Link between social class and health inequalities

The Relationship Between Social Class and Health Inequalities

Introduction

The birth of the NHS in 1948 was greeted with considerable optimism. It was believed that a fully comprehensive welfare state where people had their needs taken care of from the cradle to the grave would bridge the gap between the haves and the have nots. Governments were optimistic that increasing social equity would lead to a healthy and long living population, it was not envisaged that demands on the health system would increase rather than decrease. Those who founded the NHS believed that a lot of people were ill because they could not afford to pay for healthcare. This group had got bigger over the years and it was believed that once the backlog had been dealt with then there would be a reduction in the number of people who needed health care (Moore, 2002). However, instead of decreasing the number of people using the NHS continued to grow, this was partly because the idea of what constitutes good health changes over time. People demanded better and higher standards of healthcare and medical advancements meant that conditions that people would have died from could now be cured. All of this cost money, more money than the founders of the health system had ever envisaged and therefore the health service lurched from one financial crisis to the next with its biggest shake up occurring in 1990.

During the last twenty years there have been significant changes in healthcare policy making and in the way in which the NHS operates. Most of these changes have occurred because of politician’s concerns over the rising cost of public health.

In the 1980s Margaret Thatcher’s Government introduced marketing and business strategies into the NHS to control expenditure on healthcare and to change the health service. The most important factor here was that of the internal market. Rather than health professionals and patients it was now purchasers and providers of healthcare. This created a two tier system that created inequalities between hospitals and between patients. It split the NHS into competing NHS Trust organisations and parts of the health service were privatised. In 1990 the Community Care Act came into force and many people who were previously institutionalised were released into the community. Most of this type of care is undertaken by social services in conjunction with the health service and with voluntary organisations. The Act placed extra burdens on families to care for ageing or disabled relatives (Walsh et al, 2000). Opponents of the system argued that marketisation would lead to greater inequalities in healthcare provision and the poorer sections of society would be even worse off. It is arguably the case that the people most affected by these changes have been those in the lower classes of society. At the start of the 1970s the mortality rate for working men in the lowest social class was twice as high as for those in the highest, but by the late 1990s the figure was three times higher. This was mainly due to a decrease in the mortality rate for the most well off members where between 1970 and 1990 the rate fell by 30% but only by 10% for members of the lower class (Walsh et al, 2000). The Conservative Government’s failure to address the recommendations of the report commissioned by them to investigate the relationship between social class and health inequalities has meant that class inequalities in the standard mortality rate and the rate of

morbidity continue to be matters of substantial concern, and thus, areas for continuing research.

Epidemology

Epidemology is the study of health across populations rather than in the individual. It studies diseases and their spread, and how to control them. Within the study of health and illness social class is associated with physical risk factors including birth weight and obesity. It is also associated with economic factors and standards of housing and with the social and familial structure. There are detectable patterns of morbidity or illness associated with social class and death or mortality rate statistics also vary widely depending on a person’s class. Those who belong to the higher (capitalist) classes tend to live longer than those who are members of the working class. There is also a strong relationship between a person’s occupation and their life expectancy. [1]

Standard Mortality Rates

Browne and Bottrill (1999) have identified some of the major inequalities in health and they contend that unskilled manual workers are twice as likely to die before the age of 65 as are white collar workers in the highest class. Analysis for life expectancy differences across England and Wales from 1972-1999 found that there had been a noticeable growth in inequality in this area. During 1997-1999 males in professional occupations tended to live 7. 4 years longer than males in unskilled manual occupations. The differences for women in the same period and with respect to the same categories had risen to 5. 7 years from 5. 3 years in the period 1972-76 There are also regional differences, males born in Glasgow between 1999

and 2001 have a life expectancy of 69 years whereas males born in North Dorset may expect to live until they are 79. Cause of death also varies by social class the major areas of health which showed such differences were, Ischaemic heart disease, cerebrovascular disease, respiratory diseases andlung cancer. Semi-skilled and unskilled workers were five and half times more likely to die of respiratory diseases between the period 1986-1999 than were managerial and professional workers.

