Snakes and ladders:
To improve health outcomes in elderly people, we must reduce socio-economic inequality in earlier life.
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On the August Bank Holiday in 1980, the Thatcher government quietly released a Department of Health report by Professor Douglas Black. The report had been commissioned several years earlier by the then Labour health minister to investigate health inequalities between social classes. Black’s key finding was unsurprising – that the poorest in society had the highest rates of morbidity and mortality (2002). What was more worrying was that health inequalities across the social classes not only existed, but were widening alongside a rapidly widening gap in living standards and wealth distribution. Black advocated revision of the policies causing standards of living to diverge and recommended social provision for the vulnerable, particularly children and elderly people. Nearly 20 years later, in 1998, the Acheson report replicated Black’s findings and found that social inequalities in health continued to rise (Black et al., 1999).
Socioeconomic status (SES) and health
The relationship between socioeconomic status (SES) and health has been appreciated for well over a century. Social class is thought to shape exposure to both risk and protective factors for poor health. Although average living conditions have steadily improved over the last century, the relationship between social class and health has persisted. Why? Phelan et al., (2010) suggest that when society develops the ability to control a disease, this new ability is distributed according to social status. This explains the difference in death rates by cardiovascular causes between lower and higher social classes and why death rates from pancreatic cancer remain roughly the same between groups. The relationship between SES and disability may be even stronger than with mortality, particularly for men (Matthews et al., 2006). This means that a Glaswegian man with low SES will not only die younger than his wealthier Kensingtonian counterpart, he will also spend his last years with poorer health. SES is increasingly thought to be a fundamental cause of disease but the relationship between SES and health has been historically under-appreciated (George, 2005). George explains that ‘Because the least physically robust individuals die earliest and because they are disproportionately of low SES, research that focuses on the relationships between SES and illness or disability inevitably underestimates the total effects of SES on health (George, 2005) (p.135).

SES in later life
Is any of the above relevant in later life? Surely age is the great social leveller and we all end up in the same group with the same diseases as we approach oblivion? Both Black and Acheson highlighted that post retirement, many elderly live in relative poverty and this group is disproportionately affected by both morbidity and mortality. Research into this issue has been historically neglected, possibly due to the assumption of homogeneity in later life, but also due to the inherent difficulties in examining social status and inequality in elderly people, namely, that the measures of social status in adult life - education, income and occupation - do not readily translate post retirement. Educational attainment in the baby boomer population and annual income post retirement are poor markers of social status. Last occupation carried forward is similarly flawed for an individual that may survive for 30 years post retirement. Other possible measures of socioeconomic status in later life include housing tenure, postcode and value of assets. These also have their limitations. Grundy and Holt suggest social class or educational attainment plus an indicator of deprivation may be best available combination to help meaningfully measure social status in the retired elderly and to facilitate more research and responsive policy (Grundy and Holt, 2001).

The lifespan approach
To examine SES and health inequalities in older age, it is useful to adopt a ‘lifespan’ approach. Namely, that the health and social disparities observed at mid and later life are anchored to earlier circumstances. This has been observed in the Whitehall public servant studies where the social gradient in retirement is largely determined by working life circumstances. John Pearlin explains the mechanism for this (Pearlin et al, 2005). He argues that the effect of differential exposure to health risk and protective factors across social class is cumulative and that ‘health trajectories’ are influenced by success in ‘status attainment’. He argues that life stress that interrupts attainment of education, occupation and wealth proliferates across the lifespan. In this way, advantage begets advantage and adversity leads to further adversity. Traumas and ‘life course disruptions’ (such as early parenthood, divorce, loss of job and prolonged caregiving) are not equally distributed in all socioeconomic groups. The end result is that poverty, poor health and early death in later life reflects a lifetime of serial adversity. This effect is multiplied in ethnic minorities leading to ‘triple jeopardy’ for
elderly ethnic minorities with low SES (Shuey and Willson, 2008). Bartley strongly advocates the need for social policy 'safety nets' earlier in life to protect people from this later life health trajectory (Bartley et al., 1997).

**Policy implications**
The consequence of all this in policy terms is that any strategy to improve health outcomes for elderly people must reduce socio-economic inequality in earlier life. Both Black and Acheson made comprehensive recommendations to address this but prevailing neo-liberal rhetoric at the time was that these could not be afforded. The reality is, however, that the cost of ignoring social inequality earlier in life, can be measured in terms of increased morbidity and premature death in the poor later in life. George summarises that ‘as long as there is socioeconomic inequality, there also will be health disparities’ and that reductions in SES inequality rather blaming health behaviours in the poor, should be the target of public policy’ (p.138). This may be a difficult truth for neo-liberals come the next general election.

**References**