What Health Tells Us About Society

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1 Introduction*

Research on health inequalities is changing our understanding of how people are affected by the social structures in which they live. Differences in death rates provide 'hard' data on the impact of socio-economic inequalities on people's lives. Evidence of three-fold differences in death rates between upper and lower social classes, or between richer and poorer neighbourhoods, remind us of how sensitive health continues to be to differences in material circumstances – even in supposedly affluent developed countries. Research over the last 15 or 20 years has shown that this mortality gradient results less from the direct effect of differences in people's material circumstances than it does from the psychosocial effects of those differences. Although factors such as damp housing and inner city air pollution do have direct effects on health, much more important are the health effects of people's subjective experience of their position in society – whether it makes them feel successful, optimistic, confident, or failures, socially excluded, depressed, economically insecure and desperate.

The health gradient does not distinguish merely between the poor and the rest of society: health standards and life expectancy improve all the way up the social ladder. So for instance, even in the Whitehall Study of 17,000 civil servants working in London offices, the most junior staff were found to have death rates three times as high as the most senior staff working in the same offices, with the ranks in between having intermediate death rates (Marmot 1984). Nor is this a matter of simply one or two causes of death: with the exception of breast and skin cancer, the vast majority of causes of death are more common lower down the social scale.

After the publication of the **Black Report Inequalities in Health** in 1980, the first research task was to check whether these health differences were produced by a tendency for social mobility to move the healthy upwards (and the unhealthy down). It turned out that although there is a tendency for this to happen, it makes only a small contribution to health inequalities (Blane et al.

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1993). Indeed, social mobility seems to reduce the differences which would arise if everyone was exposed to the same advantaged or disadvantaged conditions throughout their lives.

The next research task was to look at the contribution of behavioural factors like smoking, unhealthy food choices or lack of exercise. Again, while these factors are influential, they leave most of the health inequalities – even in diseases like heart disease – unexplained. This is partly because there are only very minor differences in fat consumption between social classes, and partly because behavioural factors are less important than people imagine. Even if you minimise your risks by getting all the behavioural factors right, your most likely cause of death is still heart disease.

Although there are very strong relationships between almost any measure of health and almost any measure of social and economic circumstances, attempts to account for the bulk of this relationship in terms of the toxic effects of exposure to hazardous conditions have met with little success. It is for instance difficult to see how poor housing could increase the incidence of cardiovascular diseases or cancers. Similarly, class differences in fat consumption are much too small to explain any of the huge differences in heart disease. However, psychosocial factors, like having control over one's work and domestic circumstances, job security, a regular income, social support, the absence of long-term difficulties and threatening life events, the quality of parenting and lack of family conflict early in life, all appear unexpectedly successful in explaining differences in physical disease. Epidemiological evidence has pointed increasingly towards such psychosocial factors, and the biological pathways through which chronic stress – or worry – can effect the immune and endocrine systems and increase the risks of a wide range of diseases (Lovallo 1997).

2 Social Position

Thus, health is linked to material circumstances primarily through psychosocial rather than direct material pathways. This is confirmed by recent evidence which shows that the relationship between income and health is less a reflection of the impact of ***absolute*** income levels on health as of the effects of ***relative*** income. Living standards for the vast majority of people in the developed world have long surpassed the levels at which absolute material standards are the main limitation on health: what matters now is where your income places you in the social hierarchy.

The health impact of social status is also powerfully demonstrated by studies of non-human primates, particularly among baboons and macaques. The health impacts of social position seem to hinge on the physiological repercussions of chronic stress experienced by subordinate animals; this is strikingly similar to the effects found among human beings in low social status positions. Amongst the monkeys and baboons it is possible to manipulate social status experimentally, and so to confirm that causality does indeed run from social status to the physiological differences rather than the other way round.

3 Income Inequality

Arising from the importance of relative income and the effects of low social status is a marked tendency for more egalitarian societies to be healthier. In the developed world, it is not the richest societies like the United States which are healthiest, but the ones with smaller inequalities in income – like Japan and Sweden. This relationship has now been found in various data sets looking at international differences (at a specific point in time, and at changes over time). The same relationship has also been found recently among the 50 American states: again it is not the richest, but the most egalitarian, states which have the lowest death rates. The most important part of the explanation for this is almost certainly that greater equality reduces the burden of relative deprivation on health. In effect, societies are healthier where the hierarchy is less hierarchical.