Patterns of limiting illness are also affected by social factors such as class. Forty three percent of all men were long term unemployed or had never worked and this group were five times more likely to suffer from limiting illnesses than were the nine percent that consisted of males in professional and managerial positions. During the twentieth century, as a result of improved living conditions and availability of healthcare, infant mortality had fallen substantially this is a useful indicator of the state of the nation’s health. Nevertheless differences do exist based on the economic status of fathers, birthweight, and mother’s country of birth. There was a 16% overall fall in infant mortality between 1994 and 2002 for babies whose fathers were in managerial and professional occupations, the mortality rate was highest among those babies who were registered by single mothers, for babies registered by both parents but whose fathers were in routine occupations, this fall was only 5%. The different rates within a thousand births across England and Wales are shown in figure 1 below.

The figures for the standard mortality rate, although lower than previous periods in the twentieth century, tend to show a noticeable increase during the late nineteen nineties.

Morbidity Rates

Asthana et al (no date given) [3] undertook secondary analysis of the 1991-97 Health Survey for England found that there is a strong relationship between class and morbidity rates, although this is sometimes overshadowed by the effects of age The researchers also looked at other studies undertaken between 1984 and 2002 and again found a strong relationship between social class and self-reported morbidity. The study found that health inequalities by social class were not usually not the same for men as for women and concluded that there needed to be a separate class analysis by gender. The relationship between class and health inequalities therefore will vary by sex and will vary significantly by age. The study focussed on 16+ with respect to age and class was determined by the occupation of the head of the household. The study found that the impact of class differences was lower for the lower age groups, particularly those between 16 and 25. [4] For every one professional man who suffers and later die from coronary heart disease there are three unskilled workers who suffer the same. Manual workers make up 42% of the workforce but account for 72% of work related accidents. Obesity is a killer and twice the number (28%) of women in unskilled work compared to 14% of professional women were obese, and suffered from related symptoms. [5] Stomach cancer also varied with 2. 2% of professionals suffering from this and 3% of manual workers, the figures were the same for cancer of the oesophagus. However deaths from cancer (of the alimentary system) varied widely. McCormak et al (1995) found that there was a strong positive relationship between social class and incidences of musculoskeletal disease such as osteoporosis. People

of the lower social class were also at greater risk of developing type 2 diabetes (Ismail et al, 1999). Littlejohns and Macdonald (1993) identified a strong link between social class and respiratory diseases such as asthma and bronchitis, more unskilled workers tended to suffer in this way than did those from the professional classes.

There is a strong relationship between class and angina between the 45-75 age group and this increases with age. The difference is less marked for women but tends to peak in the age band 45-54. [6] There is quite a significant class difference between women suffering from raised blood pressure, 17% of professional women reported this condition whereas in unskilled occupations 24% of women said they suffered from hypertension. [7] People from the higher social class may be healthier because they tend to use medical services more often and also because they are more likely to eat a healthy diet. Most studies tend to take the view that although reported morbidity appears to have increased across the population generally the relationship between morbidity and social class has tended to remain much the same for the last ten years.

Strategies to Deal with Inequalities Between Social Groups

There have been a number of strategies that the Government has introduced since 1998 to combat ill health. In 2005 the Government published a report entitled *Tackling Health Inequalities* in an attempt to deal with the inequalities evident between different social groups. The Public Service Agreement states that by 2010 the Government will publish a progress

report on whether and in what ways the measures to tackle health inequalities have been successful.

In 1998 the Government introduced Health Action Zones and twenty six of them were set up in 1999 in under-privileged areas, and where the health status of the population was particularly low. The notion behind the introduction of these zones was that tackling ill health and inequalities in health was not just a job for the NHS but should be tackled by different agencies such as social services, local housing departments and primary health trusts working together to combat inequalities and improve health. Health Action Zones work in two ways, firstly they try to reduce health inequalities by addressing the wider factors associated with ill health and secondly they attempt to improve the quality of health services and increase the access to them. There is, for example a strong link between asthma and cold, damp housing, one health action zone made improvements to heating systems, insulation and damp proofing in council and private homes where children had asthma. As a result of this there was a reduction of hospital admissions for children with asthma and they also had less time off school (Moore, 2002).

