The Social Demography of Health
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• Four of the most important variables employed in epidemiological research are social class, gender, age, and race.

• It has been found that each of these variables represents important differences between people that can be correlated with health and life expectancy.
The Social Demography of Health—Social Class

• To be poor is by definition to have less of the good things in life, including health and longevity.
• Obtaining equal access to care is a major step in improving the health of the general population. However, improved access to health services is only part of the solution for advancing health.
• The fact remains that people at the bottom of society have the worst living conditions that goes along with having the worst health.
Social Class

• Regardless of what country poor people live in, what type of health insurance they have or do not have, and the level of health care they receive, they still have the worst health of all.
• This finding persists across all diseases with few exceptions and throughout the life span.
• It is therefore a fact the lower one goes in social structure of a society, the worse the health of the people on that rung of the social ladder.
Social Class

• In the United States and everywhere else in the world, socioeconomic status or social class (education) is the strongest and most consistent predictor of a person’s health and life expectancy.

• While other social demographic variables such as race, gender, and age have important effects on health, the explanatory power of class position is demonstrated when it interacts with these other variables to produce differences beyond those already produced.
Social Class

• Social class is the most fundamental form of social stratification. Mainly this is due to the fact that most of the vital social differences can be seen to have an economic base. Just as important, however, is the clear indication that both the conditions of the other strata and their relationships vary according to class context. Put as boldly as possible, being black, female or elderly and middle class is different from being black, female or elderly and working class.
Social Class

• Socioeconomic status typically consists of measures of income, occupational status or prestige, and level of education.

• Although interrelated, each of these measures reflects different dimensions of a person’s position in the class structure of a society.
Social Class

• In studies of health and illness, income reflects spending power, housing, diet, and medical care.

• Occupation measures status, responsibility, physical activity, and health risks associated with work.

• Education is indicative of a person’s skills for acquiring positive social, psychological, and economic resources.
Social Class

• While income and occupational status are important, the strongest single predictor of health appears to be education.

• Well-educated people are generally the best informed about the merits of a healthy lifestyle involving exercise, no smoking, moderate drinking, a healthy diet, and similar practices and the advantages of seeking preventive care or medical treatment for health problems when they need it.
Social Class

• In sum, education promotes healthy living and the ability to solve problems.
• Well-educated people are more likely to have well-paid jobs, giving them better control over their lives and the way they live.
• Literally all the pathways from education to health are positive and that higher education and good health generally go together.
Social Class

• By every measure American adults with college educations enjoy better health than those with lower levels of education. The better educated feel healthier, have less difficulty with common activities and tasks, more frequently feel vigorous and thriving, less often suffer from aches, pains, and malaise, less often feel worried or depressed, carry fewer diagnoses of threatening or debilitating chronic disease, expect to live longer, and probably will live longer.
Social Class

• Well-educated people—in comparison to the poorly educated—are more likely to have fulfilling, subjectively rewarding jobs, high incomes, less economic hardship, and a greater sense of control over their lives and their health.

• The well-educated are less likely to smoke and more likely to exercise, get checkups from physicians, and drink alcohol moderately.
Social Class

• The relationship between education and health is particularly strong and gets stronger over the life course, as less-educated persons have increasingly more sickness and disability, and die sooner than the well-educated.

• However, education is not the entire story when it comes to the effects of SES on health.

• New research is showing that the relationship between income, education, and health changes over the life course, with income becoming more important for health as a person moves toward older age.
Equality of Care: The British Experience

• Since many health disorders appear related to poverty, it is a logical assumption that if poverty were not a factor retarding the availability of quality medical care, the incidence and prevalence of illness in the lower classes would be reduced.
• Following World War II, socialized medicine was introduced in Great Britain to provide the lower classes with the same medical care available to the upper classes.

• Poverty and social class differences remained—only health care was supposedly equalized.

• Results have shown that the equalization of health care alone has not reduced the disparity in health between social classes.
• Britain’s experiment failed to reduce health disparities precisely because living conditions and lifestyles could not be equalized.

• The physical environment of poverty and poor nutrition continued to adversely affect lower-class health.

• Medical care alone cannot counter the adverse effects of class position on health. The evidence is clear that a significant gap in health and life expectancy continues to persist in Britain, despite improved access to medical care.
The Social Demography of Health—Gender

• In preindustrial societies, including those in Europe, the life expectancies of men and women were approximately the same.

