Socioeconomic status inequality and smoking

ASSIGN BUSTER

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In order to understand differences in health outcomes in various socioeconomic groups, we must understand the inequalities that arise. This essay will consider inequalities in smoking-related health issues, the influences of socioeconomic status [SES], and various measures of SES and health. This essay will also discuss different explanations that assist in explaining causes of these inequities and also how these inequalities arise as inequities.

In the world, there are 1. 1 billion smokers. However, this number is increasing and estimated to increase to 1. 6 billion in the next 20 years (Kuper, Adami & Boffetta, 2002). Smoking causes damage to various organs and systems in the body including breathlessness, elevated heart rate and blood pressure, increased vulnerability to infections and risk of strokes (Better Health, 2012). Smoking not only leads to physical damage but also mental like depression and anxiety (Better Health, 2012). One of the largest impacting effects of smoking is on cancer. Smoking is the primary source of death from cancer such that approximately at least 15% of all cancers are due to smoking (Kuper, Adami & Boffetta, 2002). Smoking contributes to 90% of all lung cancer deaths (CDC, 2013).

Health inequalities are differences in the distribution of health determinants between individuals or groups in the population. These differences lead to variations in health status (World Health Organization [WHO], 2014). The gap between health outcomes can be distinguished between those privileged with wealth and those who are deprived of wealth (Royal College of Nursing,

2012). This inequality between various groups leads to a social gradient where health outcomes improve as your SES increases (Centers for Disease Control and Prevention [CDC], 2014). While smoking occurs in all societies, there are more prominent differences in gender and the levels of income in various countries. Of the 1. 1 billion smokers, about 80% reside in low or middle income countries (Kuper, Adami & Boffetta, 2002). Whilst those in high income countries are quitting smoking, those in the developing countries continue smoking and have higher risks of unfavourable health (Kuper, Adami & Boffetta, 2002). Globally, men smoke 4 times as much as women. Therefore, it is more probable that men with low SES are more likely to be smokers (Kuper, Adami & Boffetta, 2002). A higher prevalence of smoking in the lower socioeconomic groups primarily contributes to cancer inequalities (Cancer Research UK, 2007). Drever and Whitehead concluded that those with lower paying like unskilled workers have five times higher lung cancer-related mortality rates and three times as much for heart disease in comparison to professionals (Marmot & Wilkinson, 2006). It can be seen that those with lower SES and diagnosed with cancer have poorer outcomes. In this manner, mortality rates are higher for those that are disadvantaged, regardless of whether the incidence of cancer is higher in high socioeconomic groups (Cancer Research UK, 2007).

In order to determine the severity of socioeconomic inequality, a measure used to determine the inequality is occupation (Daykin, 2001). In this way, people are allocated into an occupational groups based on the job they hold, income received and as a result the education they hold (Daykin, 2001). Men in the unskilled manual category have 2. 5 times the percentage of smokers

in comparison to men in the professional class. Occupation measures are a good indicator for the relationship between income and opportunities (Daykin, 2001). Thus those in lower social classes have higher mortality rates or susceptibility to diseases and less access to health services. However, this doesn’t well represent women in households primarily based on the male head of household’s job (Daykin, 2001). Other measures of SES include education, income, housing and ownership of cars (Asthana & Halliday, 2006). To understand the effect of SES on health outcomes, measures of health are also required. This includes physical ability, self-assessment of heath, years of potential life lost. Variations in health can be determined by mortality rates, life expectancy, prevalence of illness, access to health services and lifestyle factors. These variations and measures relate to the determinants of heath in the socioeconomic setting of occupation, income and education (Asthana & Halliday, 2006).

In order to understand this inequality, we need to understand the trends that occur due to this inequality. The Black Report is the foundation of explanations that can be used to understand the SES and health inequalities and also their cause. One of these justifications is the material and structural explanation. This explanation considers the role material deprivation plays in health inequalities (Asthana & Halliday, 2006). Material deprivation is divided into physical and non-physical resources. Physical resources include living and working conditions, nutrition, transport and environmental hazards. It is the inability to have a level of resources necessary for good health and participation in society (Daykin, 2001). The conditions and necessities of life, determined by considering occupational class position, is the primary

influence on health status. In the early 2000s, people in more deprived areas were 3 times more likely to smoke than the privileged (Pollock, 2013). This indicates that due to the added stress that lower socioeconomic group brings, leading to those in deprived areas to smoke. This explanation also recognizes social and behavioural aspects that influence this inequity, which can be classified under non-physical resources. Lack of social support and policies are non-physical resources that influence health status and contribute to inequalities that arise (Asthana & Halliday, 2006). For example, those that the poorer are less likely to quit smoking, contributed by being less educated about the health risks associated with smoking (Marmot & Wilkinson, 2006). This therefore contributes to the higher prevalence of lung cancer and other smoking related risks.

