Black looks . . . at habits

Not long ago I was asked to give a talk on ‘The Health Divide’ (the partially sanitised title for inequalities in health related to social deprivation). This came in a session entitled ‘Lifestyles’; so it seemed appropriate to consider what proportion of the health disadvantage experienced by manual workers and their families can fairly be accounted for by the faulty lifestyles attributed to them by those who find escape from responsibility through the elegant device of ‘blaming the victim’. It is my custom to travel, whenever convenient, by public transport—a practice commended on health grounds by one of the speakers, though I doubt from my own experience whether he had actually followed it on that occasion. The meeting was in the National Motorcycle Museum, described in our brief as being ‘adjacent’ to the National Exhibition Centre; so I made my way to Birmingham International station, and set out to walk there. After half a mile or so of muddy tracks, I saw the promised land, the pyramids of the museum; but what rolled between was not Jordan but the M42. The motorway itself is crossed by a bridge carrying the A45; but to get to it and leave it involves a trot along approach roads carrying a fair amount of traffic. This experience sharpened my wits for the meeting, and reminded me that going on foot also has its risks as does sedentary travel by car. Come to think of it, there is not much which is absolutely safe; from birth, and indeed from conception, we are engaged in risk limitation, and at no time do we enjoy freedom from risk. Perhaps there is a warning there to those dubbed by Bernard Levin as ‘single-issue fanatics’.

Apart from exercise (and it would be little short of libellous to suggest that manual workers take no exercise), the relevant behavioural variables might seem to be diet, smoking, and drinking.

Diet

The relationship between specific nutrients and health may not be so simple as it is sometimes made to appear by those who pin general theories of illness on excesses of sugar, salt, or fat (saturated or other), or on deficits of vitamins or of fibre (whether from cereals, fruit, or legumes). There is evidence from recent dietary surveys across income groups that both rich and poor are taking more fibre-rich foods than they were, and using less saturated fat; but poorer people are still taking less fruit, and their children eat more sweets [1].

These observations must in the nature of things be derived from those accessible to being surveyed; and any complacency they might engender cannot be transferred to the destitute homeless. There must remain elements of speculation both about the effect of income-related dietary intakes on health; and on the extent to which variations are a direct consequence of affluence or poverty, or reflections of family or social dietary habits, or even responses to the pressures of advertisements which seem directly related to the worthlessness and even harm of what is advertised—a danger which can be illustrated most clearly by the advertising effort put into persuading people to commit suicide by smoking.

Smoking

Whatever degree of equivocation may remain on links between diet and health, there can be none on the harmful effects of smoking on health; and consideration of the smoking habits of occupational groups identifies these as a major cause of health differentials. ‘In 1988, 16 per cent of professional-group men and 17 per cent of professional-group women were smokers compared with 43% of men in the unskilled manual category and 39% of women in that category.’ The rate for unemployed men was 56%, for women 44%; and ‘mortality from lung cancer and coronary heart disease is higher in the unemployed than in the employed population’ [1]. (Looking for a moment beyond our own shores, the massive export of cigarettes to the Third World seems to raise moral questions similar to those raised by the export of arms. To an optimist, there are hints that we may be beginning to escape from the economy of the eighties, which was based on the import of luxuries and the export of death.)

Drinking

Perhaps surprisingly, in the particular context of this article, alcohol consumption brings us back, as with diet, to an area where the evidence is complex and equivocal. There is, of course, no doubt that the consumption of alcoholic drinks in excessive amounts causes great personal and social harm; but the particular question being addressed is whether excessive drinking is a factor contributing to the generally poorer health of manual workers. An OPCS survey, reported in 1988, used a broad classification of alcohol consumption into ‘high’, ‘low/moderate’, and ‘non-drinker/very low’ categories. With progression from ‘professional’ to ‘unskilled manual’ groups, the proportion of ‘high’ drinkers did not vary systemati-
ly; the proportion of ‘low/non-drinkers’ increased; and the proportion of ‘moderate’ drinkers actually decreased [1]. These results give no support to the notion that ‘the lower classes drink themselves to death’. We should be cautious in ascribing to them any broader relevance, in view of the subjectivity of self-assessed drinking levels.

The general picture

The only clear-cut relationship with specific habits is that with the amount of tobacco smoked. Apart from the very destitute, undernutrition is absent and malnutrition equivocal. On available evidence, alcohol can almost be ruled out as an explanation of differential ill health among manual workers. Surveys are being reported in which allowance is made for known ‘risk factors’, including behavioural ones such as smoking, drinking, and exercise. For example, in the Whitehall study [2] of coronary heart disease (whose incidence as a cause of death is negatively correlated with increased Civil Service grade), controlling known risk factors only reduced the risk associated with employment grade by less than 25 per cent. (The Whitehall study is also of great interest in demonstrating that social differentials in health are not limited to the extremes of wealth and poverty—Civil Service messengers do not go about in rags, and the salary even of a permanent secretary would be a source of mirth to a captain of privatised industry). That behavioural factors account for a relatively small part of social differentials in health is also apparent from a study of mortality in Alameda County in California [3].

The very considerable amount of work which has gone on since 1980 on ‘inequalities in health’, and is now summarised in the new (1992) edition of The health divide, seems to show that the inequalities have not gone away in this country; that they are common to any socially stratified country; and that they are in the main, though not entirely, an intrinsic consequence of social stratification. If this is a ‘social disease’, it must call for a ‘social remedy’; but that is only a partial truth—health education is worthwhile in its own right, and can modify behaviour across classes; and good medical care, while it may not radically prevent them, is still necessary to ameliorate the health consequences of social deprivation.

References

1 Whitehead M. The health divide, London: Penguin Books, 1992.
2 Marmot MG, Shipley MJ, Rose G. Inequalities in death: specific explanations of a general pattern. Lancet 1984;i:1003–6.
3 Berkman LF, Breslow L. Health and ways of living: the Alameda County study. Oxford University Press, 1983.