

OCR examination questions

- 1** Identify and explain two ways of defining health. (17 marks)
- 2** Identify and explain two ways in which becoming ill is a social process. (17 marks)
- 3** Identify and explain two features of the biomedical model of understanding health and illness. (17 marks)
- 4** Identify and explain two features of the social model of health. (17 marks)
- 5** Outline and evaluate the biomedical model for understanding health and illness. (33 marks)

Patterns and explanations of ill health in society

Despite the existence of a National Health Service providing free comprehensive healthcare for all, patterns of **health inequality**, as [Marshall \(1998\)](#) argues, remain stubbornly persistent in our society. We can explore this claim by noting a range of **morbidity** and **mortality** patterns associated with **class**, **gender** and **ethnicity** and examining how each, in turn, is explained by artefact, social selection, cultural and structural models.

Social class

How we define social class is a significant factor in both the identification and explanation of patterns of morbidity and mortality. A major problem is that different sources, both sociological and non-sociological, frequently define class in slightly different ways. While some define class subjectively, for example, others insist it must be defined objectively.

Subjective definitions involve people's 'own conceptions of the class structure and their position in it' ([Bulmer 1975](#)) — in other words, how people define their own class position. There are problems in using this type of definition for our current purpose, because of the **meanings** people give to social class. They understand 'class' in different ways and consequently define class position using a variety of criteria — from how people speak, to where and how they live, to how much money they earn.

There's also a general tendency to define class in very broad ways, such as working class or middle class. This makes **comparisons** between classes difficult; if there are many different, personal meanings to class it's effectively impossible to compare 'like with like' for statistical purposes.

Objective definitions involve identifying class criteria that operate independently of subjective beliefs. The most common form of **objective class indicator** is **occupation**, mainly because the type of work people do correlates with a range of other factors — levels of education, experiences of family life and, most significantly for our purpose, levels of health and illness.

While occupation is a good, general, objective measure of class, there are disagreements about how to classify occupations. Until 1980, the most common official (government) classification was the Registrar General's social class scale (Table 11.1). This divided the population into five basic classes, based on a distinction between non-manual (middle-class) and manual (working-class) work.

Table 11.1 Registrar General's social class scale (1911–1980)

	Social class	Example occupations
Non-manual (middle class)	1 Professional	Accountant, doctor, clergyman, university teacher
	2 Intermediate	Pilot, farmer, manager, police officer, teacher
	3N Non-manual skilled	Clerical worker, sales rep., shop assistant
Manual (working class)	3M Manual skilled	Butcher, bus driver, electrician, miner
	4 Semi-skilled	Bar worker, postal worker, packer
	5 Unskilled	Labourer, office cleaner, window cleaner

Since 1980 a range of scales have been developed and used by the UK government:

- [The Standard Occupational Classification \(1990\)](#), for example, identified nine class groups, but this was revised (2000) to include slightly different occupational groups.
- [The National Statistics Socio-Economic Classification \(2005\)](#) has also been used but, to add to the confusion, it has three different versions based around groupings of eight, five and three classes.

While we need to keep these differences in mind, we can use a relatively simple distinction between manual (working class) and non-manual (middle class) for the purposes of highlighting class-based health inequalities.

We can start with the idea of **health chances** (such as chances of avoiding long-term illness or premature death). These, [Knott \(2011\)](#) observes, are unequally distributed in our society: 'Despite the welfare state and the improvement in health in all sections of societies, this discrepancy remains and it applies to all aspects of health'. An interesting benchmark, in this respect, is [The Black Report \(1980\)](#), which noted that the working class experienced:

- higher infant mortality rates
- lower life expectancy
- higher death rates (over twice as high in the lowest class as compared with the highest)
- greater inequalities in the use of medical services

Thirty years later, current morbidity and mortality patterns show a broadly similar trend.



Identify and explain one problem with defining social class.

Morbidity

We can note a range of patterns related to class.

Morbidity rates are higher in those with lower income. Around 40% of adults aged 45–64 on below-average incomes have a limiting long-standing illness or disability — a rate around three times higher than for those on high incomes. There is a similar morbidity relationship for those aged 65–74.

Morbidity rates are higher in those of lower class. Adults aged 45–64 in manual occupations have higher rates of morbidity (limiting long-standing illness or disability) than those in non-manual occupations. There is a similar morbidity relationship for those aged 65 and over.

