11 How to Study and Understand Socioeconomic Inequalities in Health

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Introduction

Socioeconomic position (SEP) refers to the position members of social groups hold in the societal hierarchy. As such, SEP has an important impact on life chances. SEP determines people's access to resources within society, such as money, power, or prestige, and their exposure to advantaged and disadvantaged conditions, which leads to social inequality (Mackenbach, 2019). In general, people with a higher SEP grow up, play, reside, work, and age in more favourable physical, social, cultural, and financial circumstances than those with a lower SEP. The fault lines in society created by SEP are likely deeper than those created by other social indicators like gender, age, migrant status, and sexual orientation, as the social networks of different socioeconomic groups are largely separate and individuals with different SEP rarely mix (Volker et al., 2014). In the workplace, different socioeconomic groups fulfil different positions and often do not meet or collaborate. People with a higher SEP live in different, more attractive, and liveable neighbourhoods and have better quality housing than people with a lower SEP (Volker et al., 2014). The limited interaction with and exposure to people belonging to different social classes has been shown to diminish tolerance and sympathy for those in other social classes, which influences perceptions about fairness and social justice (Mijs, 2018). This distance also leads to substantially different political preferences and cultural tastes between higher and lower socioeconomic groups (Kuipers & van den Haak, 2014). Limited interaction between social classes negatively influences beliefs about the deservingness of those who are worse off (Mijs, 2018), creating great challenges for solidarity and social justice and further strengthening class segregation, with potentially severe consequences for those with a lower SEP.

An important life domain that is highly influenced by SEP is health. Those in higher socioeconomic groups generally experience better health, live fewer years with diseases and disabilities, and die at older ages than those in lower socioeconomic groups. In the Netherlands, for instance, those in low socioeconomic groups live an average of about six years less than those in high socioeconomic groups and about fifteen *more* years with diseases or disabilities (Centraal Bureau voor de Statistiek, 2020). The COVID-19 pandemic has exacerbated how SEP affects life conditions, including health. The most vulnerable

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have been disproportionately impacted by the pandemic; for instance, those in lower socioeconomic groups could less easily follow the social distancing guidelines because they were more likely to have jobs that could not be practiced from home, and when infected with COVID-19, those in lower socioeconomic groups were more likely to fall severely ill due to having more comorbidities (Bambra et al., 2020).

These health differences between lower and higher socioeconomic groups are not simply referred to as differences but as inequalities or inequities. The term **socioeconomic inequalities (or inequities) in health** indicates that these health differences are unfair, unjust, unnecessary, and avoidable and should be reduced (Krieger, 2001), since they are largely seen to emerge from unequal access to resources and harmful exposures (to, e.g., pollution, violence). Socioeconomic inequalities in health are persistent and observed worldwide (Mackenbach et al., 2008, 2017). There is substantial literature on socioeconomic inequalities in health, its main explanations, and potential policy approaches to reduce these inequalities. We will address these topics in the current chapter, but before we do so, we first tackle the question of what exactly SEP is and how it can be operationalised in empirical studies. Differences in how SEP is defined can have important consequences for solidarity and social justice; people labelled as having a low SEP according to one definition but not others may still experience the negative stereotypes associated with low SEP, and people struggling to make ends meet may not receive the help they need because of the definition of low SEP used to determine who receives help. Perceptions of people targeted by social policies to address socioeconomic inequalities will be discussed extensively in Chap. 12.

Defining and Measuring Socioeconomic Position

Hierarchy and inequality are inevitable in any society (van Kleef & Cheng, 2020), although some societies have traditionally been more hierarchal and unequal than others. One extreme example is the former caste system in India, where individuals were born into a universally acknowledged caste that determined rights and privileges (Chanana, 1993). In Europe, where welfare states originated, inequality is less extreme and societies are more informal, although there are still substantial differences between European countries. Welfare schemes, which generally rely on underlying solidarity with others, enable the redistribution of wealth and minimise inequities to some extent. Despite this, SEP also varies widely between individuals within countries, with important consequences for the life opportunities, health, and well-being of those with a lower SEP.

