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While individuals' socioeconomic status is the most significant social influence on health and wellbeing, wealth distribution through society as a whole also plays a part

PART 2 OF 5: SOCIOLOGY IN NURSING

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

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Abstract Matthews D (2015) Sociology in nursing 2: Social class and its influence on health. *Nursing Times;* 111: 42, 20-21.
The article discusses how the distribution of health mirrors that of wealth. Poor health correlates with poor material circumstances but health inequalities persist across all classes. Health inequalities are more often seen in cultures where there is a more pronounced material divide.

Variations in health and wellbeing 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 2006 health inequalities between occupational groups increased.

Illustrating the social gradient of health – health status worsens as you go down the socioeconomic scale – 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.

5 key points

1. **There is an established link between poverty and poor health**
2. **Insecure, poorly paid employment has been shown to have a detrimental impact on health and wellbeing**
3. **The most important materialistic influences on health are diet, housing, working conditions, exposure to pollution, the urban environment and public services**
4. **Economic inequalities lead to inequalities in health and wellbeing**
5. **Being encouraged to strive for wealth negatively affects mental wellbeing and happiness**

Alamy

Poor housing can have serious consequences on an individual's health

TABLE 1. SOCIOECONOMIC CLASSIFICATIONS

Classification	Employment descriptor
Class 1	Higher managerial and professional
Class 2	Lower managerial and professional
Class 3	Intermediate
Class 4	Small employers and self-employed
Class 5	Lower supervisory and technical
Class 6	Semi-routine
Class 7	Routine

Source: Office for National Statistics (2011)

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% 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 risk of repetitive strain injury and sedentary conditions.

Occupation can also affect the mental health of different groups in different ways. People at the lower end of the socioeconomic scale may feel a lack of control or autonomy at work, resulting in a sense of alienation, which has a negative effect on their mental wellbeing, while more senior white-collar roles may lead to high 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 2010-12, 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 divisio. It could be argued that a healthy society is one built on equality, social justice and social cohesion. **NT**

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