

Health and social class—one

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Within Great Britain at the present time, the relationship between the standard of living and disease and premature death is by no means self-evident. In the first place, poverty of the kind which produces the high death and sickness rates of the countries of S.E. Asia, for example, has been all but eliminated during the last fifteen years. Moreover, a number of the great social, economic and technological changes of the last half-century, and particularly of the war and post-war years, could be expected not only to prolong life and reduce disablement in the nation as a whole, but also to reduce the social differences in premature death.

It is perhaps useful to recall briefly these developments, and the parallel changes which have occurred in the incidence of premature death and disease among the population as a whole, before going on to consider the social distribution of disease in this country at the present time.

Economic and social changes

The last 50 years have seen a considerable rise in the national income from which all social classes have benefited to some extent. At the same time technological changes, full employment and trade union organisation have resulted in a narrowing of the gap between the wages of skilled and unskilled manual workers in most industries. Increased purchasing power, together with the war-time measures taken to control the distribution and price of food have permitted an overall improvement in nutrition and a spectacular improvement in that of the poorest social groups.

At the same time, there has been a great expansion of the social services. Family allowances, insurance benefits and national assistance help to mitigate the effects of inadequate earning ability. A free national Health Service provides, at least theoretically, equal access irrespective of means, to all the best that curative and preventive medicine has to offer. While much remains to be done, increased responsibility of the state for the housing conditions of its citizens has resulted in a significant reduction in over-crowding and an improvement in the housing standards and domestic amenities of manual workers. Better schools, the raising of the minimum school-leaving age to fifteen, and the use of mass media of communication to diffuse information have all played their part in helping to educate the public in matters of health, personal and domestic hygiene, and nutritional requirements.

Rising standards of material well-being have been accompanied by a long-term trend towards smaller families. In the first years of this century the decline in family size was most marked among the middle and upper classes. In the last generation, however, the average size of the family of the professional classes has, if anything, increased slightly; and it is the average size of the working-class family which has decreased. Whatever the reasons for this decrease, it is likely to have had a substantial influence on the standard of living of working-class families and on health, since it is well established that both infant mortality and serious ill-health in childhood increase with the size of the family.

At the same time, developments in the field of medicine have affected both the course and the incidence of some of the diseases which once took a heavy toll of human life in this country. Diphtheria, for example, which used to be a major killer of children, has been almost as effectively brought under control by immunization as small-pox was by vaccination in the 19th century. The prognosis in cases of acute infections—like pneumonia—among children and young adults has been completely altered as a result of the discovery and use of anti-biotics. Medicine and surgery have devised effective ways of dealing with those suffering from tuberculosis. New ways of treating the mentally ill have changed the character of mental hospitals in this country. From institutions for the care of chronic sufferers they have become much more remedial centres where many patients can expect a rapid alleviation of their condition and a return to normal life.

All these developments in the economic and social life of the country and in the effectiveness of medical practice have undoubtedly brought about an overall improvement in the general standard of health of the nation. The improvement is most clearly reflected in the nation's vital statistics. Since the beginning of the century, every decade has shown a reduction in the mortality of younger age groups in the population, and the survival of more men and women of all social groupings to a ripe old age. The improvement is also shown in the comparative heights and weights of school children in the years between the wars and of those who are growing up in post-war Britain. Many doctors qualifying since 1945 have never seen a child with rickets, a disease caused by vitamin deficiency. The number of people diagnosed as suffering from TB each year continues to decline and the recovery rate of the infected to improve. The childhood infections such as measles and whooping-cough which often brought death or permanent disablement are now rarely killers.

Overall improvement

In short, the last half-century has seen a significant reduction in the incidence and severity of many of the diseases which used to be the major causes of death or permanent disablement in the nineteenth century.

The improvement in the health and length of survival of the population of working age has been less than it might have been owing to the emergence or increase of other causes of premature death or disablement which were relatively unimportant in the nineteenth century. An increasing number of middle-aged men, for example, now die prematurely from coronary heart disease and cancer of the lung. Diabetes and duodenal ulcer affect an increasing proportion of the male population between the ages of 40 and 60 and take a heavy toll in disablement and death. Road accidents are now one of the most important causes of death and disablement among school children. Nevertheless, despite the emergence of new threats to health and longevity, there is little doubt that the last 50 years have witnessed a substantial improvement in the general standard of physical health enjoyed by the younger age groups in the population as a whole.

Despite the overall improvement in health, substantial differences remain in the occupational and class incidence of many diseases and of mortality generally.

