Social class and its influence on health

In this article...

- How socioeconomic status is defined
- The effects of socioeconomic status on health
- The influence of society as a whole on health inequalities

Variations in health and well-being across the UK are significantly influenced by social and economic inequality, which is largely indicated by occupation and income or, more broadly, social class. There is an established link between low income and poor health, and a definitive correlation between health and occupation, with insecure, poorly paid work having a detrimental impact on health and wellbeing (Marmot et al, 2010). Indeed, much research into socioeconomic health inequalities uses occupational classifications to demonstrate inequality (Box 1).

Friedrich Engels recognised the link between occupation and health in the mid-Victorian era (Engels, 1845, reprinted 2009) and showed infant mortality was far higher in the working than in the upper classes. This inequality has not been eradicated: between 1982 and 1986, life expectancy for men in Class 1 was 2.3 and 4.9 years greater than those in Classes 3 and 7 respectively. By 2002-2006, although the gap between Classes 1 and 3 had declined to 1.9 years, that between Classes 1 and 7 had increased to 5.8 years (Office for National Statistics, 2011).

Materialism and life conditions

Preoccupation with socioeconomic status is known as materialism (Bartley, 2004); it is relevant to nurses because individuals’ material existence can reduce or enhance their health. This was established by the Black Report (Black et al, 1980), which exposed the extent of health inequalities in Britain, but current understanding of this approach to health has its origins in the work of Engels (1845, reprinted 2009). Ill health was seen as the result of the capitalist pursuit of profit at the expense of the working classes, most of whom worked in dangerous conditions that often caused illness and disability, and lived in overcrowded places that made it easy for disease to spread.

White (2013) stated that the most significant materialist influences on health are:

- Diet;
- Housing;
- Working conditions;
- Exposure to pollution;
- Organisation of the urban landscape.

Another important factor influencing health inequality is the provision – or lack – of public services (Bartley, 2004). The unequal distribution of income determines the relationship between individuals and these factors: those on the lowest income are likely to be most adversely affected by lack of public services.

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Diet and housing
People on lower incomes are likely to buy goods and services that negatively affect their health (Marmot et al., 2010). Poor diet, often portrayed as the result of a lack of education, is often the result of a lack of money to buy nutritious food.

Housing is overwhelmingly determined by level of income and can significantly impact on health. Poorer housing increases the risk of accidents due to overcrowding and unsafe conditions, while damp, poor air quality leads to a higher risk of respiratory problems (White, 2013).

Working conditions
Working conditions also significantly influence health. Globally, 350,000 people die each year due to workplace accidents (Mathers et al., 2009) and the physical nature of work can have serious consequences. For example, 37.6% of all back pain is due to occupational factors (Mathers et al., 2009), while jobs that expose workers to hazardous chemicals, substances and airborne particles can lead to asbestosis and silicosis; such conditions are often found in manual labour jobs. However, occupations in the middle of the scale can also negatively affect health: white-collar roles expose workers to greater levels of stress, which can also negatively affect mental wellbeing and increase the risk of cardiovascular disease.

The urban environment
The built environment can also affect socioeconomic inequalities and have serious consequences on health. A locality’s economic status affects physical features, resources and the socio-cultural environment (Annandale, 2014). The affluence or poverty of an urban area influences the availability of public services, housing conditions, pollution levels, crime rates and the quality of private sector enterprises in terms of the goods and services provided.

Between 2010 and 2012, life expectancy for women born in Dorset (relatively affluent) was 86.6 years, compared with 78.5 years in Glasgow (relatively deprived); men aged 65 in Harrow, (relatively affluent) could expect to live for another 20.9 years versus 14.9 years in Glasgow (ONS, 2014).

There are even greater variations in the length of time people can expect to live in good health. For 1910-12, healthy life expectancy for men was highest in Richmond upon Thames (affluent) at 70.0 years versus 52.5 years in Tower Hamlets (relatively deprived) (ONS, 2014). This means males in the most affluent London borough can expect 17.5 more years of healthy life than those in the most deprived.

The Royal Society for Public Health (2015) highlights the impact of the urban landscape on health in its definition of a healthy town. To promote good health, healthy towns require high streets that are:

» Free from excess noise and pollution;
» Architecturally designed to support activities such as walking and cycling;
» Planned to provide services that allow social interaction, improving social cohesion;
» Designed to encourage the establishment of businesses providing healthier services and goods.

Crucially, the research identified a link between healthy high streets and local deprivation, with the localities of the 10 unhealthiest high streets exhibiting greater levels of deprivation than those of the 10 healthiest (RSPH, 2015).

More equal and healthier
So far it has been argued that low income and material deprivation can have severe health consequences. However, it is increasingly argued that health inequalities are not just related to level of income, but that large inequalities of wealth within society in general have a negative effect on health. Economic inequality in Britain has increased dramatically over the last three decades (Annandale, 2014). This can have potentially adverse effects on individuals’ health – Wilkinson (2005) argued that the least health inequalities are seen in cultures with the smallest income differentials and greater social cohesion.

The social gradient of health is influenced by the existence of relative deprivation. The poorer health of middle-income earners relative to the most affluent is less to do with the absolute amount of income they earn than with their perceived lack of material possessions relative to others, and their anxiety to achieve greater social status.

Consumer goods, including housing, are often given a symbolic value, which is thought to reflect the worth of those who possess them. It could be argued that the pursuit of ever-more material goods encourages people to become dissatisfied with their present material circumstances, demonstrating envy and mistrust towards others, reducing social cohesion and having negative consequences, in particular on mental wellbeing and happiness.

If health inequalities are to be seriously reduced, society must invest in individuals and environments where deprivation, poverty and economic insecurity are common. An individual’s health and wellbeing cannot be reduced to genetics, biology or poor lifestyle choices; it is the result of social inequalities (Marmot et al., 2010). Further, it is clear that a society that values materialist acquisitions as representations of success breeds division. It could be argued that a healthy society is one built on equality, social justice and social cohesion.

References


