoH 1999b).

Later that year 'Opportunity for all- Tackling poverty and social exclusion' was published with the aim to eradicate child poverty in twenty years time. In November 1999, the 'Sure Start' programme began 'to promote the physical, intellectual, social and emotional development of young children and their families' (Sure Start 1999). By May 2003, around 500 Sure Start programmes were in action, reaching about one third of all children aged under four who were living in poverty. Not only do these programmes promote health and family support services but early education also. Another government initiative aimed at improving the education of disadvantaged children is the 'Education Action Zones'. And to encourage children from low-income families to remain on at school an 'Education Maintenance Allowance' was introduced (Graham 2001: 108).

The government's main target for poverty was 'to reduce the number of children in low income households by at least a quarter by 2004, as a contribution towards the broader target of halving child poverty by 2010 and eradicating it by 2020'; but by 2001/2002, midway through the period set by the target, the government were only two fifths of the way to meeting this (Palmer *et al* 2003). Tax and benefit reforms were also introduced by the government, targeted at low income families with children.

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As paid employment is seen as the best way to avoid poverty, the government developed and reformed many policies to overcome barriers to employment. The government's biggest investment was £5.2 billion in New Deal initiatives, aimed at promoting employment for different groups but especially young people who have been unemployed for six months and people over twenty five who have been unemployed for two years or more (Graham 2001). The aim of the initiative was to increase long-term employability by offering short-term employment opportunities. In April of 1999, the government introduced the first ever 'National minimal wage' to the UK, this policy was aimed at reducing 'in-work poverty' and decreasing the number of individuals dependent on social security.

## Conclusion

Numerous government reports such as *The Black Report*, (1980) *The Health Divide* (1987) and *The Acheson Report* (1998) as well as official statistics have all related class and ill health. They have revealed massive class inequalities in health, by stating that nearly every kind of illness and disease is linked to class. Both the Black Report and Acheson Report identified policies to improve the circumstances of children as an essential condition for the reduction of health inequalities. Individuals in the lower socio-economic class may find themselves tight in a lifestyle cycle where problems that contribute to health inequalities remain unchanged.

Low pay, poor social housing, lack of qualification. are the important key that need tackling by government. It is not appropriate to educate people on healthier lifestyle choices, when most of the time these choices are not



available to them. Key problems that need tackling by the government are the continuous problems of low pay, lack of qualifications and the issues faced by those people living in poor social housing. It is not just enough to educate people on healthier lifestyle choices, when often these choices are not available to them.

Taylor and Field conclude:

There is now a general acceptance in research and policy circles that health inequalities are socially caused, and the major detriment is socio-economic inequality within society (2003: 61).