In line with seminal sociological theories about social class and social inequalities (see Box 11.1), SEP is most commonly operationalised by three different indicators in empirical work: highest attained educational level, type of occupation, and income (Mackenbach, 2019). The measurement of income and highest attained educational level is relatively straightforward, although most people are less reserved in reporting their educational level than their income. One measure of occupation is the Goldthorpe class scheme, which places highly skilled workers at the top of the scheme and unskilled workers at the bottom. The scheme was created to fit the occupational structure of the UK in 1992 (Savage et al., 2013), but these occupational classifications change over time and context. For example, in the context of the COVID-19 pandemic, traditionally low status positions such as cleaners

Box 11.1 Important Sociological Theories Related to SEP

The influential social scientists Marx, Weber, and Bourdieu focused on interpreting differences in **social class** in their work, each focusing on explaining different facets of how contemporary inequalities function. Closely related to SEP, social class refers to one's position in society that car-

ries with it group membership, norms, and socialization patterns. In Marx's view, social classes are driven by unequal access to economic resources. An individual could either belong to the powerful upper class that controls the means of production or to the (much larger) less powerful working class (Bendix, 1974; Saunders, 1990).

More dimensions of social structure were introduced by Weber, who emphasised the importance of class (economic wealth), status (derived from honour and respect from others), and party (political power) in determining social position (Bendix, 1974). Consistent with social identity processes of ingroup glorification and outgroup derogation (see Chap. 3, this volume), a working class member who gained access to economic or political power could still be socially excluded from the elite due to differences in status, as social classes can create barriers and tend to exclude those who do not fit their social prestige.

Bourdieu considered social structure to be shaped and maintained by the distribution of capital among individuals (Bourdieu, 1986). He distinguished between economic capital (i.e., material resources that are immediately and directly convertible into money), social capital (i.e., the size and quality of the network of connections a person has), and cultural capital (i.e., a person's knowledge, skills, and behaviours). According to Bourdieu, unequal access to these forms of capital is what leads to social inequalities.

To summarize, Marx focused on the social means of production, Weber focused on social and economic market capacities, and Bourdieu focused on the impacts of the three forms of capital on social inequalities. These viewpoints are not incompatible with each other, and an understanding of all three can help illuminate and explain different aspects of social inequalities (Curran, 2016).

(low status based on type of occupation) or primary school teachers (low status based on income) suddenly became more appreciated and in many countries were characterised as key to the functioning of the economy (see Chap. 19, this volume). Although the three main indicators of SEP are inherently associated, each indicator can lead to different results, magnitudes, and interpretations of the causal mechanisms that contribute to socioeconomic inequalities. For instance, in one study, educational level was found to predict diabetes type-2 more strongly than income or occupation, whereas income was the strongest predictor of mortality (Geyer et al., 2006). These results show that income, educational level, and occupation cannot always be used interchangeably; the choice of a particular indicator of SEP in empirical research should fit the research question but also depends on the data available.

Intersectionality, Self-Perceived SEP, and Stereotypes

Although research often examines these SEP indicators individually, the experiences of individuals are rarely restricted to one layer. Personal factors, such as social class, but also, for example, one's ethnicity, gender, and disability, heavily influence a person's experience of inequality. Yet, similar to the SEP indicators, personal factors are often considered in research and policy as if they are mutually exclusive and unidimensional (Bowleg, 2012). The **intersectionality** framework states that multiple social categories (such as SEP, race, and gender) intersect at the micro level in forming one's individual experience (Bowleg, 2012). For example, the experience of a low-income Black female can be very different from the experience of a high-income Black female, a low-income Black male, or a low-income Caucasian female. Bauer and Scheim (2019) studied how day-to-day discrimination influenced inequalities in psychological distress across different intersections of disadvantage, specifically in Indigenous and Middle Eastern sexual and gender minority groups. They found

the accumulation of disadvantages to be greater than the sum of effects of individual disadvantages. The intersectional approach enabled them to identify a group at particular risk of health inequalities as a result of discrimination and highlighted the need to study the accumulation of factors in research about inequality rather than single indicators of SEP (Bauer & Scheim, 2019).

In addition to traditional indicators of SEP like education, income, and occupation, SEP can be operationalised as a subjective measure, self-perceived SEP. Self-perceived SEP may capture the individual experience of SEP more broadly and the intersectionality of social class with other social identities better than traditional indicators of SEP. Perceiving and experiencing social identity can lead to comparisons of one's own social identity to others' (Tajfel, 1982). Comparing your own SEP to others' SEP can lead to the experience of **relative deprivation** (see Chap. 4, this volume). Instead of having a high self-perceived SEP because you have a high *absolute* level of education (e.g., a bachelor's degree), you may perceive your SEP as low because you have a lower level of education *relative* to others in your surroundings (e.g., with a PhD), resulting in feelings of dissatisfaction with your own SEP. In a 1847 pamphlet, Marx wrote, "A house may be large or small; as long as the neighbouring houses are likewise small, it satisfies all social requirement for a residence. But let there arise next to the little house a palace, and the little house shrinks to a hut." (Marx, 1893). The idea of determining perceived SEP by making comparisons with neighbours through displays of material wealth ("keeping up with the Joneses") persists in modern societies and contributes to materialism (Kim et al., 2016). While comparing yourself to others *within* your social category used to be more common than comparing yourself to those higher up the social ladder (Walker & Pettigrew, 1984), this seems to have changed. In modern society, we are bombarded with relative deprivation-provoking cues. Through targeted advertising, regular launches of new iterations of products (e.g., iPhones), and social media, comparisons of social status can be continuously communicated. Being connected with people you know as well as with celebrities, vloggers, people in advertisements, and people from totally different backgrounds may lead to feelings of being worse off than others (high relative deprivation) (Bruni & Stanca, 2006), which may negatively impact life satisfaction and well-being. These processes of social comparison based on SEP may also enforce group boundaries (see Chap. 2, this volume) and, as such, challenge solidarity.

