The wealthy get healthy, the poor get poorly? Lay perceptions of health inequalities

Rosemary Davidson a ,*, Jenny Kitzinger b , Kate Hunt c

Abstract

Research repeatedly identifies an association between health and socio-economic status—richer people are healthier than poorer people. Richard Wilkinson has posited that socio-psychological mechanisms may be part of the explanation for the fact that socio-economic inequalities run right across the social spectrum in wealthy societies. He argues that polarised income distributions within countries have a negative impact on stress, self-esteem and social relations which, in turn, impact on physical well-being. How people experience and perceive inequalities is central to his thesis. However, relatively little empirical work has explored such lay perceptions. We attempt to address this gap by exploring how people see inequality, how they theorise its impact on health, and the extent to which they make personal and social comparisons, by drawing on 14 focus group discussions in Scotland and the north of England. Contrary to other research which suggests that people from more deprived backgrounds are more reluctant to acknowledge the effects of socio-economic deprivation, our findings demonstrate that, in some contexts at least, people from less favourable circumstances converse in a way to suggest that inequalities deeply affect their health and well-being. We discuss these findings in the light of the methodological challenges presented for pursuing such research.

Keywords: Health inequalities; Lay perceptions; Focus groups; Socio-economic inequality; UK

Introduction

Health inequalities are a major public health and policy issue within the UK (Davidson, Hunt, & Kitzinger, 2003). Attempts to address such inequalities have a long history (e.g. Chadwick, 1842), but in recent times the debate has been defined by the publication of the Black Report in 1980 (Whitehead, Townsend, & Davidson, 1992) and the subsequent flourishing of related research (Mackenback & Kunst, 1994). In 1997 health inequalities rose up the policy agenda with the election of a Labour government which commissioned an independent inquiry into this issue (Acheson report, 1998).

One focus of the inequalities debate in the 1990s was on the importance of absolute versus relative income. Richard Wilkinson, a key figure in this debate, argues that it is the differences within countries rather than socio-economic resources per se which might affect health and suggests the impact
of social hierarchies on socio-psychological factors might help explain patterns of health inequality. ‘What matters’, he writes, ‘would be not whether you have a larger or smaller house or car in itself, but what these and similar differences mean socially and what they make you feel about yourself and the world around you’ (Wilkinson, 1996, p. 75).

Wilkinson’s work has generated considerable debate and was accompanied by a growing interest in the possible role of psycho-social factors in health inequalities as well as an interest in the role of ‘social capital’ (See, for example, Carroll & Davey Smith, 1997; Davey Smith, Bartley, & Blane, 1990). Yet Wilkinson’s research has not been without its critics. Illsley, for example, took issue with the comparison of class death rates over time as such comparisons involve ‘...a number of implicit conceptual and methodological assumptions’. Social classes change in size and composition over time making it impossible to compare ‘like with like’ (Illsley, 1986, pp. 151–152). Wilkinson rebuffs these criticisms by citing research—specifically three indexes of inequality—that he claims overcomes such difficulties (Wilkinson, 1986). Other debates centred on the data used (Judge, 1995; West, 1997).

After re-analysing two sources of data used by Wilkinson, Judge claimed that the relationship between income inequality and average life expectancy had been exaggerated (Judge, 1995). In response, Wilkinson focused on Judge’s use of only two out of five sources of data to substantiate the link between income distribution and life expectancy (Wilkinson, 1995). Wilkinson conceded latterly that his view ‘...of what might lie behind the relation with income inequality has changed substantially over the years’, favouring a more multi-causal, multi-layered explanation than he had ventured previously (Wilkinson, 1999).

More recently, Lynch, Davey Smith, Kaplan, and House (2000) have questioned the existence of psycho-social mechanisms, instead favouring ‘neomaterial’ explanations. For them, a focus on perceptions of inequality ignores the material conditions that structure everyday experience, leading to an unhelpful political agenda of victim blaming (Lynch et al., 2000). Rather than focusing on any alternate theory, Marmot and Wilkinson respond by reinforcing the importance of psycho-social explanations (Marmot & Wilkinson, 2001).