Smith et al. (2010) found higher rates of **self-reported** limiting long-standing illness or disability for those lower down the class structure. They also found that the highest social classes enjoyed longer life expectancy, and also greater disability-free life expectancy (almost twice as great for a male child born in Kensington as for one born in Manchester). Upper-class males and females could expect (respectively) 12.6 and 11 years longer without a disability than their working-class counterparts.

Those at the bottom of the class structure (the poorest 20% by income) have a greater risk of developing a **mental illness** than their higher-class counterparts. Overall, those in manual occupations have a slightly higher risk of developing a mental illness than their non-manual counterparts.

Child morbidity follows a similar pattern. Working-class mothers have a higher risk of producing babies with a low birthweight, and a low birthweight greatly increases the chances of the child developing a life-threatening illness in later life. Working-class children have more dental problems (decayed or filled teeth) than their middle-class peers.

Mortality

Working-class men aged 25–64 are twice as likely to die prematurely as those from managerial or professional backgrounds. The position is not as bad for working-class women, but sizeable differences remain. These class differences are repeated for all the major causes of death (cancers and circulatory diseases, such as heart disease). Death rates from all major causes for working-class men aged 25–64 are much higher than those for middle-class men.

Working-class children are 35% more likely to die as infants than their middle-class peers and they are more likely to suffer accidental death.



Summarise the relationship between morbidity, mortality and social class.

Explanations

Artefact

According to one explanation, the apparent relationship between class and morbidity/mortality is not the result of a real and strong correlation but rather an outcome of how such statistics are created and relationships measured. In other words, the relationship we seem to observe is an **artefact** of the **measurement** process.

Defining social class is both difficult and subject to competing interpretations; measuring 'health' (in terms of things like long-term illness or premature death) is similarly problematic. Given these problems, it is argued, we should not assume that any relationship we find between the two is either **reliable** or **valid**.

There are two main problems with making **comparisons**:

- **Overgeneralisation**: When studies focus on very broad class categories (such as 'working class'), differences are overgeneralised, because the working class is getting smaller and the middle class larger. This overestimates class differences because a comparison is made between a smaller group who suffer generally poorer health and a larger group who enjoy higher levels of health.
- **Undergeneralisation**: Comparisons between those at the top of the class structure and those at the very bottom exaggerate the overall difference in health between the classes, because the two groups being compared are relatively small.

Evaluation

- **Patterns**: Although different studies use different definitions and measurements of class and health, they all show a consistent relationship between poor health and lower social class.
- **Mortality**: Even if we assume that morbidity measures are less reliable indicators, the relationship between class and life expectancy remains strong however we measure class (by occupation, household type, income, education or whatever).
- **Refinement**: **Berkman and Macintyre (1997)** argue that, while artefact effects are a particular risk when relating class to health, we should develop a more refined approach to operationalising class, rather than abandon attempts to measure it because of the difficulties. This follows, they argue, because there is clear evidence of a strong statistical relationship between class and health.

Natural/social selection

The approach explains class differences in health on the basis that those who are seriously unhealthy generally drift down the class structure because they are unable to find employment or are employed in relatively low-paid work. Periods of chronic ill health may mean they are forced to move from job to job rather than focusing on an established career. For this approach, the relationship between health and class, although real, is the reverse of what we might expect.

We might expect that class determines health — that belonging to a lower social class leads to greater morbidity and lower life expectancy. However, in this approach

health determines class. When those higher up the class structure experience serious illness, they gradually slip down the class scale (from middle to working class). This means we would naturally expect the working class to be unhealthier than the middle class because this class is continually accepting unhealthy people from higher up the class structure.

The crucial idea here is that **health**, rather than class, is the most important **variable** in the equation; individuals are sifted and sorted into different classes on the basis of their different health statuses.

Evaluation

There is some statistical evidence of a 'drift' down the class structure for those with very poor health. However, it doesn't necessarily follow that 'health determines class', since there is strong evidence that the class into which children are born plays a significant role in patterns of adult health and illness.

In terms of *physical* health, for example, the [General Household Survey \(2002\)](#) found that children born into *workless* working-class households are twice as likely to develop limiting long-standing illness. More significantly, those living in working-class households were more likely to report a long-standing illness. Since chronic illness tends to develop later in life, when working careers and patterns are already long established, it follows that class must influence health, rather than the reverse.

In addition, if class origin was *not* a significant factor in social mobility, the 'working-class healthy' should experience *upward* social mobility. The evidence suggests this isn't the case.

