Social class is dead

Social inequalities in health have long been recognised. Though there were reports as far back as the mid-nineteenth century that the poor experienced more illness, it was in the early 1980s that these inequalities became a hot topic in the fields of sociology and social policy. In 1980, Townsend and Davidson's ' The Black Report' was the first major piece of research that brought attention to the class divide in health. This report showed that despite the claims and endeavours of the NHS to provide free healthcare to all social classes, the working class had much higher morbidity rates and mortality rates than the middle and upper classes.

In 1988, The Acheson Report followed this up, showing that illness rates were closely related to class and that in almost every disease, there were significant differences between the highest and lowest social groups. There is well documented evidence of these inequalities, for example twice as many babies born to mothers in social class V (unskilled manual labour)1 die as those born to mothers in social class I (professionals). Though the overall health of the nation has improved greatly over the last century, the gap in morbidity and mortality rates between the classes has also increased. Looking at this, it would seem that Westergaard's (1995)2 declaration that class cannot be stated to be dead or disappearing in social significance when its financial constitution has become even steeper would seem more than fitting to the domain of health.

However though many sociologists in this arena still draw on income, occupation and rates of material deprivation as indicators of class, commentators on social stratification are looking increasingly to the declining significance of class analysis in sociology. Given the statistics on

higher morbidity and mortality rates among the poor it would seem contradictory to say that social class is no longer important. Annandale (1998)3 attempts to explain this apparent contradiction: ‘ Crucially, it may be that, while inequalities in health between people exist, these can no longer be viewed in class terms. ‘ Holton and Turner (1989)4 suggest that we may need to reorganise our social categories to fit in with the changes that have taken place in our society and the move towards individualism. Major changes in the organisation of society include the internalisation of capital, the decline in manual labour, the move to a service economy, the greater involvement of women in the labour force and transition of the citizen from producer to consumer. The biggest player of all of these is the collapse of the manufacturing industry and the demise of mining, the classic working class occupation.

In its place, the service sector expanded rapidly. The decline of the working class and growth of the middle class has led to a considerable shift in perspectives on class. In the 1980s, some sociologists began to argue that defining people by their ‘ class’ mean to overlook the initiative of people to form their own identity. 5 Holton and Turner point to the move of society from Gemeinschaft to Gesellschaft. With this transition in mind, class can no longer be used to describe a collective identity.

In its place, we are urged to look at consumption patterns instead. Navarro6 on the other hand argues that class divisions are as deeply ingrained as ever. Navarro highlights the hugely privileged group people with considerable hold over the county’s economic power. Westergaard (1995)7, Gallie (1994)8 and Murray (1990)9 all draw attention to the existence of an

underclass, which unlike the manual labourers of the past, consists largely of those in infrequent, insecure employment. This underclass is significantly worse off than manual labourers. Pakulski and Waters (1996)10 however retain the position that instead of looking at class we need to start looking at cultural status distinctions pursued through consumption.

While the field of sociology has begun to turn away from class as a measurement of stratification, it remains a tool used in most quantitative research. The most commonly used measurement of social class is the Registrar General's (RG) occupational measure of social class in Britain based on occupation. Socio-economic group (SEG) is a slightly different form of measurement also used commonly in research, which looks at occupation and also employment status, authority and establishment size. One of the problems with research based on occupation is that it relies on people dying during working age (which would be premature) and neglects older people (who are more likely to be ill and dying).

However there is still clear patterning in health inequalities by SEG. It is evident that there is a relationship between health and socio-economic circumstance however there is much debate over the nature of this link. First of all there are huge methodological problems in measuring health that could nullify any statistics collected on the subject. One problem in using social class as a variable is that they are changing in size. For example, between 1931 and 1881, social class I increased by 217% from 1.

8% of the working-age male population to 5. %, during the same time, social class V decreased by 55% from 12. 9% to 5. 8%. 11 Therefore whilst it could

be that health inequalities have changed, it could also be that there has been a change in social class size. There is also a problem with using occupation, as a measurement of social class because people can change their occupation throughout their lives and the occupation entered on the death certificate may not be representative of that person's ' real' social class.

Relatives of the deceased may exaggerate to make the deceased look better. Also, the measurement of occupation on the census is more sensitive than that of the death certificate therefore there may be discrepancies between the two. There are also problems in how to analyse the data gathered, whether to analyse it at group level (e. g.

social class) or at an individual level. The second debate over the nature of the correlation between health and socio-economic circumstance is how the connection should be explained. The artefact explanation takes a social-constructionist stance and argues that health inequalities are not real but a construction of misleading statistics and definitions of social class12. This approach advocated by Illsley (1986) and Bloor et al..

(1987) proposes that the method of measuring occupational class is defective and falsely overestimates the magnitude and significance of health inequalities. The authors maintain that due to the fact that the nature and composition of the labour market has changed so dramatically over recent decades, any comparison with statistics of earlier decades are useless. The artefact explanation also emphasizes that the problematic nature of measuring class must be taken into account. When carrying out research on

health and class, sociologists usually use the Registrar Generals five-tier classification system, which is used for compiling official statistics.

However this classification already has an inbuilt gender inaccuracy as a married woman is classed according to her husband’s job. With higher levels of female employment today and the sharing of the breadwinner task it would be inaccurate to look only at the man’s occupation. For a more accurate measure of class, both partners’ jobs, income, savings and property should be looked into before allocating them to their social class rank. Methods of diagnosis also vary from time to time and place to place. This approach argues that classification of illness is not merely a biological event but that there are social processes going on behind it. Another dimension of the artefact approach is the labelling perspective.

