Reports from the Programme conference The influence of lifecourse and biography

Health inequalities from a lifecourse perspective

Chris Power

It has been known for some time that disease risks tend to cluster according to socio-economic group, but only recently have we begun to appreciate the extent to which risks accumulating over long periods of life contribute to the development of health inequalities. Important new studies of mortality show that early life factors are influential for some causes of death and not others. But what of health and well-being during life, at stages that are relatively healthy for most people? Are there inequalities in health in early adulthood, and if so, what are the causes?

This presentation described socio-economic trends in health among 33 year-olds in the 1958 British birth cohort and traced the origins of these inequalities. We used three measures of health status: obesity, psychological distress and the individual's self-assessment that their health is poor or fair. Differences in health were pronounced, eg. 19% of women in unskilled manual social classes rated their health as poor, compared with 9% in professional and managerial classes. Although we might have expected self-assessed health and psychological distress to be due to influences over the short-term, in fact the explanations for inequalities appeared to reside in early life as well as in contemporary circumstances. The predominant pattern was a strong social differentiation of accumulated risks onwards from birth. Factors identified suggest a key role for material circumstances and associated acquisition of socio-emotional skills and resources in childhood, as well as for adult health behaviours and work-related experience. In contrast, findings suggested that inequalities in adult obesity may be due to early life conditions or to a synergistic relationship between early life and current factors. Given that our selected health measures are indicators of both current and future health status, the trends and likely origins observed here may well foreshadow those for future inequalities in mortality.

The influence of family patterns of ill-health and early life experiences on behaviour in mid-life

Kate Hunt, Graham Watt and Carol Emslie

The reduction in coronary heart disease (CHD) and in inequalities in CHD is a public health priority. Some of this could be achieved through changes in behavioural risk factors for CHD. However, decisions about such behaviours are complex and take account of many factors, including knowledge about the lives and health experiences of family members. In this study we conducted in-depth interviews with 61 people in their forties to examine whether ideas about 'family histories' of heart disease influenced decisions about health-related behaviours.

The study confirmed the importance of 'heredity' in lay notions of the causes of heart problems. However, while some people saw themselves as definitely 'having' a family history of heart problems, others (in particular men in manual socio-economic groups, i.e. those at highest risk of CHD) were much more ambivalent. People often made a distinction between inherited risk within their family as a whole and for themselves personally. Thus, believing that heart disease 'ran' in the family was not automatically translated into a belief that they themselves were at higher risk, or that they should be particularly careful about health-related behaviours.

The research highlighted some specific ways in which coronary advice is discounted or undermined. Lack of certainty in predicting coronary events at an individual level and the perception of heart disease as a 'good way to go' were two such barriers. Another barrier which people identified was the notion of 'legacies' from their past. Family history, past exposure to tobacco smoke and past diet were commonly mentioned. Thus, some people felt that behavioural change was not sufficient to counteract past experience and exposures.