Cultural/behavioural factors

This type of explanation focuses on the **individual** and their **health choices**, in terms of behaviour known to be **detrimental** to health (such as smoking, excessive drinking and poor diet) and behaviour known to **promote** good health (such as a healthy, varied diet and regular physical exercise). These choices are related to social class:

- **Working classes** generally display riskier and more damaging health behaviours: higher levels of smoking, heavy and regular consumption of alcohol, and diets high in saturated fats and low in fruit and green vegetables.
- **Middle classes** generally display healthier and less risky behaviour: varied diet, less smoking, more exercise and so forth.

When we aggregate these individual choices, we find that those at the bottom of the class structure have greater morbidity and on average die younger.

Evaluation

While there is clear empirical evidence of class differences in lifestyles, risky health behaviours and ill health, how we interpret this evidence is key to understanding the relationship between class and health.

One interpretation focuses on **individuals**. Lifestyle choices determine health — and the working class clearly make ‘poorer’ choices than the (healthier) middle classes. Class, therefore, is only related to health in the sense that we can group individual behaviours; there is nothing specific to social class itself that causes ill health. The solution to working-class health problems is, therefore, better health education and the adoption of less risky behaviours.

An alternative interpretation considers why risky health behaviours are rooted in **social class**. Rather than looking at individual behaviours, we need to ask if there is something about ‘being working class’ that makes people take higher individual health risks. For [Spector et al. \(2006\)](#), the strong relationship between class, ill health, age-related disease and lower life expectancy is explained in terms of ‘stress factors’. Ill health results from the strain of being in low-paid, manual work allied to ‘the psychological stress of having lots of areas you cannot control in your life’.

In this view, lifestyle choices are related to social class, not the other way around. The working classes smoke, drink and have poorer diets because of the stresses associated with low-paid work; psychological pressures relating to family life, unemployment, a lack of savings for old age and the like mean that the working classes are more likely to associate ‘risky health behaviours’ with pleasure. These behaviours are ‘ways of coping’ with a difficult and precarious social status.

Some studies suggest that cultural/behavioural explanations place too much stress on lifestyle choices. [Wadsworth et al. \(2006\)](#) found that ‘early social environment’ was crucial for many aspects of adult health, including life expectancy, ‘independent of the adult life environment’. Lifestyle choices, therefore, played only a relatively minor role in overall adult health across different classes.

Even in ‘best case scenarios’, such as the relationship between smoking and lung cancer, lifestyle choices do not explain everything. [Carroll et al. \(1994\)](#) found that, among those who had never smoked, there were higher levels of the disease in the working class than the upper class.

Structural and material factors

This approach focuses on the various ways in which the material conditions of people’s lives impact on their health. Higher levels of ill health, life-threatening conditions and infant mortality, and lower average life expectancy are all related to factors such as:

- poverty
- relative deprivation
- substandard and overcrowded housing
- lack of material resources
- lack of cultural capital (such as knowledge about health)
- lower educational achievement
- higher-risk occupations

Bartley and Blane (2008), for example, note how 'poverty exposes people to health hazards' such as air pollution and damp housing (the latter being closely associated with higher rates of childhood respiratory disease).

Over the longer term, Self and Zealey (2007) suggest that a range of **public health measures** introduced in Britain over the course of the twentieth century have played a large part in lowering working-class morbidity and mortality rates. These measures include slum housing clearance, improved public and private sanitation and clean water supplies. This argument suggests a strong relationship between class, health and material conditions.



BLACK COUNTRY IMAGES/ALAMY

Poor housing contributes to ill health

Marshall (1998) suggests that 'social factors play a major part in generating health and illness', with higher levels of good health among the highest social classes being related to factors such as the following:

- **Autonomy and control at work:** The more someone has of these, the less the likelihood of heart disease.
- **Effort-reward balance:** Work with high career prospects, excellent job security and high financial rewards is related to lower levels of physical and mental ill health. The reverse holds true: work that is highly demanding but offers limited security, career prospects and financial rewards has a greater association with serious ill health.

In this respect social class is demonstrably related to health; the working classes experience poorer health *because* they are working class — a relationship explained by their lower living standards and the riskier health behaviours that compensate in some way for their poorer material conditions.

Evaluation

The evidence for the relationship between social class, material conditions and ill health is strong — arguably stronger than the evidence for any other explanation. In addition, a strength of this approach is that it can explain, as we've seen, the relationship between lifestyle choices and health. However, several problems persist:

- **Artefact effects:** As we've seen, there are clear problems involved in defining both class and health, and some 'class differences' in health may be questionable — although, as we've also noted, these probably occur more at the margins of the overall analysis.
- **Life expectancy:** Women generally enjoy longer life expectancy than men across all cultures; and working-class women live, on average, longer than working-class men.

