DISCUSS THE POSSIBLE REASONS FOR HIGHER MORTALITY AND MORBIDITY RATES AMONG THE WORKING CLASSES.

It has been acknowledged since the 19th Century that class relates to inequality. This essay will explore this area in more detail, considering the various explanations given for these differences.

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

The Black Report was clear in its conclusion: 'In the case of adults between the ages of 15 and 64, for virtually all causes of death there is a consistent inverse relationship between social class and mortality. That is, the higher the social class group, the lower its SMR, and conversely the lower the social class group, the higher its SMR.' (Black Report, 1980)

The report also came up with four possible explanations: statistical artefact (the differences reflect the differences in methodologies used in measurement of SMR and morbidity rates); social selection (the differences are because healthier people rise up through the social classes leaving the sick or disabled at the bottom); cultural explanations (the lower social classes lead unhealthier lifestyles than the higher classes, leading to more illness and earlier deaths); and materialistic explanations (economic differences within society lead directly and indirectly to poorer health and increased death rates within the lower classes).

Since the Black Report was published, the government commissioned another report into health inequalities, published in 1998, the Acheson Report. This showed that not only had inequalities continued since 1980, but the relative differences between classes I and V had *increased* even further. For example, in 1970 the mortality rate for men in class V was twice that of those in class I; in the 1990s it had increased to *three* times as high. (In 1998 there were less people in class V than in 1970, so to try to account for this, Acheson combined the top two classes and the bottom two. However this still showed that in the 1970s a person in classes IV & V had a 53% higher chance of death than one in classes I & II, rising to 68% by 1990). Measures of morbidity showed the same differences- among the age group 45- 64 in the 1990s, 17% of men in classes I & II complained of a limiting long standing illness, compared with 48% of men from classes IV & V. Similar differences applied to women.

So the Black Report, alongside many other studies, identifies a clear statistical link between social class and mortality and morbidity rates. However this link has been questioned by certain researchers, and the artefact theory presented as an explanation. One such is Illsley (1987) who criticised the Black Report for concentrating on the

relative inequalities of social class rather than on the general improvements in the health of the population as a whole. He argued that although relative differences between the classes were increasing, the number of people affected by these differences was small, due to the size of the lowest classes reducing. For example, during the period of statistical collation, the number of people in class V fell from 12.9% of the population to 8.4%, and class I increased from 1.8% to 5%. These criticisms were addressed by the combining of the two lowest and highest groups in the Acheson Report, but a gap was still apparent.

It has also been claimed that occupations stated upon death certificates were wrongly categorized, thereby making the statistics inaccurate. Le Grand (1985) examined individual death certificates, and found smaller differences between the classes than Pamuk (1985) who collated the existing statistical evidence.

The second explanation given for the inequalities identified by the two reports is social selection i.e. that social class status is related to an individual's health status. For example, healthy people are more likely to have a higher social status than those who are sick/ disabled because they can work harder and are therefore more likely to be promoted. (Illsley, 1987). Wadsworth (1986) supports this view, finding that males who suffered childhood illness experience more downward mobility than those who had healthy childhoods. Other researchers have argued that the opposite is in fact true, however: that those from poorer backgrounds face a wealth of economic, social and employment factors that contribute to ill health. Therefore they say that class position shapes health, and not vice versa.

The third explanation is that of culture, and says that the lower classes engage in more unhealthy lifestyles: smoking, eating more fatty and sugary foods, and drinking more. All lead to higher morbidity levels and earlier deaths (HMSO, 1999). Blame for these statistics is therefore laid firmly at the individual's door, or with the social environment in which they live, and educational programmes are advocated.

However critics argue that these behaviours are a rational response to the circumstances in which people live. For example, Graham & Blackburn (1993) found that mothers on Income Support smoke because they have lower 'psycho-social' health than the general population, and smoking provides a very real form of relief for them. It may be the only thing that they do for themselves in a day filled with childcare responsibilities, and may also be an economic necessity, in that the nicotine abates hunger so that food is not as necessary.

A further explanation given for the class inequalities in health is the materialistic explanation, which traces the main influences on health to the structures of society and conditions of life for its members. The theory doesn't deny the effects of an individual's behaviour, but blames the way society is organised- certain groups are systematically disadvantaged so that they inevitably experience ill health. This theory's roots can be traced back to the late 19th century, when Engels (1974) concluded that ill health was the result of the capitalist pursuit of profit, resulting in dangerous jobs for the workers, long hours and poor pay.

Exponents of this explanation argue that the poor diet eaten by many of the lower classes is not due to personal choice, but an inability to afford healthy food. Lobstein

(1995) compared prices of foodstuffs in different areas of London in 1988 and 1995. He found that healthy food was priced more cheaply in affluent areas, whereas unhealthy food was cheaper in poorer areas. Healthy food may now be priced more cheaply at the out of town supermarkets that are common, but as Wrigley (1998) argues, it is still unavailable to those with no car. With higher transport costs to reach the supermarket, they are then left with less money to buy the food that is available. It has been calculated that 15% of all early deaths are due to a poor diet, but Doyal & Pennell (1979) also support the view that this is not the individual's fault, arguing that manufacturers produce poor quality food, filled with harmful chemicals and salt, sugar and fat, which in turn leads to obesity and heart disease.

Another fact upon which most people agree is that housing is related to health. It is well accepted by most that damp, cold rooms contribute to respiratory diseases and overcrowding can lead to stress and psychological problems. Thomson et al (2001) comment that many studies show an improvement in health when efforts are made to improve housing.

Another material factor in ill health is unemployment- men in manual occupations who have a limiting long-standing illness are more likely to be unemployed than men in higher classes with the same conditions. It has been stated that the relative risk of mortality in a middle aged man who is unemployed is double that after five years than that of one who has not been unemployed. (Morris et al, 1994).

Finally,another possible reason for the higher SMR and morbidity rates among the working classes could be to do with access to healthcare, neatly put by Tudor-Hart's Inverse Care Law (1971): 'the availability of good medical care tends to vary inversely with the need for it in the population served'. Other studies have found fewer doctors practicing in areas of greater need, usually where the population is of a lower social class (Appleby & Deeming, 2001). It has also been suggested that doctors in these areas give less good service, based on the amount of surgical referrals made for certain conditions e.g. hernias, gallstones, when compared with the amount of consultations made by patients (Chaturvedi & Ben-Shlomo, 1995) and often once a referral has been made a patient from a deprived area will be given lower priority and therefore wait longer for surgery than one from a better-off area (Pell et al, 2000).

In conclusion, it has been shown that vast inequalities in health status, and also in health care provision, exist between the social classes, even in modern Britain, despite the popular conception of a 'classless society'. Despite improvements in medical knowledge, nutrition, housing, sanitation, employment conditions and the health services, people of a lower social class are still more likely to die before they reach one year of age, and, if they reach that milestone, are three times more likely to die before the age of 64 than somebody in a higher social class. Various explanations for these facts have been put forward, and criticised, but the theory that seems to have most support from the research available is that of the materialists. This links with the social model of health, which is gradually becoming more widely accepted. It will take huge effort on behalf of a government to reduce, and eventually eradicate, the inequalities in health experienced by those in the lowest social classes within Britain today, but that is not to say it is impossible given consistent and committed effort.

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