The labelling perspective challenges the validity of the statistics by saying that disease labels are applied differentially to different groups, including class. Doctors are believed to apply specific disease labels more readily to some groups than others. There have also been arguments that doctors spend more time with the upper and middle classes than with the working class and therefore may give them a more accurate diagnosis than the working class. Therefore, different morbidity rates amongst the social classes are really a product of differential, subjective labelling rather than a reflection of reality. This explanation may hold some truth but it seems unlikely that the vast number of statistics collected on class and health are all down to labelling and misdiagnosis. Another approach is the health selection explanation.

This social-Darwinist approach suggests that one’s social class position is a consequence of health or illness rather than a cause, and that levels of health influence social mobility: the less healthy you are, the less upwardly mobile you’ll be. Wadsworth (1986)13, looking at data from the 1946 British National Birth Cohort found that males who experience serious illness in childhood are more likely to be downwardly mobile by the age of 26. Whitehead (1987)14 also found that taller woman were more likely than shorter women to move up the ranks of social class through marriage. Healthy people tend to be upwardly mobile while unhealthy people tend to be downwardly mobile. The effect of this social selection is that the higher classes appear healthier; therefore they select healthy people from all classes and vice-versa. One of the reasons, supporting this idea is that due to the competitive nature of the professional job market, there is no room for people who will have to spend a lot of time off sick.

This approach is generally regarded as only being able to account for a small proportion of health differences between the lower and higher classes. This is largely due to the acknowledgement of other factors regarding social class, such as education, individual behaviours and inheritance at birth. West (1991)15 also brings labelling theory into this perspective in arguing that people who are sick are likely to be discriminated against in education and employment and that it is these underlying social processes which lead to the less healthy becoming downwardly mobile. In direct opposition to this approach is the cultural or behavioural explanation.

Instead of arguing that ill health leads to lower class position, this approach argues that it is social class that leads to better or worse health. In contrast,

to the materialist explanation, which we will look at next, the cultural explanation argues that it is the lifestyle assumed by the different classes rather than material circumstances that dictates health inequalities. This view was extolled by Edwina Currie in 1986 in response to the revelations of The Black Report. I honestly don’t think it has anything to do with poverty.

The problem very often, for many people is just ignorance… and failing to realise they do have some control over their own lives. ’16 It is argued that the working class are more prone to risk-taking behaviour because of ignorance and also their culture. The behavioural/cultural approach argues that the working classes have a poorer diet because they are uneducated in the department of nutrition and have a culture of less healthy foods.

However, according to the National Food Survey (1989), low-income families obtain more nutrients per pound than higher income families, this challenges the idea that the working class are uneducated in the field of nutrition. However, the government and medical profession at this time extol this behavioural approach. The emphasis is on health promotion, which conveniently releases the government from the more expensive responsibility of improving the material circumstances of the working class. The structural-materialist approach calls attention to the impact of socio-economic circumstance on health.

This alternative social causation approach looks at factors such as poverty, living conditions, unemployment, working hours and condition and pollution. This was the explanation put forward by The Working Group, under Sir Douglas Black at the time of the Black Report’s release (1980). The effects

on health of the working conditions of the working class can be seen clearly amongst former miners who now suffer from respiratory problems, dermatitis and other skin conditions due to prolonged exposure to coal dust. There is also a lot of evidence that poor housing has a strong negative impact on health.

For example, Martin et al (1987) found clear effects of damp housing in the health of children in a deprived area of Edinburgh in 1986. Martin found children living in damp housing were especially prone to respiratory problems, headaches and diarrhoea. The materialist approach also points out that the working class have a high chance of unemployment, which is shown to be a cause of ill health. There is evidence that mortality and morbidity rates are greater among the unemployed and even their families. MacIntyre et al.

(1993)17 amongst others argue that it would be helpful to combine both the cultural and the materialist approaches in attempting to explain the correlation between class and health. Annandale18 argues that actually, occupation and therefore social class is no longer the key factor in determining health. Annandale argues that so significant are the changes in the composition of society as described at the beginning of this essay that social class is no longer enough of an indicator of the kind of lifestyle one leads. Savage et al. (1992)19 point to three major lifestyle categories that have recently emerged among the middle classes: the post-modern lifestyle maintained by high earners of extravagance and excess mixed with the culture of the gym body; the ascetic lifestyle maintained by the intellectuals, those with high cultural capital and low economic capital, of health food and

gentle exercise and finally the conventional or undistinguished group who don’t really care about health at all.

Despite the huge transitions that have occurred regarding the economic and social structure of our society, there evidently remains a middle class or more precisely middle classes and a working class, though a reconstituted one, some sociologists suggest there is also a new underclass. There is a definite need to transfer attention away from a focus on a manual/non-manual class divide. Class has become a concept we cannot do without when measuring health inequalities and does need to be retained as a variable, yet perhaps more loosely. It cannot be denied that there is a clear link between health and wealth.

However it would serve to turn towards other axes of health differentiation in society such as consumption and lifestyle which it has been disputed do not align with class as has previously been conceded, such as the afore-mentioned post-modern, ascetic and conventional lifestyle types.