The Government also introduced something called NHS Direct, a telephone based helpline which gives advice to people who are unsure what to do about a health problem. The line not only makes health advice more accessible but in the long run saves money on unnecessary doctor or hospital appointments. NHS walk in centres are located in shopping centres and supermarkets as well as by the side of A&E Departments. They are staffed by nurses who give advice and treat minor health problems (Moore,

2002). In 2002 the Government set targets to reduce health outcome inequalities by 2010 with the standards of measurement being the infant mortality rate and the life expectancy rate overall. This standard was chosen because the long term trend in the gap in mortality between professional and manual workers evidenced the fact that it had increased by two and a half times since the period 1930-32. The latest figures on infant mortality and life expectancy show a continuing of widening inequality in those areas with the routine and manual work group being 19% higher than the total population in the period 2001-3. Certainly the Government are aware in this report that class inequalities are in health are a result of a number of inter-related factors including diet and housing. Government claim to have invested in the area of housing so that there are less people living in housing that is not suitable to positive health outcomes. They have also taken steps to ensure that vulnerable groups can afford to heat their homes properly in winter.

In their 2005 Report the Government say that their efforts to reduce child poverty are showing signs of success and that this will also contribute to children from less well off families having better health. The report claims that the number of deaths from heart disease and strokes is falling, that health inequalities generally are being reduced, and that the gap between disadvantaged areas and the country as a whole has fallen by 22% over the last six years. The Government aims to develop its Healthy Schools Programme in the most deprived communities which are measured by the number of children in receipt of free school meals. [8] The introduction of Sure Start Centres and Healthy Living Centres provide pre-school education

for nearly half a million children under four at over five hundred local centres and delivering health and social services to hard to reach groups. Government have increased their campaign to get people to give up smoking with massive advertising campaigns, smoking clinics and a ban on smoking in bars and restaurants comes into force in the summer of 2007. Community and school initiatives to back the five a day campaign for consumption of more fruit and vegetables shows that class five families are eating more than similar families in other areas.

The report claims that all new policy proposals by government departments also have to take into account health impacts and also how that might have an effect on health inequalities. There are some indications to assume that the gap in health outcomes is beginning to narrow, teenage pregnancies are beginning to fall and there has been an increase in the take up of flue vaccine among vulnerable groups since 2002. Local exercise action plans have been set up in some disadvantaged areas to encourage people to take more exercise and Government have managed to provide intermediate care for more people. Government seem to be taking a much more integrated approach to the problem, an approach which rests on the findings of the Acheson Report.

The Acheson Report

The Acheson Report needs to be seen in its historical context. In 1978 the Tory Government commissioned the Black Report to investigate the health of the nation. The Report was published in 1980 its brief had been to examine the reasons behind inequalities in health between different groups of people so that policy could be tailored to meet health needs. The report found that

there were significant and worrying differences in health outcomes between the social classes. Research has come up with a number of different explanations for the relationship between social class and health inequalities. These are:

- Artefact explanations

The artefact explanation is based on the argument that the growing gap between the classes is the result of a misreading of the statistics and claims for any relationship between the two should be treated with suspicion.

- Social Selection explanations

The social selection explanation is that people who are in poor health are more likely to be unemployed or in low paid work whereas those who are healthy are more likely to have better jobs and living conditions.

- Cultural explanations

Cultural explanations identify consumption and lifestyle as the main causes of poor health. Thus the individual must take responsibility for the sake of their health. Certainly some government campaigns have planted the suggestion that a change in lifestyle can leader to better health and greater longevity (Walsh et al, 2000).

- Material explanations

Materialist explanations regard the cause of health inequalities as the result of wider structures of power, poor working conditions, low pay and associated living standards such as bad diet and poor housing and lack of education.

