Social class and health status

Sir,

I find it difficult to answer adequately the points which Wilson and Madely make in their letter (October *Journal,* p.555). they charge me with statements and beliefs which are not in my paper[1] and misinterpret statements which I made. The data and the arguments in that paper are complex and nothing short of reiteration of what I actually said would be an adequate response. Regarding: the distinction between inequality and difference; the distinction between doctor and patient initiated activities which they confuse with the distinction between short-term (and on the whole less serious) illness and long-term illness; the counting of consultations as a basis for quality of care (which is not what I did); the non-use of a use/needs ratio (I believe this was discredited by Collins and Kline [1980] as explained in my previous letter [October *Journal,* p.557]); the reference to Sweden where I specifically point out that social class differences do exist there. I ask that readers refer to what I actually said in my paper about these points.

The fact that characteristics of doctors contribute more to variations in many of the rates, in particular consultation and referral rates, than do characteristics of patients (such as age, sex and social class) or of the environment, is the cornerstone of my subsequent arguments.

The Black Report[2] (para 4.44) did suggest that middle class patients 'appear to receive a better service when they present themselves than do their working class counterparts'. Far from 'citing no evidence to refute this sugestion', the whole of one main section of my paper headed 'consulting behaviour and social class' deals specifically with this mistaken belief. This section is the most important part of my paper and is based on data not available to Black.

Nowhere do I 'deny any responsibility for low use of preventive services by social class 5'. What I did say was: 'The data strongly suggests that any deficiency that might exist by social class 5 in the use of health services is most likely due to their own under-use of services (all services, not just preventive), and is certainly not due to the general practitioner's diminished response to the patient initiative.' Nor did I identify 'increased efficiency of the service' but increased complexity as the nub of the problem for the patient least able to cope with life.

Wilson and Madely do raise valid arguments about the possibility of 'inequalities' rather than 'difference' in the context of perinatal mortality. Perinatal mortality is one subject where on the whole I agree with the Black Report.

To the extent that differences in health status are due to under-use or mis-use of health care services by the patient, it is inefficient to try to equalize these differences by biassing resources in favour of those with lower health status when this must be at the expense of those with higher health status. The logical solution is surely to find ways of improving the uptake of services by patients.

For example, the French in contrast to the Swedes have introduced a system of bribery and compulsion based on linking financial and other material benefits to the satisfactory involvement of the mother-to-be in an appropriate antenatal and immediate postnatal programme. In the United States of America measles has almost been eliminated by the simple expedient of insisting that a completed immunization programme is an essential qualification for first entry to schooling. They are now about to tackle mumps and whooping cough in the same way.

If the approach of Wilson and Madely is logically applied to all groupings of the community where 'inequalities' of the kind associated with social class exist, we should have to start by redressing the advantages that women have over men as evidenced by the ratio 1.91:1 of male to female deaths per 1000 population at risk. This is greater than the equivalent ratio of 1.56:1 for social class 5 compared with social class 1 (based on deaths per 1000 living). Can it be seriously suggested that we have a social obligation to deal with this problem by an ever-increasing bias in the way health services and other resources are deployed, in favour of men and to the disadvantage of women, until equal status is achieved?

My paper was on a contentious subject. I believe the data and direct inferences from it justify themselves. They are an honest and scientifically based attempt to create a factual basis for discussion and decision making in the area of personal responsibilities of patients as well as doctors in the maintenance of the patient's health.

I would agree with Wilson and Madely that all is not well with the state of general practice but society is going to get nowhere by passing its communal guilt on to honest craftsmen who are doing their best with the tools that society provides for them.

Dr Robson in his letter (December *Journal,* p.667), makes several interesting technical points. I must point out first however that I did not base my arguments on recurrent episodes of illness and the more general criticisms by McPherson, Coulter and McPherson (September *Journal,* p.492) were I believe dealt with in my previous letter. The data which Dr Robson requests on individual diagnoses are given for persons consulting rates in Tables 7 and 8 of *Morbidity statistics from general practice 1970-71 — socio-economic analysis. Studies on medical and population subjects no. 46.*

Robson draws attention to the comments of Fox and Goldblat on the confusing effects of social classes 6 and 7 (which were omitted from the material published in my paper). First of all Fox and Goldblat were dealing with mortality statistics where the rates for those aged over 65 years are obviously overwhelmingly important. The material from the second national morbidity survey shows small inter-social class differences for morbidity in those aged over 65 years. Of the 16 965 individuals in the morbidity survey file classified in social class 6, over 8589 were over 65 years of age.

I have estimated the various rates in Tables 14, 15, 16, 17, 19b[1] and Figure 3 for classes 6 and 7 as well as social classes 1–5. Results show that individuals in class 6 tend to have rates that are similar to those of class 5. This bears out the point that Dr Robson is making, that social class 6 individuals have close affinities with social class 5, and we are able to show that the arguments that were developed for social class 5 apply equally to social class 6. Certainly any selection process of the kind that Dr Robson was worried about would not have reduced or altered the rates in classes 3, 4 or 5 to any degree that is of consequence and the slopes would also remain unchanged.

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References

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2. Black Report. *Inequalities in health.* Townsend P, Davidson N (Eds). London: Penguin, 1982.