The only generally agreed method among epidemiologists for assessing "class" membership is based on the Registrar General's Classification of Occupations (1950) which was drawn up for use in the 1951 Census. Several thousand occupations were listed and allocated to one of five social classes. Social Class I represents the major professional and business occupations and Social Class II the intermediate professional occupations; Class III, to which rather more than 50 per cent of working and retired men were allocated at the 1951 Census, covers skilled manual workers, intermediate supervisory grades, shop assistants and clerical workers; Class IV covers semi-skilled manual workers and agricultural labourers, and Class V, unskilled workers, dockers and building trade labourers.

The allocation of occupations to the various social classes is based on the assessment of socio-economic standing of occupations prior to the 1911 Census, and is recognised by both sociologists and epidemiologists to be a rather crude and unsatisfactory indication of both economic level and social standing in the occupational hierarchy today. In particular, the allocation of occupations to Social Classes III, IV and V, that is to those classes which represent people who would popularly be described in the main as "working class", is generally recognised to be in urgent need of revision in the light of the changes which have occurred in the social and economic structure of this country during the last fifty years. Pending such revision, however, social scientists continue to use the Registrar General's divisions as an indication of Social Class.

Premature Death

The first indication of the social distribution of disease is to be found in comparative mortality rates. In 1950, the standardised mortality ratio for men aged 20 to 64 showed 118 deaths in Social Class V for every 97 deaths in Class I. The contrast between Classes II and V was even more striking, Social Class II showing the lowest mortality ratio at 86. Between the ages of 25 and 35, the death rate was twice as high for Class V as it was for Class II. Where married women between 20 and 64, grouped according to their husbands' occupations, were concerned, the overall position was similar; but in the 20 to 24 age group, the death rate for Social Class V married women was more than four times as great as for Social Class I.

The diseases which account, in the main, for the higher mortality rates in adults of working age in Class V are tuberculosis, pneumonia, bronchitis, rheumatic heart disease, and cancer of the stomach. Class V was also more likely to die from accidents both on the road and in the home. Where some other diseases were concerned, for example, coronary heart disease, the social gradient was reversed and Class I showed the highest mortality rates; moreover, it would appear that in the case of at least some of the diseases which appear to be increasing, there is either no gradient between social classes or a gradient which works against the professional groups. In short, the high standard of material well-being which is enjoyed today has its own health hazards; but in 1950, mortality from these causes was not sufficient to affect the differences in death rates between Class I and V.

Class differences in infant mortality in 1950 were even more marked than differences in adult mortality. In Class V, deaths occurring within four weeks of birth were about one and three-quarter times as great as for Class I. Deaths occurring between four weeks and a year were over three and a half times as great in Class V families as they were in Class I. Moreover, a similar comparison between the infant mortality rates of different Social Classes in 1921, shows that the relative differences between classes are as great today as they were then. In other words, in the last 30 years, mortality rates of the infants born into the most privileged families in the community have fallen proportionally as much as have those of infants born into the least privileged.

The significance of such evidence taken over time is difficult to measure. The class system in this country is not a rigid caste system, and there is mobility between classes. In other words, when we talk today about those whose occupations place them in Class III, we may be talking about men whose fathers were in Class V. In addition, changes in industrial techniques have themselves affected occupational classification. A smaller proportion of the labour force, for example, is now called "labourer" and therefore classified as Class V. Class III, on the other hand, which covers an enormous range of manual and routine clerical jobs has expanded greatly. It is possible, therefore, that a narrowing of the range of social differences has occurred which is not revealed when comparisons are made over a period of time, between the mortality rates of the Classes at the top and bottom of the social scale.

Class Difference in Illness

Another indication of the social distribution of disease is to be found in morbidity indices. Accurate measurements of illness in any community are difficult to obtain. Some community surveys have been made in order to estimate the prevalence of certain diseases; but such surveys are expensive and when undertaken always fall short of complete accuracy since they depend on the voluntary co-operation of individuals and their ability to describe their symptoms.

In most cases, therefore, epidemiologists fall back on hospital or general practitioners' records in order to estimate the social distribution of disease. If, as seems likely, certain social classes are less prone to seek medical treatment than others, the comparisons based on hospital or other diagnostic centres will contain some errors. Nevertheless, it is agreed by epidemiologists that such errors are not likely to alter materially the general picture of class differences in disease which has been observed in this way.

Various field and hospital studies undertaken since 1945 have established beyond any reasonable doubt that to be low down the social scale increased one's chances of illness. In early childhood, the children of unskilled workers are more likely to fall ill with serious respiratory and gastro-intestinal infections than are the children of other classes. The former are more likely too, to be sent to hospital as a result of serious accidents. During their school years, their heights and weights are likely to be less than those of other children of the same age. At eighteen, the boys are more likely to be rejected for national service in the armed forces on both physical and psychological grounds. As adults, they are more likely, in most industries, to lose working days through ill-health than skilled manual workers. There are also likely to be propor-

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tionally more of such workers suffering from one of the most serious mental illnesses requiring hospital treatment—namely schizophrenia.