The relationship between greater equality and better health is surprisingly strong. If, as the statistics suggest, it accounts for anywhere near half the differences in life expectancy between developed countries, the amount of inequality would be the most powerful influence on population health yet identified.

While there can be little doubt that the main health benefits of greater equality accrue to the least well-off, there may also be some knock-on effects of

living in a more egalitarian society that benefit the rich. Although the major categories of cause of death – including cancers, infections, cardiovascular and respiratory diseases – all tend to be more common in more unequal societies, the causes which respond most dramatically (in terms of percentage changes) to the scale of income inequality are accidents, alcohol related causes, violence and infections. These rather social causes suggest that there are differences in the nature of the social fabric and in risk behaviour between more and less egalitarian societies. Even though the least well-off will suffer most from the higher rates of homicide, accidents and infections, the rich are unlikely to be fully insulated from them or the social processes behind them.

4 Social Cohesion

It seems then that death rates reflect the powerful effects of inequality on the psychosocial welfare of populations. But if income differences have a sufficiently powerful effect on the social fabric to affect death rates, they must surely also influence other social problems. The much higher death rates from alcohol related causes, accidents and violence in less egalitarian societies already point the way to other effects. Research has shown that homicide rates are related to income inequality both internationally and in the USA where they explain an important proportion of the nine-fold differences in homicide rates in different states (Kaplan et al. 1996). Violent crime is similarly related but, at least in some statistical series, property crime appears less closely related. In Britain, overall crime rates are so closely related to measures of deprivation that it is hard to distinguish between maps of crime and maps of deprivation. Japan is interesting here: after income differences had narrowed during most of the post-war period, by the end of the 1980s Japan had the narrowest income differences and highest life expectancy in the developed world. It had also enjoyed a long-term decline in most categories of crime – particularly those associated with deprived areas and lower socio-economic status. Indeed, only categories of 'white collar' crime had not declined.

In Britain, between 1979 and the early 1990s, the proportion of children who came from homes in which people live on less than half the average income grew from about ten per cent to over 30 per cent. Much the most rapid part of this growth took place after 1985. During that period, reading standards in primary schools declined, and research showed that this had nothing to do with the use of the reading methods (which various government ministers had sought to blame); the watershed year was 1985, and the deterioration was most apparent in the inner cities and in schools with poor catchment areas. In the same period there was also a marked decline in the rate of improvement in death rates among infants, children, and adults under 45. Again, the poor performance was clearly concentrated in the most deprived areas.

If almost a third of children come from homes below the poverty line, teaching and learning obviously become more difficult. Brought up by parents coping with the increased stress of caring for children with inadequate and insecure resources, levels of tolerance and patience will be lower and children will suffer more emotional and behavioural problems as a result. Because of the close links between health and emotional welfare, domestic conflict in childhood not only leads to poorer school performance and to an increased willingness to resort to violence, but also to worse health later in life.

A quite different short-term indicator of the effects of widening income differences on psychosocial welfare comes from smoking statistics. As the poor got poorer, it seems that – despite the expense – they smoked more. The continuing long-term decline in smoking among most of the population was reversed among poorer men and women (Marsh and McKay 1994). Just when their relative poverty was increasing most rapidly, the poor devoted a larger proportion of their income to smoking. It is hardest to give up smoking when you feel hopeless and least in control of your life.

Several pieces of evidence suggest that part of the reason why more egalitarian societies are healthier is that they tend to be more socially cohesive. Several examples of unusually healthy and egalitarian societies described in my **Unhealthy Societies** – like Britain during the two World Wars, Japan, and an Italian-American town called Roseto in Pennsylvania – suggest that what may be important is a sense of camaraderie, or something approaching a community of values capable of ensuring that the

public space is a social space and that social life does not stop outside the front door. The impression that something like social cohesion is involved is strengthened by data, again, from the United States. It shows that the relationship between greater income equality and lower mortality rates is mediated – at least in statistical terms – by the extent to which people feel they can trust each other.

5 The Declining Importance of Economic Growth

Thus the nature of the social environment appears crucially important to human welfare. Since the so-called 'epidemiological transition', when infectious diseases gave way to the degenerative diseases as the main causes of death, the grip which material living standards used to have on mortality has loosened. Infections remain the most common causes of death in poorer countries, primarily because a threshold of material status has not yet been reached by a large proportion of their populations. Indicative of the attainment of this threshold in the developed world is that, in the later stages of the decline in infections, a number of the so-called 'diseases of affluence' reversed their social distributions to become more common among the poor in affluent societies. Amongst others, coronary heart diseases, stroke, lung cancer, duodenal ulcers and obesity, from being most common among the rich, became most common among the poor in affluent societies. Throughout history the rich had been fat and the poor thin, but with rising living standards the poor could now afford to be fat. Obesity lost its association with social status, ideas of physical attractiveness changed, and the slimming industry was born.