Despite such reservations about Wilkinson’s theory, his work contributed to the opening of new debates within the inequalities field and raised new questions. The issue of how people actually experience and perceive inequalities is one obvious avenue to explore. However, in spite of an extensive body of work into lay perceptions of various aspects of health, there has been less work on lay perceptions of social inequalities and health (Backett-Milburn, Cunningham-Burley, & Davis, 2003; Bolam, Murphy, & Gleeson, 2004).

Work which does touch on these areas would include studies into differing health discourses constructed by working and middle class respondents (Pierret, 1993); attempts to link health behaviours with psycho-social characteristics (Lynch, Kaplan, & Salonen, 1997) and some of the research into the possible role of social capital and social networks in generating good health (Campbell, Wood, & Kelly, 1999; Sixsmith & Boneham, 2002). Even in this body of work, however, there is little direct attempt to explore how people see health inequalities and locate themselves within social hierarchies. One exception would be work by Cattell (1995, 2001), Cattell and Evans (1999), which identifies three factors influencing social networks and social capital: neighbourhood characteristics and perceptions; poverty and social exclusion; and social consciousness (Cattell, 2001, p. 1501). Blaxter (1997), Popay, Bennett, et al. (2003) and Popay, Thomas, et al. (2003) provide two further important contributions to the debate.

Mildred Blaxter used existing quantitative data and reviewed findings from a number of qualitative studies of health (though not focused on inequalities per se) in order to draw out relevant evidence about lay perceptions of health. This suggested that people rarely talked in terms of structural determinants of health and illness when asked open-ended questions about the causes of ill health. Instead they tended to emphasise the importance of healthy lifestyle choices. In these studies, those who did refer to socio-economic factors as a possible influence on health tended to be in non-manual jobs and have higher incomes (Blaxter, 1997). Blaxter concluded that there was ‘a feeling of disbelief or unease [about the association between socio-economic status and health inequalities]… especially among those most at risk’ and that those ‘most exposed to ‘unequal’ health[…] will be least likely to talk readily about their risk status’ (Blaxter, 1997, p. 753, 756). However, such observations need to take into account that this is a sensitive issue for people most
at risk because ‘To acknowledge ‘inequality’ would be to admit an inferior moral status for oneself or one’s peers’ (Blaxter, 1997, p. 754). Furthermore, the data must be considered in their socio-historical context; for example, some derive from women giving accounts of their lives in the late 1970s from the viewpoint of observing marked improvements in social conditions (Blaxter & Paterson 1982). The experiences of different generations to very different social conditions are likely to be critical to their views on health inequalities (Blaxter, 2000).

Research by Popay and colleagues in the 1990s presents some overlapping insights. They explored lay understandings of social inequalities in health using both postal questionnaires and in-depth interviews. They report that, although people had ‘no problem’ offering socio-economic explanations for health inequalities in their questionnaires, they were much more reticent in interviews. The in-depth interviews revealed that those living in disadvantaged areas were ‘reluctant to accept the existence of health inequalities highlighting the moral dilemmas such questions pose for people living in poor material circumstances’ (Popay, Bennett, et al., 2003, p. 1).

Clearly this area of research raises fundamental methodological issues because essentially the researcher is asking respondents to ‘engage actively in the construction…of their own social identity’ in a highly sensitive area (Blaxter, 1997, p. 755). Nevertheless this is precisely what our research attempted to do. The findings we present here first explore the ways in which people discuss their sense of relative deprivation and their ideas about how it impacts on health, and secondly examine if and how people compare themselves with others. To conclude we position these findings in relation to existing theory and research and reflect on the implications of our chosen research method.

**Method**

The findings presented here originated from research exploring public representations and lay perceptions of societal and health inequalities by conducting focus groups, and analysing public health policy documents and their subsequent press coverage (Davidson, 2003; Davidson et al., 2003). Our main concern in this paper is on lay perceptions and therefore it is this part of the method that will be outlined here.

**Recruitment and group composition**

Fourteen focus groups involving 76 research participants were conducted between January 1999 and February 2000 in various parts of Scotland and northern England. We recruited pre-existing groups of people within the same social networks (e.g. community centre groups, work colleagues) because this study was concerned with observing how individuals and groups relate to each other, and we explicitly wanted to access ‘the networks in which people might normally discuss (or evade) the sorts of issues likely to be raised in the research session’ (Kitzinger & Barbour, 1999, pp. 8–9).