• This was the situation as late as 1850 in England and Wales where 15 year old boys could expect to live another 43.2 years and girls an additional 43.9 years.

• By 1950, 15 year old girls in England and Wales typically outlived boys of the same age by 6 years.
Gender

• Between 1850 and 1950, the life expectancy for women had increased 41 percent as compared with 30 percent among men.

• In the 1990s, the gap in life expectancy between men and women in England and Wales persisted.
  – The same pattern exists in most of the world.

• Life expectancy increased for both men and women in the 20\textsuperscript{th} century, but women live longer on average than men.
Gender

• The only exception worldwide is in a few countries in South Asia such as Bangladesh and Nepal, where men outlive women.
• Nutritional deprivation and lessened access to medical care are among the possible reasons for this reversal of the usual female superiority in life expectancy.
• Outside of South Asia, women have a definite advantage over men in longevity.
Gender

• Males typically exceed female death rates at all ages and for the leading causes of death.
• Women tend to suffer from more frequent illnesses and disabilities, but their usual health disorders are not as serious or as life threatening as those encountered by men.
• Yet, women, especially later in life, also die from the same illnesses as men.
Gender

- As of 2005, the average life expectancy in the United States was 77.8 years.
  - For Females about 80 years.
    - White: 80.0
    - Black: 76.5
  - For Males about 75 years.
    - White: 75.7
    - Black: 69.6
Gender

• Men have a substantial health inferiority in terms of life expectancy because of the combined result of two major effects: (1) biological and (2) social-psychological.
  – The male is at a biological disadvantage to the female.
  – The fact that the male is weaker physiologically than the female is demonstrated by higher mortality rates from the prenatal and neonatal stages of life onward.
  – Although the percentages may vary somewhat from year to year, the chances of dying during the prenatal stage are approximately 12 percent greater among males than females and 130 percent greater during the neonatal (newborn) stage.
Gender

• While the evidence is not conclusive, social and psychological influences are nonetheless presumed to play an important part in the determination of life expectancy.

• Accidents, for example, cause more deaths among males than females, which reflects a difference in sex roles.
  – Men tend to be more aggressive than women in both work and play.
  – High accident rates among males may be attributed to the male’s increased exposure to dangerous activities.
Gender

• Another factor contributing to excess male mortality rates may be occupational competition and the pressure associated with a job.

• Middle-aged professionals in the US today are noted by life insurance companies as a high-risk group, particularly if they smoke, are overweight, and tend to overwork.
Gender

• While men have a higher rate of mortality, women appear to have a higher morbidity or sickness rate.

• Females have higher rates of acute illness—namely, infectious and parasitic diseases and digestive and respiratory conditions.

• The only category of acute health problems in which males have a higher incidence is injuries.

• The rate for acute conditions not related to pregnancy is eleven times greater for females than males.
Gender

• There is, however, renewed interest in investigating the health differences of men and women because of changes in the way people now live.

• The lives of men and women used to be more predictable in that men typically behaved in certain distinct ways and women in others.

• Thus, gender differences in activities, goals, and life expectancy were taken for granted and more or less anticipated.
Gender

- Research now indicates that important clues are emerging that show Americans may be moving toward greater equality in mortality between the sexes.
- This suggestion is based upon evidence that sex differences for some major causes of death have either decreased, stabilized, or only slowly widened.
- Considerable speculation exists with respect to the possible effects on female life expectancy posed by their increased participation in the labor force and changes in lifestyle.
- Women in recent years, as compared to the 1950s, are more likely to work in occupations that were once almost exclusively male, drink more alcohol, and smoke more cigarettes.
- It will be several years before these effects on women’s health can be fully determined.
The Social Demography of Health--Age

• A number of factors including improved medical care, nutrition, sanitation, and housing combined over the course of the 20th century to help prolong lives for most Americans.

• In 2005, the average infant at birth in the US could expect to live 77.8 years.
  – This figure represents an increase in longevity of approximately 60 percent since 1900 when life expectancy was 47.3 years.
Age

• Less than one-half of all children born in 1900 could expect to reach age 65, whereas today about 80 percent can expect to live to age 65 and one-third will live to be at least 85 years of age.