SEP is also experienced through **SEP-related stereotypes**, cultural products that support gaps between those with low and high SEP (Durante et al., 2017). Complementary stereotypes (see Chap. 4, this volume) are observed in research about SEP-related stereotypes. Those with a high SEP are often viewed as more competent but colder, and those with a low SEP are viewed as less competent and warmer. This was found to be true regardless of the SEP of the person being asked, indicating that these stereotypes are also endorsed by stereotyped groups themselves (Durante & Fiske, 2017). Findings about SEP-related stereotypes have been relatively consistent for different measures of SEP (income, educational level, occupation), although especially for occupation, other attributes like trustworthiness may play a significant role within groups defined by SEP. For example, doctors are considered more trustworthy than lawyers despite both being occupations associated with high SEP. At a societal level, the amount of inequality also impacts stereotype perceptions. In more unequal countries, status is more strongly linked with competence, reinforcing the stereotype that people with a lower SEP are considered less competent (Durante & Fiske, 2017). People with a higher SEP were considered colder in countries with higher inequalities. In short, inequality penalises the perceived competence of people with a lower SEP and penalises the perceived warmth of those with a higher SEP. One study found that stereotypes about the wealthy were associated with participants' tax policy preferences (Ragusa, 2014), showing that SEP-related stereotypes can put pressure on between-group solidarity.

Consequences of SEP for Health and Well-Being

Overall, those in low socioeconomic groups experience poorer health than those in high socioeconomic groups (Cookson et al., 2016). These inequalities are observed for many health indicators: life expectancy, chronic diseases like Type 2 diabetes and cardiovascular diseases, different types of cancers, and respiratory diseases. While it is clear that socioeconomic inequities in health exist, there are two competing hypotheses about the direction of the relationship between SEP and health: **social selection** and **social causation**. The social selection hypothesis posits that being in poor health can, over time, lead people to either drift to a lower socioeconomic group or fail to move to a higher socioeconomic group. For example, the symptoms of prolonged mental illness could limit a person's ability to stay in school or keep a job, leading to a drop in SEP (Mossakowski, 2014). The social causation hypothesis, on the other hand, posits that experiencing disadvantaged SEP leads to an increased risk of poor health via different underlying mechanisms. Although there is evidence for both hypotheses, the social causation hypothesis has been studied most often in the field of social epidemiology (Mackenbach, 2019), with studies aiming to find explanatory mechanisms on which policies and interventions could intervene to reduce inequalities.

Within the social causation hypothesis, multiple explanations for socioeconomic inequities have been put forward, including material, psychosocial, and behavioural approaches (Bartley, 2004). All three approaches propose certain intermediary mechanisms that drive the effect of SEP on health. The materialist approach focuses on material resources, like income, and what those resources enable in terms of population health (e.g., welfare programs, adequate housing, access to services). The psychosocial approach focuses on the unequal social distribution of psychosocial risk factors, such as self-esteem and social support, and the impact of those risk factors on health. The behavioural approach emphasises the role of health-related behaviour (e.g., smoking, physical exercise, and diet), as lower socioeconomic groups are generally more likely to practice unhealthier behaviours than higher socioeconomic groups.