Groups were targeted to encompass a wide range of socio-economic circumstances across the sample as possible, although individual groups tended to be socially homogenous rather than heterogeneous. Recruitment of groups was guided with the aid of categories of deprivation based on areas of residence available for all Scottish postcodes (and local knowledge for the two groups in Greater Manchester) (McClone, 1994). Participants were asked to complete a one-page questionnaire in order to collect information on socio-economic status and voting patterns (See Table 1).

In the analysis that follows, groups are described as ‘affluent’ or ‘deprived’, or ‘high(er)’ or ‘low(er)’ socio-economic status, as ascertained from their accounts and the information they gave in the questionnaires. In addition, the table provides information about the type of neighbourhood in which they were living.

**Conduct of the focus group discussions**

A schedule for conducting the focus groups was developed after piloting on four preliminary groups. All groups were facilitated by the first author. Prior to their focus group, respondents were told that they would be exploring media coverage of health issues, and each session started with a general discussion on this topic. Research participants were then explicitly prompted to talk about inequalities in health with the introduction of images and headlines from the reporting of government consultative and policy documents and the Acheson Report (Department of Health, 1998, 1999; Scottish Office, 1998, 1999). Participants were presented with a newspaper picture of a rundown area, another juxtaposing men in suits drinking champagne with a woman walking through an estate, and a close-up
of an infant being held aloft. In each case they were asked to give their opinions of what the images were depicting. The groups were then shown newspaper headlines from the same coverage: ‘Living in Glasgow takes five years off your life’, ‘Gap between rich and poor widens again’, and ‘Children at risk as health inequality between rich and poor increases’. Participants were asked to reflect on the type of story which might have appeared under each headline, their own views on this type of story, and what they thought was meant by the term ‘health inequality’.

At all times research participants were encouraged to exchange opinions with one another rather than address themselves to the researcher. Sessions were thus conducted as genuine ‘focus groups’ rather than merely group interviews and interaction between people was used both to generate data and as part of the analytical process. The discussions were recorded, fully transcribed, and coded onto NUDIST. The analysis focused on both explicit and implicit references to inequalities, and both prompted and unprompted responses. As well as noting the number of references to inequality, the analysis also involved looking back at the context in which comments were made, the tone of the exchange and the specific group dynamics. Quotes representing a spectrum of opinion were flagged as key themes emerged from the data. Less common or unusual viewpoints were also noted, as was any dissent within groups. Confidentiality was protected by using pseudonyms or respondent identifiers, and omitting any local place names which could lead to the identification of participants.

Findings

The following section addresses three questions central to Wilkinson’s thesis:

- Do people accept that health inequalities are associated with socio-economic status?
- How do they explain this association?
- Do they consider relative socio-economic status to be important, and do they compare themselves to, or feel judged by, others?

Do people accept that health inequalities are associated with socio-economic status?

Among all the lower socio-economic groups in our research there was widespread acceptance of the idea that sharp inequalities exist within contemporary society. For example, a charity officer stated, ‘I tend to think there’s two types of people now: the haves and the have-nots’ [R4, FG5:6, lower SES] and, in another group, a lone parent said ‘the rich get richer, the poor get poorer’ [R1, FG1:39, lower SES]. Such comments were met by murhurs of assent and nods from other group members. Similar ideas were expressed in two of the six more affluent groups. However, participants in the other four groups of relatively affluent participants did not discuss society in these terms.
Research participants from the lower socio-economic groups were also quick to link these socio-economic inequalities to differences in health and often talked vividly about the impact of their environment on their own illnesses and life expectancy. By contrast, although some respondents who were living in better socio-economic circumstances accepted such data, others questioned whether poor living conditions really did reduce life expectancy. Take, for example, the following comments from a group of Conservative-voting graduates in their twenties where all four participants resist the suggestion that life expectancy was related to class:

R4: Depends on the individual.
R2: I don’t think that’s necessarily true ‘cause...
R3: [...] Just because you live in a well-off area doesn’t mean to say...
R1: You can have a hereditary disease, or you can have alcohol problems. [...]  
R3: ... so I don’t think you can separate it into class problems that way. I mean, things like cancer you just don’t know who’s going to carry it [...] [FG8:30, higher SES]

Thus, in contrast to Blaxter’s findings that the people most at risk from health inequalities are those least likely to talk about this issue (Blaxter, 1997, p. 751), we found the opposite to be true. In our research it was the groups from deprived areas who most readily volunteered socio-economic explanations of ill health and who most readily accepted the notion that where you live impacts on how long you live. The next section takes a closer look at how such associations were explained.

How do people explain the association between socio-economic status and health?

The research participants in the lower socio-economic groups had ready explanations for why health is associated with living conditions. A lone parent living in a deprived area of Glasgow appears to speak for herself, and for other participants, when describing her financial circumstances:

R5: The poor get poorer, or poorly, it’s because we don’t have—you’re fighting to get your benefits. You get yourself into a state, you get depressed, stress sets in, because of the circumstances you’re in. [FG1:48, lower SES]

People often identified mental stress as a mediator between poor socio-economic circumstances and poor health (see also Popay, Bennett, et al., 2003). They also highlighted the direct health implications of poor housing and talked about the ways in which richer people can buy peace of mind, as is the case with the following group of Glaswegian women working as cleaners where three of the six participants engage in the following discussion:

R4: they’re [wealthier people] no living in damp houses that’s overrun with rats and dampness.
R2: And they’re no stressed out ‘cause they’ve got alarms in their houses and everything.
R4: And plus if they can afford to live there, they’ve got a better standard of living than what somebody has, say maybe in Drumchapel, Possil Park [two more deprived areas of Greater Glasgow]. [...]  
R3: And they wouldnae have gangs hanging about the corners...
R2: So they’re okay in their own houses, staying theirself whereas an old person in a tenement, they are getting battered [...] 
R3: They’ve got the money to buy the best of food, their clothing, best of houses, whilst we are living in slums. [FG10:28-31, lower SES]

In discussing ‘health issues’, participants from a range of groups spontaneously referred to inequalities in healthcare provision and/or resources, as well as the duality of a public/private system. These appeared to be already common topics for discussion that mobilised established viewpoints. However, the lower socio-economic groups tended to discuss concerns about issues such as hospital waiting lists (and being unable to receive faster treatment by going private) and the general cost of staying healthy with more passion and anger. In addition, richer people, they pointed out, had easier access to fresh fruit and vegetables, nice relaxing holidays and had the money and time to use a health club. Within the lower socio-economic groups, research participants often supplemented their responses by offering vivid personal accounts describing how living in difficult circumstances impacted on both mental and thus physical well being in the course of discussion and exchanging experiences with their peers. They discussed issues such as not being able to afford the price of school dinners for their children—as one mother stated simply ‘I’m too poor to pay that’ [FG9:4, lower SES]. They discussed how cramped conditions at home led to arguments or social difficulties such as children lacking space to do homework. They
recounted vivid stories about the problems of social breakdown. Fear of street violence was prevalent and intense anger was expressed against neighbours who made life difficult for others through anti-social or criminal behaviour. All of this was seen to impact directly on health. One research participant, for example, explained how she was no longer going to a local shop to avoid having to pass a gang of young people: ‘[…] the impact on your health is quite tremendous because you feel threatened […] So you get depressed, you get anxious’ [R5, FG9: 23-24, lower SES]. (For detailed discussion of how people talk about the impact of place on health see Davidson & Hunt, submitted.)

By contrast, in seeking explanations as to why health inequalities exist, higher socio-economic status participants tended to explore a narrower range of causes. Although some more affluent research participants produced explanations which overlapped with the type of explanation offered above, others blamed health inequalities on life style choices rather than social conditions. If they accepted that poorer people had poorer health (and, as noted previously, some were reluctant to do so) then the explanations they offered for this were more often associated with poorer people’s lack of education, criminal behaviour (‘they’re all shooting each other’), self-abuse (especially illegal drugs) or poor consumer choices and misguided priorities. A group of employees at a firm of accountants, for example, saw the existence of health inequalities as the result of a lack of education and failure to attend to health information. One commented that:

R1: […] you’ll still find that these poor people can afford their cigarettes. [FG7:11, higher SES]

Other members of the group agree and go on to expand on this:

R3: Diet, cigarettes, alcohol, stress, drugs, prostitution [laughter], they’ve all got to be real.