- **Long-term effects:** While the kind of material improvements noted by Self and Zealey have clearly impacted on working-class morbidity and mortality, their long-term effects are more questionable. The working class in the twenty-first century generally live under material conditions which are far superior to those experienced by their counterparts at the beginning of the twentieth century — yet they still suffer relatively worse health than those higher up the class structure. [Bartley and Blane \(2008\)](#) also note that ‘In the UK, relatively disadvantaged people receive various kinds of state help (rent, school meals etc.) which, some argue, makes diet or poor housing unlikely to account for all inequalities [in] health outcomes’.

Structural explanation

A rtefact
L ife expectancy
L ong-term effects



Identify and explain two material factors that are more likely to affect working-class health.

Gender

‘Women get sicker, but men die quicker’: this observation is often used as a simple way of summarising the relationship between gender and health. We can demonstrate this by outlining gendered patterns of morbidity and mortality.

Morbidity

Physical health

The overall picture is one of greater morbidity in women. Women are more likely to:

- visit their doctor more frequently
- have regular health checks
- be admitted to hospital
- suffer conditions such as allergies and headaches

[Sweet \(2011\)](#), however, notes broad similarities between men and women in two areas (Table 11.2): first, the proportion of life spent free from a disability (disability-free life expectancy), and second, the proportion of life spent free from debilitating illness (healthy life expectancy).

Table 11.2 Freedom from disability and debilitating illness by gender

	Males	Females
Disability-free life expectancy	82%	79%
Healthy life expectancy	63%	64.5%

Source: [Sweet \(2011\)](#)

Self-reported illness is a less reliable measure, but the evidence suggests little or no gender difference in self-reported health and sickness (Table 11.3). These differences have remained roughly constant over the past 30 years.

Table 11.3 Self-reported health and sickness

2009	Males	Females
Bad or very bad health	5%	5%
Long-standing illness or disability	30%	31%
Limiting long-standing illness or disability	17%	19%
Restricted activity	10%	12%

Source: Sweet (2011)

Mental health

In terms of common mental disorders (those generally seen as 'lower-level' disorders, such as anxiety and depression), Sweet notes that women are significantly more likely than men (21% versus 14%) to suffer some form of mental health problem. In addition, women have:

- higher hospital admission rates for mental illnesses
- greater antidepressant drug use
- more psychotic, neurotic and depressive disorders
- more depressive episodes (and for longer periods)

Men, on the other hand, are more likely to receive treatment for alcohol-related and drug-dependency problems.

Mortality

Hughes and Church (2010) note that **average life expectancy** for both males and females has risen by around 30 years over the past century. In 2008, men could expect to live on average for 78 years and women for 82 years (a gender difference that holds true across all industrialised nations).

Men suffer **premature death** more frequently than women. Men are more likely to commit suicide or die an accidental death. However, Sweet (2011) notes that cancer is the main cause of death for both sexes.

Men have a higher risk factor for the three main causes of death (circulatory and respiratory diseases and cancers). This trend has been consistent over the past 40 years.

Explanations

Artefact

Compared to men, women have greater general morbidity, measured in terms of things like doctor visits, hospital admissions and levels of ill health. However, they have similar levels of chronic illness and higher average life expectancy. This suggests that morbidity levels are a statistical artefact — that higher morbidity is explained by women being more willing to seek medical attention and more likely to visit doctors for routine health checks. As Ashley (2010) reports, 'Women are more likely than men to complain about their health even when they are in better shape'.

Although [White et al. \(2010\)](#) found 'limited evidence' that men delay reporting symptoms of serious *physical* illness such as cancer, they did find that men are more likely to under-report mental health problems. [Pilgrim and Rogers \(2010\)](#) also found that 'women are approximately twice as likely as men to refer themselves on for psychiatric treatment'. One possible reason is the greater **stigma** attached to mental illness in men.

Evaluation

An alternative interpretation focuses on women having a greater willingness to:

- identify symptoms
- act on those symptoms
- seek treatment for illness

[Pilgrim and Rogers \(2010\)](#), for example, suggest that a greater willingness to report ill health increases the chances of the early diagnosis of serious illness and, most importantly, *recovery*. Greater morbidity and lower mortality are not, therefore, mutually exclusive but *complementary*.

