UK health inequalities: the class system is alive and well

The NHS was founded on the principle of access to adequate healthcare for all

Roman society in Britain was highly classified. At the top were . . . the legions, the provincial administration, the government of towns and the wealthy traders and commercial classes who enjoyed legal privileges not generally accorded to the majority of the population. In 212 AD, the Emperor Caracalla extended citizenship to all free-born inhabitants of the empire, but social and legal distinctions remained rigidly set between the upper rank of citizens known as *honestiores* and the masses, known as *humiliores*. At the lowest end of the scale were the slaves . . .[1]

In the United Kingdom today, the widening gap between upper and lower "social classes" is regularly presented by politicians and health bureaucrats to professional and lay audiences alike, and used to justify the public health agenda. Health inequalities have become the driving force for public health initiatives. The government under Thatcher explored "variations" in health outcomes and in health service provision. Subsequently, the Blair government replaced "variations" with the more class-oriented "inequalities". All too often, however, attempts to deal with the real and frequently demonstrated social gradient in disease and in health service provision is limited to "hand-wringing epidemiology". In any case, discussion of a widening gap reflects a failure to understand the difference between relative and absolute risk, as well as demographic change and the type of outcomes amenable to prevention.

The debate in Australia is rather more sophisticated: for example, in the report of the Chief Health Officer of New South Wales,[2] trends over time in the social gradient are presented in terms of absolute risk, as well as for diseases in which social interventions are likely to be effective. Presented in this way, the social gradient persists, but does not necessarily appear to widen over time, and some improvement in the experience of the least affluent may also be apparent.

Are we carping and nit-picking to criticise the UK approach? No, because unless public health programs are based on sound theoretical bases they will fail. Implausible and non-achievable targets aimed at "narrowing the gap" have been established. These include:

- reducing, by 10%, the difference in infant mortality between the children of manual workers and the whole population; and
- reducing, by 10%, the gap in life expectancy at birth between the quintile of local council areas with the lowest life expectancy and the whole population.

Far better would be to aim at the more important goal of improving the health of the whole community, as well as the disadvantaged part. The NHS was founded on the principle of access to adequate healthcare for all. Selectivity, even well intentioned selectivity, not only flies in the face of this ideal, it ignores the late Geoffrey Rose's astute observation[3] that small changes in the average for the whole population can bring great benefits to those at greatest risk, provided the change involves the whole population.

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People in the UK still talk about, and measure, social class. Although the use of the term "socioeconomic status" may be an example of political correctness, the fact that "class" is still an acceptable form of scientific terminology in the UK reflects the underlying acceptance of its existence. People typically "know their place". They measure themselves against a social standard. Those who are "working class" stoutly defend their place in the social hierarchy and are proud of it. Expectations of health and of access to healthcare are firmly rooted in the class system. It is "posh" to eat healthy food, and "posh" is a derogatory term. If men (and women) are born into such shackles of social convention, their freedom to improve their health is distinctly limited.

The claim that Australian society is classless is oft made but open to challenge. The concept of social class, as developed by Weber and Marx, is a complex one that involves consciousness of social position and sharing of values and outlooks within the group. If Australia has social classes, they are probably blue collar, white collar, "squattocracy" and those on the dole, but ranged against this are the acknowledged rights of all to "have a go" and to "a fair go". These maxims make attempts to improve everyone's health possible, as well as socially and politically legitimate.

Why should we care if socially entrenched self-denial of the chance for better health exists in the UK? The reason is that attempts to deal with health inequalities are doomed to failure in such a climate. The debate about equity and health is complex and wide-ranging, and has an international component — all countries have inequality and inequity.

The ancient Romans introduced a rigid social class structure into Britain, but the current inhabitants of the British Isles have made its perpetuation an art form.

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1 Williams PN. England. A narrative history. Part 2: the Roman period. Britannia. America's gateway to the British Isles. History. Available at: www.britannia.com/history/narromhist.html (accessed May 2004).

2 Public Health Division. The health of the people of New South Wales. Report of the Chief Health Officer. Sydney: NSW Department of Health. Available at: www.health.nsw.gov.au/public-health/chorep/toc/choindex.htm (accessed Mar 2004).

3 Rose G. Sick individuals and sick populations. *Int J Epidemiol* 1985; 14: 32-38.