R4: I think, really, more affluent people throughout the country tend to take more notice of […] what people tell us we need to do to live a healthy life em, than those that are poorer. [FG7:12, higher SES]

Similarly, within a group of neighbours in an affluent part of Greater Manchester, one participant questions the consumption patterns of lower socio-economic groups:

R3: They want this wonderful life that’s put to them on the television. […] Instead of having enough money to pay your bills and a roof over your head, warm food in your stomach and a comfy bed. That is the lowest priority on their list. They want designer this, designer that, and a fast car and if they haven’t got that then they feel they’ve underachieved in life, and they therefore, they feel depressed. [FG11:25, 56, higher SES]

Others in the group interject with comments such as ‘[They want] all the gadgets’ [R4], ‘They’ve got their priorities totally wrong’ [R1].

The implications of such consumer choices were discussed in some of the lower socio-economic groups too. But, in these groups, such choices were more likely to be placed in context by linking behaviour to the social conditions in which people lived. For example, a group of unemployed participants discussed their ‘need’ to smoke, despite knowing the health consequences, as a response to a stressful environment:

R5: […] Well, me as well Jake [R3], I’m well aware that this is knocking seconds off my life every time I take a puff [indicating her cigarette], it’s doing my head in.

R6: But it calms you down, it keeps you, don’t it. It does. [FG9:42, lower SES]

Contrasting perspectives on the consumption of designer goods were displayed in groups of varying socio-economic status. Thus while the more affluent individuals cited above tended to attribute people’s ‘inappropriate spending’ to ignorance, susceptibility to media influence, bad judgment and moral failing, different accounts were offered by other research participants, particularly in the groups of people from lower socio-economic backgrounds. Poorer research participants talked, for example, about how the ‘dream’ of a better life was a necessary fantasy for people living in deprived conditions—hence the popularity of buying lottery tickets: ‘the quick fix […] into nae worries…everybody’s looking to escape from that’ [FG6:33-34, lower SES]. In a group consisting of four unemployed members of a community centre, the discussion turns to how joblessness might make people turn to drugs:

R3: They’re [people from poorer areas] drinking and taking drugs and that’s […] taking more off their life than what it is for the rich ones, isn’t it, ‘cause they’re at work.[…] Whereas the poor
have no got any work so, all they do is take drink and drugs isn’t it?
R1: That’s right.
R2: To pass the time possibly.
R1: Aye, to forget all their worries, just take the drugs and take the drink. [FG2:22-23, lower SES]

Similarly, some of the less affluent groups acknowledged the ‘problem’ of poor people spending on designer goods, but they offered complex accounts of this. In the following extract, for example, two people from a community group in a deprived area discuss how someone with no money might feel to see more affluent people enjoying expensive products. They reflect on how this might impact on the person’s confidence and self-esteem, as well as how they would be judged by others.

R3: [They’ll think]... ‘Why have I no got that?’ And that’ll put them down as well, they’ll think ‘I must be an inferior type person’ [FG6:32-34, lower SES]

In this context some research participants from the lower socio-economic groups saw the purchase of designer goods as a reasonable, if double edged, way of trying to create, or project, a sense of self-worth within an unequal society which made poorer people feel worthless. Some talked about feeling lured into trying to buy over-priced products that made them, or their children, feel better in the short term, even when this was at the expense of buying good quality food. Being unable to buy particular goods, and hence being unable to buy into the values associated with them, prompted feelings of failure and inferiority.