While the three approaches were developed separately, they are not mutually exclusive; material, psychosocial, and behavioural factors all play a role in shaping health, and other types of factors, such as cultural, biomedical, and environmental factors, are increasingly considered by researchers. Studies on this topic have shown that many types of factors, considered simultaneously, help explain socioeconomic inequities in health outcomes (Duijster et al., 2018). These types of studies are helpful, but they assume that each type of factor influences socioeconomic inequities in health through isolated pathways. There is increasing recognition that understanding the interplay between different factors may be important to help understand, and ultimately reduce, socioeconomic inequities in health. For instance, smoking (a behavioural factor more common among those with a lower SEP (Stronks et al., 1997)) may be a means to cope with stress (a psychosocial factor) caused by financial problems or job uncertainty (material factors). The broader socioeconomic, environmental, and political contexts that individuals live in (structural factors), which are largely out of the individual's control, have also been considered important in explaining socioeconomic inequities in health (Diez Roux, 1998; Macintyre et al., 1993). The interplay between structural and individual factors may be key to understanding how resources can be transformed into action and how socioeconomic inequalities in health are shaped (see Sen's capabilities approach in Chap. 5, this volume). The mechanisms driving socioeconomic inequities in health are numerous, multileveled, interrelated, and complex, which has led to recommendations that researchers consider the broader systems shaping health and well-being rather than examining single mechanisms (Diez Roux, 2011).

Battling Socioeconomic Inequalities in Health and Well-Being

Depending on the definition of SEP as well as the mechanisms deemed central to explaining health inequities, different policy approaches are likely to be taken. The role of the individual is key in the behavioural approach, leading to interventions like health education that place the responsibility for changing health behaviours and outcomes on the individual. As a result, individualised approaches, focusing on groups like "the obese" or "the smokers", are likely to induce stigmatisation (MacLean et al., 2009). Interventions based on the material approach (such as subsidies) or the psychosocial approach (targeting the social environment by enhancing social support, for example) may be less stigmatising and more effective (MacLean et al., 2009). Vice versa, the policy approach taken is also likely to affect public opinions regarding SEP and ill health (see, for instance, Chap. 12, this volume).

Many policy initiatives aim to address health inequalities by targeting the root of the issue, the **social determinants of health**, that is, structural factors such as housing and employment. However, evaluations have shown that it can be challenging for health policy to impact these social determinants of health due to health policymakers' lack of power, influence, and expertise in other policy areas (Gore & Kothari, 2012; Melkas, 2013; Popay et al., 2010; Williams & Fullagar, 2019). When priorities for social justice are not aligned between policy domains, opportunities to develop and implement policy at the structural level may be limited. A review of diet and physical activity policy initiatives in Canada found that the more an intervention was focused on structure, the less it was supported by the public, which the authors posited was partly due to Canada's increasingly neoliberal political and economic policy (Gore & Kothari, 2012). The review also found that the vast majority of policies remained focused on individual and behavioural factors, showing that alignment in what is perceived as a social justice priority between different policy domains is necessary to effectively target structural factors. This trend has also been observed in Finland and the UK (Melkas, 2013; Williams & Fullagar, 2019). The tendency of policy-makers to circle back to lifestyle factors instead of structural factors is referred to as the **lifestyle drift** (Popay et al., 2010).

The lifestyle drift not only takes away resources from targeting structural factors but has been suggested to contribute to the widening of socioeconomic inequalities in health (McGill et al., 2015), which likely has an adverse impact on solidarity because these types of policies unfairly place blame and responsibility on disadvantaged individuals. Moreover, education programs or lifestyle interventions are relatively more accessible to those with a higher SEP, whereas those who are in highest need are the most difficult to reach and the least likely to benefit from these types of interventions (Broeders et al., 2018). Lifestyle interventions are often designed by professionals educated in the field of health promotion and, consequently, by people with a high SEP. This makes identification with and fully understanding and considering the needs of people with a lower SEP difficult. As interventions are often designed from the perspective of people with a high SEP, they often primarily match the needs and opportunities of those in higher social positions (Adler et al., 1993). This contributes to the lack of effect of lifestyle interventions on those with a lower SEP (Williams & Fullagar, 2019). The few interventions that do achieve positive outcomes for those with a low SEP cannot be expected to have lasting results without simultaneously addressing structural factors (Gore & Kothari, 2012).

There is a need to move from the lifestyle and individual responsibility viewpoint to a focus on health equity, addressing social determinants of health and enabling equal opportunities for healthy behaviour across all layers of society, thereby increasing social justice (Godziewski, 2020). However, the size of socioeconomic inequalities in health in a society can challenge solidarity and, specifically, people's willingness to contribute to the costs of healthcare and disease prevention. For example, people with a high SEP are less willing than people with a low SEP

to invest in cures for diseases that are strongly associated with unhealthy behaviours (i.e., lung cancer, which is strongly linked to smoking behaviour), as they consider these behaviours controllable and, therefore, preventable (Penner et al., 2018). Further, the stereotypes people hold regarding those with low and high SEP may influence which policies are deemed necessary, fruitful, and acceptable. People with political power often have a high SEP and are likely to be socially distanced from those with a low SEP. As a result, people with political power may be more likely to hold negative stereotypes towards those with a low SEP compared to those without political power (Cozzarelli et al., 2001). For instance, if those with political power or the public consider people with a low SEP to be lazy, they might be more in favour of behavioural approaches that emphasise individual responsibility for a healthy lifestyle. However, when those in political power or the public consider SEP to be largely determined by luck and living environment, they may be more inclined to accept subsidies that target individuals by improving the material conditions they live in. As such, SEP-related stereotypes may influence and be influenced by the social policies that are in place to address health inequalities.