The decline of the infections, together with the way the diseases of affluence became the diseases of the poor in affluent societies, shows that the epidemiological transition marks the attainment of minimum material living standards for the bulk of the population. This explains the subsequent weakness of the link between rising life expectancy and economic growth. Although life expectancy continues to rise, how fast it does so now bears very little relationship to long-term economic growth rates. Having attained a threshold standard of living consistent with good health, economic growth does much less for us than it once did. Although there is still homelessness and absolute material need, not only is the proportion of the population affected too small to influence population mortality rates, but these problems have re-emerged despite economic growth, partly as a result of widening income differences.

A much more important source of the continuing improvements in life expectancy than economic growth are the social and cultural changes which, though partly enabled by the dramatic reduction of material need, sweep across the developed world, largely unaffected by different growth rates. The central features of this progress are likely to involve the civilising processes of a general psychosocial liberalisation. Its most easily identifiable outward features – such as the abolition of the corporal punishment of schoolchildren – are reflections of deeper processes. The same is true of the abolition of capital punishment, the legalisation of homosexuality, the abolition of conscription, the greater informality of social life at all levels and the growing recognition of the importance of our psychological and emotional development. Indeed, it seems likely that these factors move forward more rapidly in more egalitarian societies. Here, the contrast between countries like the United States and Sweden with respect to issues like capital punishment, is telling.

Going through the emerging picture of the social determinants of health, it is difficult not to believe that even more important than what society tells us about health, is what health tells us about society and the quality of life. (But note that although it is easy to be dismissive of a few years extra life expectancy in societies which already think of themselves as overburdened by the proportion of old people, most of the increase in life expectancy has come from reducing deaths at younger ages.)

6 The Social Environment

The picture of health inequalities might have looked much the same had we looked at other social problems such as violent crime, the educational performance of schoolchildren, or drug taking. They – and social cohesion itself – are all powerfully affected by the scale of relative deprivation. We are dealing with the socially corrosive effects of inequality on the real subjective quality of

life. The material problems of those on low incomes have increased as a result of widening income differences, rather than from a lack of economic growth.

Our highly developed sensitivity to the social environment is almost certainly attributable to the fact that the quality of social relations has always been a crucial determinant of human welfare. Other human beings are potentially our most awesome competitors, competing for the same food, housing, sexual partners, jobs, even the shirt off our backs. But equally, our fellow human beings have the potential to be the greatest source of comfort, love, solace, help and fellowship. The nature of social relations must always have been crucial to human welfare. Indeed, this is likely to be why the hunting and gathering societies which dominated human pre-history were 'assertively egalitarian' and usually eschewed forms of exchange which were overtly self-interested. The reliance on gift exchange and food sharing almost certainly shows the importance of investment in social relations. After all, 'gifts make friends and friends make gifts'. Keeping on friendly terms with other people and avoiding envy and conflict were basic to survival and to the quality of life.

At the centre of the current contemplations about the collapse of communist thought seems to be a lack of any idea of a coherent alternative to the market. The opposition between socialist values and the market has been so central that we have often seen the need to work out a coherent alternative to the market as the precondition for any socialist or humanitarian society. The central problem is the way the exploitative and overtly self-interested rationale of the market conflicts with the mutuality which is fundamental to social relations. The impossibility of inventing an alternative to the market has politically immobilised many who recognise the need for a more social society.

But even market societies can develop in very different ways. It is only too easy to imagine a future in a divided society, in which the rich live in protected enclaves, while the poor themselves are left to hopelessness and the fight for whatever meagre resources are left to them. Fortunately, it is also easy to imagine a more egalitarian and cohesive future in a society which has invested in the education and welfare of the whole population and, by enabling new forms of social expression, sows the seeds of a more social future. There are already examples of such societies. The more egalitarian societies such as those of Japan or Sweden contrast sharply with the much more violent inegalitarian countries like the United States or the even more divided but poorer societies such as South Africa, Brazil, Columbia and perhaps even Russia. The immediate political task is to ensure that we take the more social path.