The Black Report concentrated heavily on materialist explanations of health inequality. It recommended that there was a need for a more effective anti-poverty strategy and for better education to combat such inequalities. Since that time there has been a considerable amount of subsequent research e. g. Macintyre (1997) that supported these recommendations, but Margaret Thatcher dismissed the findings on the basis that its recommendations were unworkable because of the amount of public expenditure that would be required to do this. The Conservative Government concentrated on cultural explanations and placed an emphasis on individual life style choices as being the result of inequalities in health.

The Black Report was highly influential on later health research and its findings have been used extensively to measure inequalities. Almost twenty years later in 1997 the Labour Government commissioned a similar report, the Acheson Enquiry. The resultant Acheson Report, published in 1998, also recognised the wider factors that contributed to the relationship between class and inequalities in health. The Acheson Report reiterated the fact that materialist explanations of ill health recognise the wider context of material deprivation and inequalities can only be reduced by addressing its root causes. Thus the Report recommended that any attempt at policy making across government departments had to pay attention to any particular health impacts, particularly as they affected those who were disenfranchised, and to legislate in favour of the less well off. The Report argued that the Government take an approach that used what it called both ‘ upstream’ and ‘ downstream’ approaches. Upstream work is characterised by initiatives such as Health Action Zones which attempts to improve health

and reduce inequalities by working on the wider factors that contribute to poor health, such as insufficient income and poor standards of housing. There was a particular focus on the inequalities that faced young families and pensioners. There was a recommendation that an automatic Income Support top-up be paid to the poorest pensioners, i. e. those totally reliant on the state pension and who might not recognise their entitlement to further benefits. Such people are also at risk of what the report termed fuel poverty and they may feel unable to heat their homes properly. Government have now substantially increased winter fuel payments to all pensioners in an attempt to lessen inequality in this area. The Acheson Report recommended that there should be an increase in benefits for parents with young children, or a decent living wage for those in unskilled occupations, because bringing up a young child entailed more expense than when children got older. The Report also recommended that Government should address housing problems to ensure that people at the lower end of the social scale had decent living conditions. These recommendations were taken on board by the current government who have made inroads into addressing inadequate housing, have introduced a national minimum wage, and have restructured the tax and benefits system. Downstream work is connected with improvements in the NHS and easier access to health services, particularly in deprived areas. The Government has also made inroads in this are through the use of NHS Direct, Sure Start Centres, and Healthy Living Centres.

There were recommendations that health inequalities should be monitored and should take account of those groups who were often ignored in policy making, those from ethnic groups and in particular women who for too long

had been seen only in terms of their husbands class and occupation. [9] It was further recommended that Government improve conditions for pregnant mothers and for all women of child bearing age to reduce health inequalities and inequalities in infant mortality rates.

Conclusion

Medical researchers and social scientists investigate why people have poor health, what factors contribute to this and what might be necessary to improve people's health. Social scientists in particular are interested in all aspects of social life and in the structures that govern society. They investigate why some people have better health than others, why we are a society of rich and poor stratified into classes, and what the wider social effects of the inequalities that result from stratification might be. This paper has looked at epidemiological evidence which indicates a strong and enduring relationship between class and health inequalities. It has found that when the aims of the welfare state for healthy nation and an end to inequity were not realised and Governments found the cost of providing healthcare for all was spiralling out of control. The answer has been, what some people describe as a gradual dismantling of the welfare state and of the health service. However, while such policies may have had adverse effects New Labour's response to the recommendations of the Acheson Report offsets some of these effects and demonstrates an integrated attempt to reduce the inequalities in health outcomes that exist between social classes. Things are not yet on the decline but there is evidence to suggest that life expectancy and morbidity figures have remained much the same for the last ten years. With new policies coming into play, and Government promises to

substantially reduce health inequalities by 2010 it might be said that there is some cause for optimism that the most worrying of these inequalities may, in the future, be satisfactorily addressed.