Conclusion

Socioeconomic position (SEP) is a major fault line in contemporary Western societies. It is a highly defining social identity that largely determines with whom people interact. Moreover, SEP has far-reaching consequences, not only for where people are born, grow up, play, reside, work, and age, but also for the health state in which they are able to do so. SEP significantly impacts health and well-being, and these socioeconomic inequalities seem to be widening (Mackenbach, 2019). In this chapter, we have shown how difficult it is to study and combat socioeconomic inequalities in health. Not only is it a complex process that may have varying causes and involve many interrelated factors, but public health policy-makers trying to battle socioeconomic inequalities in health also have to deal with stereotypes that may impede the acceptance of policies aimed at changing structural factors, both by policy-makers in other domains as well as society. The COVID-19 pandemic has disproportionately hit the most vulnerable and further contributes to widening socioeconomic inequalities in health, yet it may also create a window of opportunity for structural, equitable improvements and for future breakthroughs in public health.

Glossary

Intersectionality: The complex, cumulative way in which multiple aspects of personal identity (such as gender, SEP, and race/ethnicity) intersect in forming one's experience of marginalisation.

Lifestyle drift: The tendency of policymakers to focus on lifestyle- and disease-related factors instead of the social determinants of health while aiming to address socioeconomic health inequalities.

Public health policy: Policy that aims to protect and improve health for the general or a specific population.

Relative deprivation: The extent to which a person or social group is deprived compared to others in society. In highly unequal societies, relative deprivation is larger than in less unequal societies.

SEP-related stereotypes: An oversimplified characterisation of a certain group or type of individual based on their perceived SEP, such as stereotyping those with a low level of education as lazy and implying blame for their position.

Social causation: The hypothesis that economic hardship, or having a low SEP, increases the risk of poor health outcomes. There are three main explanatory mechanisms through which SEP influences health: material (i.e., housing), psychosocial (i.e., social support), and behavioural (i.e., dietary) factors.

Social class: The broad culture, norms, social identity, and socialisation patterns associated

with belonging to a certain socioeconomic group.

Social determinants of health: The non-medical factors that influence one's health. These are the wider set of forces and systems shaping the conditions of daily life, such as education, healthcare, working conditions, housing, safety, and social inclusion.

Social selection: The hypothesis that poor health outcomes lead to economic hardship or to having a low SEP.

Socioeconomic inequalities (or inequities) in health: Systematic health differences between individuals or groups that are socially produced and that stem from a form of injustice. Socioeconomic health inequalities between those in lower and higher SEPs reflect an unfair distribution of social determinants of health. In the public health literature, there is a distinction between inequalities and inequities. In this book, we use the two definitions interchangeably.

Socioeconomic position: A concept used to define an individual's socioeconomic standing within society. The concept captures both resources and prestige and is often measured using one or more indicators such as level of income (economic status), educational level (social status), and occupation (work prestige). Note that the objective measurement using SEP indicators is different from subjective measures of SEP, where people are asked about perceptions of their SEP relative to others' SEP.

Comprehension Questions

1. What is an example of how to measure absolute SEP and relative SEP, and how could one's absolute SEP be different from one's relative SEP?
2. Provide an example of how material, behavioural, and psychosocial factors affect one another. How do these interactions contribute to why those in lower socioeconomic groups generally experience poorer health than those in higher socioeconomic groups?
3. How could SEP-related stereotyping negatively influence solidarity and the willingness to invest in social policies?

Discussion Questions

1. One could argue that public health policymakers are mainly responsible for developing policies and interventions to reduce socioeconomic inequalities in health. However, given the interplay between the many factors that contribute to socioeconomic inequalities in health, one could also argue that interventions from other policy domains are at least as important. Which other relevant policy domains can you think of, and what policy measures could they put in place to improve the living conditions and thereby the health of those in lower socioeconomic groups?
2. Which intersections of social categories do you think are most important in shaping people's experience of inequality in society? Why?

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