We stand at the watershed between these two courses. With future hindsight, perhaps the choice of this new Labour government will prove to have been the moment when the decision to take the more social route was taken; but the political changes in Britain have been bound up with the wider demise of a monetarist approach, an economic theory associated with a pessimistic theory of human motivation and of society, providing the ideological underpinnings of the political right. This was beginning to look like a played out force before the end of the 1980s; the size of the Labour victory simply reflecting how far it had got beyond its sell-by date. Its moral and social bankruptcy had become plain in the government's disregard for increasing relative poverty and in the frequent signs of corruption in public office.

7 Equality, Cohesion and Economic Growth

Particularly timely in terms of the possibility for developing a more social economy is a change in thinking on the relationship between greater equality and economic growth. One of the most important obstacles to reducing income inequalities, and indeed one of the reasons why recent governments allowed them to grow, was the belief that inequality was a stimulus to effort and economic growth. Now, however, most of the ground for that wisdom has been swept away. There are at least four studies using independent data which all suggest that more egalitarian societies have faster growth rates (Glyn and Miliband (eds) 1994). Indeed, the signs are of a new economic orthodoxy which says that equity is good for growth (Osberg 1995). The shift in opinion has even started to percolate into the World Bank. Explanations of the association between equity and faster growth range from issues to do

with the expense and wastage of 'human resources' caused by relative poverty and the failure to invest in people, to the ways in which trust and better social cohesion lubricate the workings of society so reducing a firm's 'external costs'.

These changes in the empirical evidence and the new thinking are crucially important: they tell us not only that we do not face a choice between going under in the face of international competition or accepting the social costs of greater inequality, but that our economic position is likely to improve as a result of tackling the social divisions in our society. If inequality and the destructive effects of relative poverty lower society's productivity, then the need for economic efficiency becomes a socially progressive force. Economic efficiency means raising educational standards throughout the population, it means improving social cohesion and ensuring that people are able to develop their productive potential.

What is true at the societal level may also be true in terms of the social organisation of work. Rather than reducing efficiency, a more cohesive and egalitarian ethos which improved working relationships seems likely to improve productivity. Consider the implications of a situation (shown in the Whitehall Studies) in which death rates are three times as high among the most junior as among the most senior office staff. What does it mean if sickness absences are six times as high among the most junior staff (North et al. 1993)? The problem for employers is twofold: poor health is expensive; but also, the most important causes of health differences at work are things like the amount of control people have over their work, their security, the social support they get from colleagues, their self-esteem, anger and depression. These are all quite closely related to morale, and it is likely that people are less productive where morale is low. Therefore, business interests can no longer afford to ignore health inequalities. Employees will have better morale, will be healthier and will make a bigger contribution to the organisation's efficiency if they feel valued instead of used, and are able to combine a sense of purpose in their work with greater control over it.

Although firms already try to foster a sense of commitment and loyalty in their staff, having a sense of purpose about one's work and feeling a valued member of a team are surely ultimately incompatible with a structure of exploitative employer/employee relationships. Finding a resolution to these issues may well tend to favour firms which move closer to some form of industrial democracy. Emancipated and purposeful human beings function better, and the institutional arrangements which foster their emancipation will have a competitive advantage.

The astonishing flexibility of capitalism and the market means that they need not be incompatible with economic democracy (a term which can cover a wide range of institutional forms including the election of directors and chief executives by employees – essentially making bosses accountable to employees – to more cumbersome arrangements for involving employees more directly in decision making). Already a great deal of capital is, like the pension funds, is owned by institutions, and there are examples of pension funds controlled by the members whose pensions they manage. Firms controlled democratically by employees would be perfectly capable of raising capital by paying agreed interest rates without having to give control to the providers of loans; and investors would be able to make their assessments of risk and act accordingly.

There are numerous opportunities for social progress to which the market mechanism itself may not be an obstacle. It is important to distinguish between opposition arising from the institutional power of the privileged and the effects of the market mechanism itself. Indeed, the vested interests of the privileged often act as a brake on the more democratic tendencies in the market. It was this democratic aspect of the market which made Tom Paine see free trade as a counter to the institutionalised power of the aristocracy, and perhaps explains why the rapid economic growth among the so-called Asian 'tiger' economies started only after the combined effects of the Second World War and the struggle with communism had weakened or removed the previous ruling elites and ushered in a number of social reforms, including greater equality.