Among women, an excess of illness is also found among those with husbands or fathers whose occupations are graded as Class V. They are more likely to give birth to premature or still-born infants, and they are more likely to die in childbirth. (In parenthesis, however, it is interesting to note that the social gradient, descending fairly steeply from Social Class V to Social Class II, so far as maternal mortality is concerned, ascends steeply for Social Class I, whose maternal mortality rate is higher than that of all other classes with the exception of Class V.)

Where health is concerned, therefore, there is little room for doubt that there is a persistent excess among the families of unskilled workers of those conditions which have yielded most, in the recent past, to the joint onslaught of improved material well-being and good medical care.

Other Indices of Class Difference

The lag of Class V behind other classes, and the smooth class gradient, which is still apparent in the prevalence of many illnesses and their outcome, are not confined to the health field. They appear in other indices of types of behaviour, which, given our present value system, we use to measure the extent of social "efficiency" or social "mal-functioning".

For example, where precautionary measures, designed to promote health and prevent disease, are concerned, Class V appears to differ significantly from other classes in society. Local enquiries have shown, for example, that the wives of unskilled workers are less likely to use the free infant welfare services of the local authority Health departments than the wives of skilled workers. They are less likely to give their children cheap or free vitamin supplements in the form of cod liver oil or orange juice, or to have their children immunized against diphtheria or vaccinated against smallpox. They are also less likely to seek ante-natal care and advice at an early stage of pregnancy, and, when they or their children fall ill, are more prone to postpone securing medical treatment until a critical stage of the disease.

An accumulation of other evidence suggests an excess of socially unacceptable types of behaviour among the families of unskilled workers. For example, it would appear that an undue proportion of the children referred to Child Guidance Clinics or convicted before the Juvenile Courts are from the families of unskilled workers. Similarly, illegitimate births in at least one city—Aberdeen—were found to be far more frequent among women whose fathers were unskilled manual workers than among other groups; and, although there is a justifiable distrust of the term "problem family", there is little doubt that much of the work of social case work agencies is concentrated among families where the father drifts in and out of casual, unskilled employment.

The Challenge

The persistence of marked differences of health between social classes and in aspects of behaviour which have an important bearing on the maintenance of social order constitutes a major challenge for the health and social welfare services today. Quite clearly, there is still room for a reduction in the incidence of premature death, disease, delinquency and inadequate social behaviour among all

social classes. It is still true that the biggest contribution to the health and welfare of the community as a whole would be achieved by a narrowing of the range of social differences, and an improvement in the health of those who occupy the lowest rungs of the social ladder to the level enjoyed by people on the middle and upper rungs.

How such an improvement can be achieved will depend, however, on our ability to trace the reasons for the disparity between the health of different social groupings.

Explanations for Social Differences

What lies behind the concentration of hardy perennial problems of ill-health and delinquency among certain groups of manual workers and their families?

In the past, many socialists have suggested that there was a simple explanation for social differentials in health. It lay, quite simply, in the different levels of material well-being enjoyed by different groups in the community. The remedy, therefore, although difficult to achieve, was clear and straightforward. Raise the purchasing power of the poorest groups in the community, provide social services of a high standard in the field of education, health and housing, let access to all the best available in these fields be based on need and common citizenship and not on private means, and social differences in the pattern of health and delinquency would disappear.

In the last few years, however, when a great deal has been achieved in all these directions, this simple explanation for class differences in health appears inadequate. Moreover, alternative theories are being developed. For example, some human geneticists are inclined to the theory that inherent biological factors are involved; that, as the result of a process of social selection which favours the most efficient intellectually and physically, the ranks of unskilled workers are tending increasingly to consist of those who in our society, are least healthy and least likely to survive, while the healthier specimens move up the social scale.

A second theory is that differences in health experience are due, not primarily to differences in standards of material well-being, but to the different values which motivate various occupational and social groupings. In other words, social groups have different attitudes towards life, health and disease and towards medical treatment, and it is these differences, rather than differences in economic standing or physical environment, which affect health.

These theories cannot be dismissed arbitrarily. Evidence is accumulating that both theories contain important elements of truth, although neither theory provides, in itself, a completely satisfactory explanation. How far their further development is likely to contradict or merely to modify the view that man's health depends primarily on his external man-made and socially-governed environment will be the subject of a second article to be published in the next issue of this review. The article will discuss the evidence which supports these two types of explanation for social class differences in health matters, and the criticisms which can be made of them. It will also discuss the extent to which criticism of the environmental explanation of social class differences has been valid, and suggest the lines of research which might be explored, particularly on the social side, if we are to get nearer to an understanding of the multiplicity of factors which affect man's chances of health and survival in 20th century Britain.