Before continuing, however, it is important to disrupt the simple generalised contrast between the talk in the more and less affluent groups by drawing attention to the variable of age. Some of the research participants of pensionable age, regardless of their socio-economic status, were sceptical of the idea that the sort of socio-economic inequalities that existed today might impact on health. In their view living standards had improved immeasurably during their lifetime and everyone was better off. ‘Real’ poverty no longer existed. They were also at a loss to explain the spending choices and higher expectations taken for granted by ‘the younger generation’:

R3: Look at the price they pay for training shoes now, I mean, we never had that, we were lucky if we had a pair of sand shoes on our feet. [FG3:29-30, lower SES]
R6: And how about holidays, they’re off on foreign holidays. [...] Years ago we were lucky if we got to Dunoon [a local seaside town]. [FG4:61, lower SES]

Some of these older research participants therefore found the statistics about health inequalities hard to believe or, at the very least, felt the statistics should be understood in context of an extended life expectancy for everyone.

Do people think relative socio-economic status is important? Do they compare themselves to, or feel judged by, others?

A language of division permeated all groups in the study with research participants talking in ‘us’ and ‘them’ terms about different ‘classes’ of people. People routinely compared themselves to other groups or ‘types’ of people in constructing their identities. There was also a widespread consciousness across all the groups about how they were placed in social hierarchies and how they might be seen by others.

For participants of higher socio-economic status, however, this was not usually a very emotive subject. They might joke about being seen as snobs, but comparing themselves to others was not a painful process. So for a group of female graduates, for example, it seemed unproblematic to openly discuss signifiers of social status, revealing their expectations of the actions of people at different levels of the social strata:

R3: I think it’d be worse for somebody from [affluent area] going in to buy ‘Value’ bread—you’d look more down on that than you would somebody from [deprived area] who was buying it, [...]. You’d think, why are they really buying that when they can afford Kingsmill Gold or whatever.
R4: They’ve been sacked [laughter] [FG8:25-26, higher SES]

Some had personally witnessed the effects of poverty and inequality (e.g. through their work) and displayed awareness, or even a little guilt, about
their relative privilege. Other members of the more affluent groups, however, were either unaware of the conditions under which poorer people lived, or expressed a strong sense of distance from ‘such people’. In the extract below, for example, a participant from a higher income group does try to speculate on the feelings of others ‘less fortunate’ than herself. However, she confesses that she is unable to identify with them or understand what she describes as their apathy, inability to help themselves or ‘lack of pride’. The subsequent comment from another member of the group, about her difficulty in obtaining someone to clean her windows, underlies this distanced viewpoint:

R5: People don’t have a sense of pride, or they think nobody cares about them [...] I can’t make a kind of connection with them mentally because I don’t know where they’re coming from and I don’t know why they’re there. Um, and there are a lot of people like that in fact. [...] I tend to think ‘well why are they there, you know, what happens to actually get like that?’

R4: Yes, yes. I wonder why, you know, since Christmas we’ve been unable to get a window cleaner in this area [...] [FG11:6, higher SES]

Beyond the problem of finding a window cleaner, few higher socio-economic status groups spoke with any passion on the subject of class divisions and how these might impact on people. However, for those from lower socio-economic groups, the issue of their position in the hierarchy generated very strong feelings indeed. They could readily identify with people who don’t have ‘a sense of pride’ because they sometimes struggled to maintain their own and they were acutely aware of how they were judged by others. Several research participants feared ‘postcode prejudice’—whereby, for example, putting your local postcode on a job application might prevent you from getting a job interview. A few defiantly claimed that the ‘rough’ image of their local area did not bother them, and some said it was important simply to ignore such stigma. As an unemployed man commented: ‘you just don’t be too sensitive [...] I think you just live with it’ [R5, FG6:14, lower SES]. Many, however, expressed a direct sense of shame or embarrassment (Davidson & Hunt, submitted).

Thus, socio-economic deprivation brought not only material disadvantage but was seen to impact on people’s sense of themselves and their aspirations. As two unemployed men comment:

R5: You go to up here [local area] and you’re hammered and looked down on and you’re just a pest. And it’s like so you grow up with that kind of attitude, knowing your place, and if you don’t, then you’re a trouble-maker or you’re a...[...]