Opportunity structures may be an overlooked factor. We can't take 'medical visits' at face value. Gendered assumptions about the female caring role mean that women are more likely than men to take their children to the doctor for minor conditions — and this gives them greater opportunity to talk about their own health problems. [Verbrugge \(1985\)](#) found evidence of greater female opportunity, both through their children and because their roles as part-time workers or housewives allowed greater flexibility in medical visits. This kind of explanation fits with [Macintyre et al.'s \(1999\)](#) findings of little real evidence that men were less willing to report serious symptoms or seek healthcare.

Natural and social selection

Morbidity

Higher female morbidity rates can be partly explained in terms of natural and social selection:

- **Natural selection:** Women are more likely to come into contact with the medical profession for reasons of pregnancy and childbirth, especially if complications occur.
- **Social selection:** Where women have greater responsibility for childcare, they are more likely to have greater contact with doctors through the needs of their children.

Mortality

Explanations for greater female longevity focus on life expectancy as a function of natural and social selection:

- **Natural selection:** One of the most striking features of mortality rates, consistent across all industrialised nations, is longer average female life expectancy. One explanation for this is biological — women are 'genetically programmed' to live longer because of greater resistance to serious diseases and so forth.

- **Social selection:** Where men have traditionally had greater involvement in the public sphere, such as the workplace, they are exposed to greater levels of risk. This includes both general risk (e.g. from harder physical labour) and specific risk (coal miners, for example, have far higher rates of respiratory diseases). It is this greater exposure to risk that explains their lower average life expectancy.

Evaluation

Social factors play a significant role in rates of male and female mortality. Over the course of the twentieth century, for example, average female life expectancy has risen faster than male life expectancy — mainly because fewer women now die in childbirth (which means that the increase is a **statistical artefact**).

A further qualification is that average life expectancy is influenced by **class**. Table 11.4 (using region as a proxy for social class) demonstrates that longevity is not simply a biological phenomenon, since upper-class males have a higher life expectancy than lower-class females. This suggests that we need to explain gendered mortality rates in some other way.

Table 11.4: Chances of reaching age 75 by gender and region (class)

	Males	Females
Highest	78% [Buckinghamshire]	86% [Surrey]
Lowest	54% [Manchester]	69% [Manchester]

Source: Smith (2011)

Cultural/behavioural factors

Morbidity

Explanations for gendered morbidity focus on the following factors:

- **Patriarchy:** Female bodies are subjected to higher levels of scrutiny and control (from parents, partners and medical practitioners) which leads to higher morbidity reporting.
- **Risk:** Men are exposed to greater health risks in the workplace (such as accidents and unhealthy working conditions).

Mortality

Explanations for gendered mortality focus around the following:

- **Lifestyles:** Men generally tend to have riskier lifestyles in terms of smoking and excessive drinking. Women, therefore, live more healthily and hence longer.
- **Dieting and eating disorders:** These, on the other hand, have greater associations with women and can lead to a wide range of medical problems (some of which, like anorexia, are life-threatening).

- **Social selection:** As previously noted, men have greater risk exposure to serious work-related diseases, which makes them more prone to chronic illnesses.

Evaluation

- **Self-fulfilling prophecy:** Greater public and private scrutiny of female bodies leads to higher morbidity: the greater the scrutiny, the more likely illness will be discovered. In other words, women may not necessarily have higher morbidity, just a higher *reported* morbidity.
- **Discourses:** Where media discourses highlight female mental health problems, women are more likely to recognise symptoms of mental illness. The question once again is the extent to which gender differences in mental health are real differences or simply the outcome of a greater female willingness to embrace the idea of mental illness (an **artefact** explanation).

Structural and material factors

Patterns of gender morbidity and, in particular, mortality are sensitive to social inequalities; both male and female morbidity and mortality rates correlate significantly with social class, with a general trend towards lower rates in higher classes. There are a range of material reasons for these patterns.

Inter-class differences focus around the effects of:

- poverty
- substandard and overcrowded housing
- unemployment

These correlate with a range of lifestyle factors:

- smoking
- alcohol intake
- poor diet

This, however, is only part of the explanation. **Intra-class differences** between men and women can't be adequately explained by material factors alone, since they are *shared* by men and women of the *same class*. To understand why women have higher morbidity and mortality, we must look more closely at gender relationships *within* social classes.

Material differences include the following:

- **Diet:** **Spencer (1996)** suggests that, where family income is tight, working-class mothers are more likely to go without food, or to eat bulky but unhealthy food, to ensure their children (and partner) eat reasonably well.
- **Essential services**, such as gas and electricity: These are often limited by poverty. Where women are more likely to spend most of their time within the home, this can contribute to a cold, unhealthy environment that leaves them vulnerable to a range of illnesses.
- **Substandard housing** that is cold and damp: Such conditions are similarly likely to adversely affect female morbidity.