References

Acheson, D. 1998. *Independent Inquiry into Inequalities in Health Report* London, HMSO

Asthana, S Gibson, A. Moon, G. Brigham, P and Dicker J (no date given accessed 18/3/06) *The Demographic and Social Class Basis of Inequality in Self-Reported Morbidiity: An Exploration Using the Health Survey for England* http://eprints. libr. port. ac. uk/archive/00000016/01/jechdiv3. pdf

Black Report *Inequalities in Health* London, DOH 1980

Browne, K. and Bottrill, I. 1999. " Our unequal, unhealthy nation", *Sociology Review, 9*

Giddens, A. 2001 4 th ed. *Sociology,* Cambridge, Polity Press.

Ismail, A. A., Beeching, N. J., Gill, G. V. and Bellis, M. A. (1999) ' Capture-recapture-adjusted prevalence rates of type 2 diabetes are related to social deprivation', *QJM: Monthly Journal of the Association of Physicians* , vol 92, no 12, pp 707-10.

Littlejohns, P. and Macdonald, L. D. (1993) ' The relationship between severe asthma and social class' *Respiratory Medicine* , vol 87, pp 139-43.

McCormick, A., Fleming, D. and Charlton, J. (1995) *Morbidity statistics from general practice* : *Fourth national study, 1991-1992* , London: HMSO.

Macintyre, S. 1997. “ The Black Report and beyond: What are the Issues?” *Social Science and Medicine, 44*

Moore, S. 2002 3 rd ed. *Social Welfare Alive* Gloucestershire, Nelson Thornes

Townsend, P. Davidson, N. and Whitehead, M. (eds) 1988 *Inequalities in Health, the Black Report and the Health Divide* Harmondsworth, Penguin

Walsh, M. Stephens, P. and Moore, S. 2000 *Social Policy and Welfare.* Cheltenham,

http://www. sochealth. co. uk/history/black. htm

http://www. statistics. gov. uk/downloads/theme_compendia/fosi2004/SocialInequalities_summary. pdfaccessed 18/3/06

http://www. statistics. gov. uk/downloads/theme_compendia/fosi2004/Health. pdf ch. 6 p. 4accessed 18/3/06

http://eprints. libr. port. ac. uk/archive/00000016/01/jechdiv3. pdfaccessed 19/3/06

http://72. 14. 203. 104/search? q= cache: STDauFm9KtQJ: image. guardian. co. uk/sys-files/Society/documents/2002/11/20/TacklingHealthInequalities. pdf+class+inequalities+in+morbidity&hl= en&gl= uk&ct= clnk&cd= 30accessed 19/3/06

http://www. archive. official-documents. co. uk/document/doh/ih/part1b. htmaccessed 19/3/06

http://www. dh. gov. uk/assetRoot/04/11/76/98/04117698. pdf p. 6accessed 19/3/06 *Tackling Health Inequalities* 2005

http://www. archive. official-documents. co. uk/document/doh/ih/part2a. htmpart 2 no page number given accessed 19/3/06

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[1] http://www. statistics. gov. uk/downloads/theme_compendia/fosi2004/SocialInequalities_summary. pdf

[2] Sourcehttp://www. statistics. gov. uk/downloads/theme_compendia/fosi2004/Health. pdfch. 6 p. 4

[3] http://eprints. libr. port. ac. uk/archive/00000016/01/jechdiv3. pdf

[4] Ibid p, 8

[5] http://72. 14. 203. 104/search? q= cache: STDauFm9KtQJ: image. guardian. co. uk/sys-files/Society/documents/2002/11/20/TacklingHealthInequalities. pdf+class+inequalities+in+morbidity&hl= en&gl= uk&ct= clnk&cd= 30

[6] Ibid p, 8

[7] http://www. archive. official-documents. co. uk/document/doh/ih/part1b. htm

[8] http://www. dh. gov. uk/assetRoot/04/11/76/98/04117698. pdf p. 6accessed 19/3/06

[9] http://www. archive. official-documents. co. uk/document/doh/ih/part2a. htmpart 2 no page number given accessed 19/3/06