Another explanation involves the cultural and behavioural aspect. We observe that behaviours like smoking have higher prevalence in those deprived and less advantaged (Asthana & Halliday, 2006). The social distribution of poor health can be associated with behaviour differences like smoking and the attitudes of different groups to health (Daykin, 2001). These behaviours relate more at an individual level, thus those in lower socioeconomic groups make decisions that lead to poorer health outcomes. In relation to smoking, this ‘ culture’ persuades individuals based on the influence of social norms as well as helping individuals deal with the surrounding environment (Socialist Health Association, 2014). For example, women in the working class perceive smoking as a method of coping with the accompanied stress (Asthana & Halliday, 2006). Adults who smoke also influence children. Teenagers in lower socioeconomic groups are 3 times

more likely to smoke which can be reflected by the environment surrounding the teenagers (Marmot & Wilkinson, 2006). If they constantly see adults smoking or are in an environment where smoking is normal, they are more likely to take up smoking and be at risk of various health issues related to smoking.

Social selection is also used as an explanation, which refers to the idea of social mobility. This refers to those with poor health moving down in terms of social class while those with good health move up on the scale (Asthana & Halliday, 2006). Therefore, it would appear that society favours those with better health, in a way that your health impacts on the employment of those disadvantaged (Daykin, 2001). For example, those that are disabled or ill can be excluded from certain jobs or excluded from work entirely (Asthana & Halliday, 2006). Darwinism in the social context leads to the idea that health people are more likely to advance and receive promotions while those unhealthy are likely to be excluded or lose their jobs (Steinbach, 2006). In this explanation, adversities can direct people into particular ways of life, thus contributing to their disadvantaged health status and outcomes (Asthana & Halliday, 2006). As there are more smokers in lower socioeconomic groups, this indicates more individuals with poorer health and thus is less likely to improve their SES.

The last example discussed that helps the understanding of inequality is historical context. This explanation considers past significant events that have influences on social groups. An example of this can be seen in how colonisation has affected the Maori in New Zealand. By the early 1990s, 18 million acres of land was lost to settlers but hardly any of this was settled by

Maori. At the loss of this land, Maori lost their independence and ability to extend their financial prospective (Te Puni Kokiri, 2007). Not only this but Maori are mainly represented as part of the less-skilled jobs and lower levels of education (Te Puni Kokiri, 2007). Thus due to the stresses of lack of resources or the education required for higher paying jobs, smoking rates are higher in Maori than non-Maori and thus leading to higher prevalence of smoking related issues such as lung cancer. This can be seen in statistics where Maori's are affected by lung cancer 3 times as much as non-Maori (Asthma and Respiratory Foundation of New Zealand, 2009).

However these explanations do not necessarily work at explaining these inequalities in their context alone. Often these explanations work in conjunction with others to further build on the description of the inequalities that arise. An example of this can be seen from Graham, who notes that women caring for younger children smoke due to deprivation experiences like poor housing. In this manner smoking is an escape and relief from stresses they face (Daykin, 2001). Therefore those with lower SES have less material resources which lead to stress and therefore higher smoking prevalence due to the relief of stresses accompanied with this level of deprivation. This is further influenced when, for those in deprived areas, it is the method of coping in this ' culture', linking the cultural and behaviour explanation. Social selection explanation links to this as there are higher rates of smoking in lower socioeconomic groups and thus higher rates of poor health in deprived areas. Therefore, due to having poor health, this influences not only their current job status but future jobs they may try to get (Daykin, 2001). The historical context also links in that the situations

they were in have impacted on their health status today. By the loss of land or other resources such as income or services available to them, this induces a more stressful environment, leading to more smoking and increasing the inequality present.

The concept of health inequalities is used to describe trends that are observed. As discussed above, health inequalities are the health differences between individuals and different groups of people (Graham, 2007). However, this does not consider the moral or ethical implications of such differences. Health inequities are the differences in health that are deemed to be unfair or unjust. Thus these inequalities that can be seen in the lower socioeconomic groups have poorer health outcomes can be deemed inequities when they are avoidable or unnecessary (WHO, 2014). In a world where we are entitled to moral equality, inequities are thus avoidable. In the case of smoking and its health related issues like lung cancer, the differences in prevalence between different social groups can be avoided by many factors. For example, if education was evenly available to different populations, this could narrow the differences between socioeconomic groups which could lead to a rise in material resources and thus lower smoking rates. With this decrease in smoking rates, prevalence of lung cancer will also diminish. Therefore inequalities seen in smoking and their issues in different socioeconomic groups are also considered inequities.

While there are high rates of smoking, there are prominent differences in the prevalence of smoking and health issues associated like lung cancer, predominantly in socioeconomic groups. Understanding these inequalities allows us to understand why these inequalities arise and their influence.

Material, cultural and behavioural, social selection and historical events are four explanations that help us understand these inequalities. As inequalities are also inequities as they can be avoidable, by understanding how these inequalities, we can develop ways of decreasing the inequalities, however difficult this may be.

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