A **structural factor** that contributes to greater female morbidity in working-class families (and also extends into the middle classes) is a female **double shift**. Where women are expected to be both paid employees and unpaid domestic labourers, they work long hours that leave them more vulnerable to physical morbidity.

Duncombe and Marsden (1993) also note a **triple shift** — the third element being emotional labour. Where women invest time and effort in the *psychological* well-being of family members, this leaves them more exposed to **mental morbidity** (such as depressive illnesses); they are more likely to neglect their own well-being for the sake of their partner and children. Nazroo et al. (1998), for example, found an increased risk of depression in women as a result of gendered role differences; in households ‘where there was a clear distinction in roles between men and women’, problems concerning ‘children, housing and reproduction’ were found to trigger depressive illnesses in women.

Another factor is **social capital**. Klinenberg (2003) has shown that higher levels of **social isolation** result in higher levels of morbidity. Home-bound working-class women, for example, are more likely to experience social isolation than professional middle-class women. In addition, **lone parenthood** is one of the most socially isolated and materially deprived family structures in our society, and the majority of these structures (around 90%) are headed by women. Where poverty and isolation have a strong association with ill health, this is one reason for higher rates of female morbidity.

Evaluation

Material factors *alone* don’t adequately explain why males and females of the *same* class display different rates of morbidity and mortality. To explain this situation we need to link different **gender roles** to material factors; *within social classes* material factors, such as poverty and deprivation, affect males and females differently.

Wilkinson and Pickett (2010) argue that increasing **living standards** do not go hand-in-glove with lower male morbidity and higher life expectancy beyond a certain point. Once certain material conditions have been met (such as access to clean water), there are no dramatic improvements in health. What matters in contemporary societies, they argue, is not unequal access to material resources but rather unequal access to **social resources**. In other words, **social exclusion** is the key to understanding health differences. Women of different social classes, for example, show higher rates of morbidity compared to men because they experience higher rates of exclusion within their particular class circles.



Identify and explain one cultural factor that influences the health of men rather than women.

Ethnicity

Although ethnicity refers to **cultural differences** in areas like religion, family structures, beliefs, values and norms, this relatively simple statement hides a wide

range of **definitional problems** that make it difficult to establish a strong relationship between ethnicity and health. These problems relate less to how an ethnic group defines itself — **subjectively**, on the basis of what group members believe or how other groups define different ethnicities, or **objectively** on the basis of some agreed criteria, such as country of origin — and more to how **official statistical definitions** converge and diverge.

A major problem here is that different studies and sources often use different definitions of ethnic groups — and this makes comparisons between ethnic groups difficult (and possibly **invalid**). A further problem, as [Steinbach \(2009\)](#) notes, is that 'Ethnicity is not recorded on UK death certificates'; while mortality data uses 'country of birth' as a useful alternative, this fails to adequately classify members of ethnic minorities born in the UK.

While keeping the limitations of classification and measurement firmly in mind, we can note a range of health differences between ethnic groups defined in terms of their 'historic country of origin'. Black British ethnicities, for example, are defined in terms of categories such as black Caribbean and black African.

Morbidity

[Cooper's \(2002\)](#) examination of 'the self-reported health of men and women from white and minority ethnic groups in the UK' found the following:

- All ethnic minority groups had poorer health compared to whites.
- Morbidity was higher for many minority ethnic women than for their male counterparts.
- The highest morbidity for all adults occurred in the most disadvantaged groups, 'notably Pakistanis and Bangladeshis' — a finding replicated by [Fitzpatrick et al. \(2007\)](#).
- Class inequalities explained the 'health disadvantage experienced by minority ethnic men and women', but morbidity was higher for women than for men of the same class (something that mirrors gendered inequalities in morbidity found across all ethnic groups).

The [Office for National Statistics \(2005\)](#) reported that women from all ethnic groups were more likely than men to rate their health as 'not good'.

Concerning **hospital admissions**, [Fitzpatrick et al. \(2007\)](#) note the following points:

- Asian ethnicities have higher rates of admission due to coronary heart disease.
- Asian and black Caribbean ethnicities have higher rates of diabetes.
- Asian ethnicities have above average hospitalisation for cataract surgery (diabetes is 'a known risk factor for cataracts').
- Black Africans are the largest ethnic group receiving HIV care. This group also has the highest rates of tuberculosis.



Identify two morbidity differences between ethnic minority groups.

Mortality

Kelly and Nazroo (2008) identify a range of ethnic differences in mortality rates, as follows.