• The rise in life expectancy has brought a corresponding increase in the growth of the elderly population.
  – Men and women are living to 65 in greater numbers and proportions than ever before.
  – In 1940, the elderly (65 and over) constituted 9 million or about 7% of the total population.
  – By 2005, their number had increased to about 15%.
Age

- The 20th century can be described as a period of rapid growth of the aged population worldwide.
- In the US, not only are people living longer, but since 1958 the fertility rate has been in a period of decline.
- The lower death rate coupled with the lower birth rate has produced a much higher proportion of older Americans in relation to the total population.
Age

• This trend will undoubtedly bring about a marked change in American society in general and in health care in particular.

• The aged population will be healthier, better educated, and more affluent than any group of elderly persons in the past.

• They are likely to have not only a higher standard of living but also increased political power because of their larger numbers and experience with the political process.
Age

• As a result, they will have the clout to bring about legislation for public services to meet their social and health needs.

• Even though elderly Americans will be healthier than ever before, more pressure is likely to be put on health delivery systems and public health insurance, namely Medicare, to keep them fit.

• The need for health services, however, becomes greater as one ages because even minor ailments can more easily develop into serious problems or simply linger longer than usual.
The Social Demography of Health--Race

• One reflection of social inequality in the United States is the differences among the health profiles of racial groups.
• Asian Americans have typically enjoyed high levels of health, with blacks being especially disadvantaged.
• Hispanics and Native Americans also have disadvantaged relative to whites.
Race

• A comparison of the life expectancy of African Americans and whites show that black males are especially disadvantaged with respect to longevity.

• Life Expectancy (2005):
  – Black Males: 69.5, Black Females: 76.5
  – White Males: 75.7, White Females: 80.8
Race

• Underlying the lessened life expectancy of blacks is a higher prevalence of several life-threatening illnesses, such as AIDS, cancer, heart disease, and hypertension.

• Hypertension or high blood pressure has been a particular health problem for African Americans.
  – Some 24 and 20 percent of all white males and females, respectively, over the age of 20 have hypertension compared to over 30 percent of all black males and females in the same age category.
Race

• The end result is that proportionately more black people than white have hypertension.

• The exact cause of the higher rates of hypertension among blacks is not known.

• Some research suggests that the genetic hypothesis and the psychological hypothesis contribute the most to providing an answer, since blacks in general—not just low-income blacks—have higher rates of hypertension.
Race

• Other research, however, suggests that socioeconomic factors are particularly important because low-income blacks have three times more hypertension than affluent blacks.

• Rates of hypertension among blacks had declined since 1960 but remained the leading cause of death from kidney failure and a major contributor to deaths from end stage renal disease, heart disease, and stroke.
Race

• Blacks also differ from whites and other races in relation to health problems other than hypertension.

• For all causes of death, non-Hispanic blacks have the highest death rates, followed by non-Hispanic whites, American Indians/Alaska Natives, Hispanics, and Asians/Pacific Islanders.
Race

• When it comes to infant mortality, blacks are again disadvantaged.

• Black infants have traditionally had almost twice as high an infant mortality rate as white infants.

• In 1960, there were approximately 43 infant deaths per 1,000 black infants compared to an infant mortality rate of 22.9 among whites.
Race

• The gap remains today.
• In 1999, the black infant mortality rate was 14.6 versus 5.8 for whites.
• A major factor causing this difference is poverty.
• Blacks are overrepresented among the poor, and the poor have the highest rates of infant mortality regardless of race.
Race

• The adverse health situation of African Americans identifies a pattern that is generally produced by socioeconomic, not biological factors.

• This does not mean that race and biology are unimportant, as genetic research shows a few notable exceptions.
  – Gene variation that increases the risk of developing a rare type of abnormal cardiac rhythm
  – Sickle cell anemia
Race

• The most important overall factor appears to be socioeconomic status.
• Socioeconomic factors like poverty, marginal employment, low incomes, segregated living conditions, and inadequate education are more common among blacks than whites, and are features of socioeconomic stratification known to contribute to poor health.
Race

• Blacks are more likely than whites, for example, to live in disadvantaged neighborhoods characterized by despair, crime, danger, public drinking or drug use, and incivility.

• The daily stress associated with these neighborhood conditions has been linked to worse health on the part of the residents.
Race

- Living in less safe neighborhoods also explains why adult blacks are less likely than non-blacks to show participation in vigorous exercise as an outdoor activity.
- Socioeconomic conditions not only reduce opportunities for exercise, but they also promote risk behaviors.
- There is strong evidence that many blacks are at greater risk because of smoking, alcohol intake, and excess weight that contribute to high blood pressure, high cholesterol levels, and diabetes.