9 Socialising the Market

In the absence of an alternative to the market, the social fabric depends on the extent to which the market can be socialised. Few of the progressive features of market societies have come about

directly as a result of the unfettered working of the market. Most have involved political organisation, trade unions, energetic campaigns and the use of legislative power. Democratisation of economic life, the development of egalitarian working relationships, and more cohesive societies, are not only winnable within the prevailing system, but are made all the more urgent by the demands of economic efficiency. Without social reform, the market, guided only by the institutionalised power of the rich, would jeopardise not only the real quality of life, but also the social and economic progress of our society.

In material practice we become ever more interdependent as we produce goods and services for the use of others and rely for the satisfaction of almost all our needs on what others – all over the world – produce. This social activity will need to be co-ordinated by the market until our sociality is sufficiently developed for us to be able to act directly in relation to the social purposes inherent in it. But it is surely imaginable that, as we grow to experience ourselves as gaining a sense of purpose from working on equal terms with others in a cohesive society, that we will also start being able to reduce reliance on the market in other areas. If so, the humanisation of society will depend more on pushing back the boundaries of the market. By expanding the sphere of interactions which we experience as social, egalitarian and humanistic – rather than as anti-social market transactions – we will increase our social capacities, so paving the way for further advances and a fuller realisation of our human sociality.

There is now strong evidence from evolutionary psychology that we have genetically enshrined capacities for living co-operatively based on relations of 'reciprocal altruism': a tendency to feel indebted, to reciprocate gifts, and to be intolerant of freeloaders (Ridley 1996). The dominance of gift exchange and food sharing among hunter-gatherers depended on the power of the gift to create a sense of indebtedness and the need to make a return gift. These patterns of meaning are human characteristics found in all societies. But they extend more widely and more deeply than the aspects of reciprocity most directly involved in reciprocal gift exchange. Contributing to the welfare of others brings with it a sense of having a role and a function in relation to others, a sense of self-worth and self-realisation. Contributing voluntarily to the welfare of others is self-validating and provides a sense of meaning in a way which activity motivated by the self-interested rationale of the market often cannot.

It is the unmediated and inherently social links which are most fundamentally inconsistent with the market. Our capacity for reciprocal altruism is the basis of social relations and was once the basis of social organisation. Membership of the sharing group was also the nearest thing to a guarantee of security. It seems increasingly likely that the social environment most conducive to good health will turn out to be one in which people are bound together by relations of practical reciprocity, and daily life is organised in a way which makes more of that reciprocity apparent. The deep social needs illustrated by the health patterns with which this article started probably depend for their satisfaction on experiencing ourselves as part of a web of human relations, providing mutual support through reciprocal altruism.

10 The Quality of the Social Environment

Titmuss's work on blood donors indicates the potential for reciprocal altruism to find wider expression. An essential part of the socialisation of life involves expanding the areas of working life and life on the streets which are egalitarian and socially mediated. This includes not only areas like health services which are free to users, but also a huge range of voluntary work. It is not simply a matter of an intimate cocoon of social relationships for each of us; it is also a matter of social inroads into the public life of society, of finding ways of making the public space more of a social space. Perhaps provisions such as free urban public transport would serve to increase the sense of common citizenship.

The project of making modern societies more user-friendly is partly a project of exploiting the unrealised social potential of the market and of expanding the area of life which is not mediated by the market. The determinants of health contain a message about our social needs and our potential for social motivation to which the institutions of our society must adapt.

The quality of the social environment is clearly the next big project facing developed societies. The increasing interest in ideas like stakeholding societies, communitarianism and social cohesion show how this project is moving up the political agenda. There is now ample evidence that the real human benefits of continued economic growth are subject to sharply diminishing returns in the developed world. As well as posing environmental problems, further increases in the absolute material standards are now less important to our subjective welfare than psychosocial factors influenced by income inequalities and the quality of social relations. As Frank (1996) has shown, the individual desire for increased income is better understood as a desire to improve one's relative position in society than as a desire for economic growth with no change in relative position.

To say that we do not need economic growth as much as we did, or as poorer countries still do, does not mean an end to technical change. Instead it means thinking about qualitative rather than quantitative change. We need continued innovation partly to save resources and decrease the impact of economic activity on the environment; we also need innovation and qualitative improvements to deal with the incoherent material infrastructure of our society – but that need not involve quantitative growth. We need to maintain international competitiveness; but this is consistent with the central project of improving the psychosocial quality of life throughout society.

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