Non-white ethnic groups have:

- lower mortality rates from respiratory disease and lung cancer
- higher mortality rates for conditions relating to diabetes

Black Caribbean men have:

- lower rates of mortality
- low rates of heart disease mortality
- high rates of stroke mortality

Black Africans have:

- high overall mortality rates
- high rates of stroke mortality
- low rates of heart disease mortality

South Asians have:

- high rates of heart disease mortality
- high rates of stroke mortality

Overall, there are wide variations in ethnic morbidity and mortality both across and within groups:

- **Across groups:** Pakistani and Bangladeshi men and women have the highest rates of disability, while non-white groups have higher rates for specific illnesses, such as diabetes.
- **Within groups:** Women have higher rates of morbidity but lower mortality, and age differences in morbidity exist within all ethnic groups.

Explanations

Artefact

This approach argues that the relationship between ethnicity and health is difficult to establish for several reasons:

- There are problems in defining 'ethnicity'.
- Different definitions are used by different studies, which makes comparisons difficult.
- There is a lack of official statistics about the morbidity and mortality of different ethnicities. Harding (2007), for example, argues that explanations of ethnic inequality in health are 'compromised by the lack of relevant data'.
- Misclassifications may occur. Nazroo and King (2002) argue that, while black Caribbeans have higher levels of treatment for psychosis, it doesn't follow that they have higher levels of mental illness; rather, it means that they are more likely to be prescribed treatment on the basis of the symptoms they express.

It is therefore argued that we have little or no way of knowing if apparent relationships between ethnicity and health involve real differences or are simply the result of statistical artefact.

Age may be a complicating factor. The [Office for National Statistics \(2005\)](#) notes that 'Differences between minority ethnic groups and the general population may be partly due to their age differences'; that is, different ethnic groups may have different age profiles, and this may affect the patterns of health found. For example, some ethnic groups have much larger proportions of very old and very young members, which can adversely affect morbidity and mortality rates.

Class is also likely to be a complicating factor. A lack of definitional clarity or standardisation compounds the argument that 'ethnicity statistics' actually measure class differences. Pakistanis, for example, have the highest levels of morbidity and mortality, and are also the most deprived ethnic group in our society.



Suggest one problem we have with defining ethnicity.

Evaluation

Artefact arguments have some validity because there are clearly major problems concerning:

- standardised definitions of ethnicity
- failures to standardise age profiles across ethnic groups
- the separation of class and gender variables from 'ethnic effects'

However, the [Office for National Statistics \(2005\)](#) notes that, where age differences *are* standardised, Pakistani and Bangladeshi ethnicities still report rates of ill health twice that of their white British counterparts. Similarly, where we can identify differences in morbidity and mortality between broadly defined ethnic groups (using, for example, country of origin as the baseline difference), it's logical to assume that refinements in measurement are more likely than not to reveal greater ethnic differences.

In addition, while ethnic class differences are significant, this doesn't mean we should ignore general ethnic differences in morbidity and mortality — especially when looking at differences in rates for specific forms of ill health, such as diabetes.

Natural/social selection

Explanations of this kind focus on two areas:

- **Genetic disorders:** Some ethnic groups show a greater incidence of certain types of genetic disorder than others. Examples include sickle-cell anaemia in black African/Caribbean ethnicities and Tay-Sachs, a disease of the nervous system, in Jewish populations.
- **Mental health:** [Ramon \(2007\)](#) argues that genetic and biochemical explanations for ethnic differences in mental health tend to dominate psychiatric interpretations

— and since psychiatrists tend to be primary definers of mental health, they have a significant input to mental health decisions.

Evaluation

- **Natural selection:** While some ethnic groups do have a genetic predisposition for certain types of disease, these are not sufficient to account for the broad differences found between ethnic groups in our society.
- **Mental health:** [Ramon \(2007\)](#) argues that different patterns of mental health among ethnic groups can be explained by **social**, rather than **genetic**, causes. [Morgan et al. \(2008\)](#), for example, found a strong relationship between class and mental disorders in the black Caribbean working-class population. The most disadvantaged in the black population developed greater mental health problems in later life.

Cultural/behavioural factors

These explanations focus on two main variables: lifestyle choices and behavioural choices.