R3: Or you’re marked, as soon as you’re born you’re marked. That’s your station in life, don’t move out of it. [FG6:43, lower SES]

Research participants from lower socio-economic groups also talked eloquently about feeling that their communities were unheard and ignored. Although some were reserving judgment on the (then new) Labour administration, others were not optimistic and described feeling victimised by an obstructive or uncaring government at both national and local level. The theme of ‘knowing your place’ ran through many of these discussions. As one woman commented: ‘when you try to better yourself they slap you back into place’ [FG1:49, lower SES]. Some research participants also expressed a strong sense of alienation. One man described his belief that whole sections of society were now seen as disposable ‘fling away people’ [R4, FG5:27, lower SES], and another research participant declared:

R5: [T]he government’s made us feel, as if we’re a carpet for [them] to wipe their feet on, and to be brushed aside [...]. I’m talking about me personally, I feel rejected by the government, like I’ve been told, we don’t need you, I mean, who cares about yous up there, right, we’ll just deal with people that’s in our category, with the suits. [FG1:49, lower SES]

Discussion and methodological reflection

This study has attempted to make a specific contribution to the debate about the potential role of psycho-social factors in health inequalities through exploring how people see inequality, how they theorise its impact on health, and the extent to which they compare themselves to others and feel this impacts on them. Our research suggests that many of Wilkinson’s ideas about lay perceptions may have some foundation. In particular it demonstrates that, in some contexts, those ‘at the bottom of the heap’ converse in a way that suggests
inequalities deeply affect their health and well-being. Accounts of community breakdown were plentiful and people powerfully expressed their feelings of being ‘marked’, of feeling shame, anger, frustration, rejection, injustice and alienation. These emotional states were perceived to lead to sleeplessness, fear, anxiety, and stress. The notion that living emotional states were perceived to lead to sleeplessness, frustration, rejection, injustice and alienation. These feelings of being ‘marked’, of feeling shame, anger, inferiority and depression) and also impacted on some of their decisions about how to use scarce financial resources. Those on low incomes talked of how pressures to compete materially can affect health, for example by diverting resources from good food to designer goods for children. This accords with Wilkinson’s assertion that economic inequalities might impact on people, not so much (or only) because of what they had, or lacked, but because of the social symbolism of ownership. These research participants’ accounts also expand on Wilkinson’s assertion by explaining some of the practical consequences of responding to the symbolic economy around designer goods. In light of the alternative ‘neo-materialist’ explanations put forward by Lynch et al. (2000), our focus group data illustrate people’s accounts of their experience of poverty as well as relative deprivation. However, the lay perceptions gathered in this study do convey more than the experience of living in impoverished circumstances, exploring the impact of status, hierarchies, and personal comparisons.

The focus group discussion with more affluent groups proved less supportive of Wilkinson’s thesis. These research participants were less likely to suggest that their (or other people’s) health was affected by socio-economic status and they gave less credence to the idea that social comparisons were important to them. The more affluent groups spoke little of the negative (or positive) effects of living in an unequal society. This suggests that those further up the social scale are less ‘affected’, in so far as such effects may relate to people’s conscious experience of, or willingness to talk about, such inequalities. Therefore Wilkinson’s assertions that people across the entire social spectrum are affected by a skewed income distribution remains unsupported, at least by the voices of those more towards the ‘middle’ of that spectrum.

In order to contextualise the findings outlined above it is important to consider how they relate to other research and to reflect on the methodological implications of different ways of accessing people’s views, experiences and voices. In particular it is interesting to note that our findings in some ways seem to challenge results from other studies. Many research findings and reviews suggest that structural risk factors’ may not hold great meaning at the individual level (Bolam et al., 2004, p. 1363) and that few people think in economic or environmental terms about the aetiology of ill health—and those who do so tend to be the more affluent respondents (Blaxter, 1990; MacIntyre, McKay, & Ellaway, 2005). In contrast, our study shows that a sizeable proportion of our research participants were not surprised in the slightest at the existence of large socio-economic differences in mortality rates and that this was especially true of the research participants living in more deprived circumstances.

Such variations in findings are most probably attributable to methodological differences. Wide variation in the type of response collected by different methods of data collection in this area has been noted by others (see Blaxter, 2000; Popay, Thomas, et al., 2003) and it seems likely that several aspects of our focus group research design impacted on the type of talk generated. Our recruitment method may be the first important site of difference. Our emphasis on recruiting groups rather than individuals privileged people who were socially networked within their communities and were perhaps, therefore, more likely to have a sense of collectivity and have developed shared accounts.

