Reports from the Programme conference Ethnicity, gender and socio-economic status

Ethnicity, socio-economic position and health

George Davey Smith

Health status differs between ethnic groups and also varies by socio-economic position. The relationship between ethnicity, socio-economic position and health is complex, however, and has changed over time and can differ between countries.

In the USA there is a long tradition of treating ethnic group membership simply as a socio-economic measure, and differentials in health status between African-Americans and groups of initially European origin have been considered purely socio-economic. A contrary position sees the differences as either 'cultural' or due to some inherent 'racial' differences.

While conventionally measured socio-economic indicators statistically explain much of the African-American/European origin health differences, it is not the full story. Ways of indexing socio-economic position clearly contribute to this - for example, at a given level of income, African-Americans have less wealth and poorer socio-economic backgrounds than the European origin population, and these factors are known to influence health independently of current income. Additional factors, such as the extent of racism, are also likely to be of importance.

Similar complexity exists when analysing ethnicity, social position and health in Britain, and this was briefly illustrated with quantitative and qualitative data. It was concluded that studies which inadequately account for socio-economic circumstances when examining ethnic group differences in health can reify ethnicity (and its supposed correlates); however, the simple reduction of all ethnic differences in health to socio-economic factors is untenable. The only productive way forward is through studies which recognise the complexity of the relationships between socio-economic position, ethnicity and health which exist within particular populations at particular times.

Health inequality in women

Mel Bartley

It is often assumed that health inequality in women is not as great as it is in men, and for this reason women's health inequality is given less attention in research. There are also a number of technical problems for researchers. One of these is the major responsibility that women take for domestic labour and for the care of children and older people, which has meant that women's working careers are far more interrupted than those of men. This is one reason why, in the past, employment-based measures of the husband's or male partner's social class have been found to influence women's health more strongly than their own. The assumption was made that some co-variate of the male partner's occupational class, such as income or prestige, must be the 'real' reason for the observed relationships.

It is now possible to measure social inequality in at least three different ways: according to income, prestige and employment relationships and conditions. When we do this we see that health inequality in women is at least as great as in men, although the ways in which this is produced may be rather different. Socio-economic position based on employment relations and conditions has less influence in women, particularly in women who are looking after the home and family full time or who are employed part time. General social and material advantage independent of employment is the decisive influence on health behaviour in both men and women, but in women it far outweighs the effects of employment-based social class.

The use of independent measures of household living standards, and of the level of general social and material advantage of the household, therefore allowed us to begin to see the links between socio-economic inequality and health in ways that are more relevant for policy discussion.