In considering **lifestyle choices**, the focus is on a range of practices that promote or inhibit good health:

- **Risky health behaviours** such as smoking and alcohol consumption: Asian ethnicities tend to smoke less and consume less alcohol than their white counterparts (with certain exceptions — Bangladeshi men, for example, smoke more).
- **Dietary differences:** [Higgins and Dale \(2011\)](#) found that Pakistani and Bangladeshi women, as well as men from most ethnic minorities, were more likely to eat five portions of fruit or vegetables a day than their white counterparts. Some Asian ethnicities consume higher than average amounts of dairy products.
- **Physical exercise:** [Higgins and Dale \(2011\)](#) found that levels of physical exercise were lower for Pakistani and Bangladeshi men and women, and for Indian and Chinese women.

[Fitzpatrick et al. \(2007\)](#) note that Irish and Scottish ethnicities have the highest mortality rates from all causes of death — which suggests that cultural behaviours play a significant part in rates of morbidity and mortality.

In terms of **behavioural choices**, this approach considers such areas as the extent to which different ethnic groups make use of medical services. [Stuart \(2008\)](#),



Ethnic groups often differ in their dietary patterns

for example, notes how 'Low take-up of services among black and minority ethnic communities' is often explained in terms of 'cultural differences' such as:

- language barriers
- lack of interest
- alternative services

Stuart, however, suggests different reasons for ethnic minorities receiving, in the main, poorer-quality care:

- social and physical isolation
- poor communication between some ethnic groups
- lack of interpreting services
- interaction difficulties with GPs, receptionists and hospital staff
- difficulties registering with GPs

Evaluation

Lifestyle choices are significant for some specific forms of ill health, such as cancer rates among different ethnic groups. Particular cultural practices can be important: for example, very few Bangladeshi women smoke. However, apart from particular practices of that kind, it's not clear how individual ethnic lifestyle choices have an overall effect on morbidity and mortality rates.

Equality of opportunity is an issue. Minority groups are often criticised for a failure to take up free, readily available health services, and a similar criticism is levelled at the white working class. This assumes, however, that every individual is equally positioned to take advantage of these services.

Stuart (2008) points out that when a cultural factor such as 'language differences' is raised as an explanation for low take-up, the implication is that the problem lies with the individual rather than the service. When take-up is seen as a matter of behavioural choice, there is a strong element of **victim blaming** and of expecting individuals to adapt themselves to health services rather than the other way around. An alternative view would recognise the need for the service to adapt, for example by providing interpreters.

Structural and material factors

As artefact explanations point out, one of the problems with explaining different ethnic morbidity and mortality rates is the influence of social class. This is especially pertinent when the **demographic profile** of many ethnic minorities is one where they are *generally* over-represented in the lowest social classes:

- Asian ethnicities are most likely to feature in the *least wealthy* 10% of the UK population, while Chinese ethnicities are most likely to appear in the *wealthiest* 10%.
- Self and Zealey (2007) report that Asian and black African ethnicities are most likely to experience low incomes.

- [Berthoud \(1998\)](#) identifies Pakistanis and Bangladeshis as being among the very poorest in our society.

Given that class is an important factor in morbidity and mortality, one dimension to this approach suggests that poorer levels of health among ethnic minority groups are related to **material deprivation** — higher levels of poverty and poor housing, lower levels of employment and income, riskier work environments and the like.

A further dimension involves **social deprivation** — some groups have greater difficulties in taking advantage of health services than others. This kind of social deprivation involves:

- not knowing one's health rights
- not accessing health services (such as a GP)
- not establishing and maintaining relationships with health services and carers

Social deprivation correlates with material deprivation, with the working classes experiencing higher levels of both.

Furthermore, this approach argues that ethnic minority groups face an added problem of racism. This racism is sometimes **overt**, but increasingly **covert** in the form of **cultural racism**. This is seen in the idea that an ethnic minority culture is to blame for their unequal treatment — that, for example, an inability to speak 'standard English' is a feature of ethnic minority groups that prevents them from accessing health services.

Cultural racism places the blame for 'discrimination' on those who are victimised — in terms of a 'failure to integrate', for instance — rather than locating it in the culture and practice of a dominant majority culture. [Fitzpatrick et al. \(2007\)](#), for example, found that Asian minorities reported the worst levels of patient experience when dealing with doctors and hospitals.

Evaluation

[Harriss \(2007\)](#) concludes that 'much of the variation in self-reported health between and within Black and Minority ethnic groups can be explained by differences in socio-economic status':

- higher rates of poverty and unemployment
- lower levels of income and of benefits take-up

However, Harriss also suggests that this picture is complicated by an 'interplay of factors affecting ethnic health':

- the long-term impact of migration
- racism and discrimination
- poor delivery and take-up of healthcare
- differences in culture and lifestyles
- biological susceptibility