Secondly, facilitator/research participant interaction is very different in a focus group than in a one-to-one interview or a questionnaire. Individuals talking with an interviewer (perhaps perceived to be from a more privileged background) might feel inhibited in talking about their experience of relative deprivation. By contrast, group discussion with one’s peers might have the opposite effect, diluting the significance of the interviewer’s persona, promoting the discussion of ‘lay expertise’ rather than the ‘right’ answers and encouraging people to...
share stories about how their socio-economic context impacts on their health.

The location of our focus groups may also have been a significant factor. The fact that the sessions were conducted on ‘home territory’ (e.g. in community centres) may have increased the potential for discussion about local concerns, particularly for those in deprived areas. It may well be that although people do not often think in abstract structural terms about class and health inequalities—they do experience and express such ideas through the notion of their own locality and place.

Finally there are elements in group discussion which may provide different responses to those generated by individuals in isolation. It has been well documented that the nature of the group process itself facilitates the expression of collective accounts and that it is a method which ‘can help individuals to develop a perspective which transcends their individual context and thus may transform ‘personal troubles’ into ‘public issues’” (Kitzinger & Barbour, 1999, p. 19; Mills, 1959, p. 9). Certainly the trajectory of the group discussions in this study suggested a progression toward further acknowledgement of inequalities impacting on health as the discussion evolved, and from more individualistic explanations to increasingly focus on shared experiences of socio-economic deprivation and how this impacted on health.

In some ways our focus group research might be seen as less ‘representative’ of the ‘true’ pattern of opinion than that accessed by other methods. In other ways, however, it might be that our research approach offers one way of overcoming the problem that Blaxter highlights, namely that those most at risk from health inequalities may be least likely to acknowledge them because ‘[t]o acknowledge ‘inequality’ would be to admit an inferior moral status for oneself or one’s peers’ (Blaxter, 1997, p. 754).

The potential stigma of talking about inequalities was certainly evident in the groups. Research participants engaged in careful linguistic ‘work’ in order to manage the implications of the discussion for their own identities. However, in the context of the focus group discussions, people were still able to address the issue of inequality explicitly and locate themselves within the hierarchies and own the consequences for their own lives. People were sometimes prepared to compare incomes and talk about what they could, or could not, afford (‘I’m too poor to pay that [school dinners]’). They acknowledged the impact of inequalities on their own life expectancy (‘Aye, we’ve lost five years off our life, well, I have’) and eloquently express feelings of rejection (‘I’m talking about me personally, I feel rejected by the government’). In addition to owning the issues personally, they also often talked collectively about ‘us’ and ‘we’ (e.g. ‘we are living in slums’). The research design used in this study thus seemed to allow some groups to vividly give voice to their views on inequalities and this gave us access to a key area of their experience which might be more muted in other contexts.

Conclusion

From the mid eighties Richard Wilkinson has formulated a theory based on the health effects of subjective experience of inequality, yet there have been only a few studies conducted on lay perceptions of inequalities in health. The various criticisms of Wilkinson’s thesis deserve careful consideration (e.g. Judge, 1995; West, 1997). However, the accounts which we present here lend some support to the psycho-social theory he has put forward. This is not of course to suggest that material disparities are not responsible for inequalities in health. Rather it suggests that people at the bottom of the social hierarchy have to bear the direct consequences of their poverty alongside living in a society which also makes them acutely aware of the goods and privileges they lack. The present study is limited in size and in who it accessed. Future research could, we would suggest, pursue the question of age differences, seek to access views from people at more extreme ends of the scale of affluence and deprivation, and attend to rural and urban diversity and the experiences of ethnic minorities. Only by obtaining personal accounts from right across the social spectrum on a large scale, using multiple research methods, will a more comprehensive picture emerge. However, we think the study presented here provides some compelling evidence of lay awareness of social hierarchies and the impact of socio-economic factors on health. In the light of our findings, the conclusions drawn from other studies, which have suggested that those from poorer circumstances are least likely to discuss the impact of structural factors on health, may be premature.

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References


