SOCIAL TRENDS
The social context of healthy living

This paper highlights advances in society and the way people live their lives, and the consequent demands that are placed on health care services. Examples of societal changes include the changes in people's working patterns and changing household arrangements, including the growth of single person households. Ray Pahl highlights some of the negative effects of developments, including polarisation between those that are able to take advantage of developments and those that are not, and the effect of changing arrangements and lifestyle on alcohol abuse and mental disorders that provide challenges for health care services. This paper asks the question: Should reducing social inequality be seen as a health issue?

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POLICY FUTURES FOR UK HEALTH

Edited by Charlotte Dargie

This paper is part of a series written for the Policy Futures for UK Health Project, which examines the future environment for UK health, with a time horizon of 2015. The full series is listed below.

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NO 6 SOCIAL TRENDS
The social context of healthy living

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Ray Pahl

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Charlotte Dargie

FOREWORD

Since its inception the Nuffield Trust has identified individuals and subjects that would impact on health and health care policy in the United Kingdom, with notable examples being *Screening in Medical Care* [1], Archie Cochrane's *Effectiveness and Efficiency: Random Reflections on Health Services* [2], Thomas McKeown's *The Role of Medicine: Dream, Mirage or Nemesis?* [3], David Weatherall's *The New Genetics and Clinical Practice* [4] and Alain Enthoven's *Reflections on the Management of the National Health Service* [5].

In keeping with tradition and reflecting the more complex issues in health and health care policy today, the Nuffield Trust established a Policy and Evaluation Advisory Group (PEAG), supported by the appointment of a Nuffield Trust Fellow at the Judge Institute of Management Studies at the University of Cambridge, to provide a research and intelligence capability for the Trust.

The Policy Futures for UK Health Project stems from the work of PEAG. It involves examining the future environment for UK health, with a time horizon of 2015. The first environmental scan has resulted in a series of 10 technical papers, which cover the following areas[1]:

1. The Global Context
2. The Physical Environment
3. Demography
4. Science and Technology
5. Economy and Finance
6. Social Trends
7. Organisation and Management
8. Workforce
9. Ethics
10. Public Expectations

Each paper in the series is a stand-alone piece, but has also been used by the project to derive an overview report, which focuses on policy assessment in the light of the environmental scan. Entitled 'Pathfinder Report', the overview report is published separately and will be subject to external consultation[2].

The Policy Futures for UK Health Project and the work of PEAG are ongoing. Further reports and publications will appear in subsequent years. The technical papers will also be revisited and different subjects will be tackled.

The strength of the technical series is in providing a context for analysing health and health care policy for the United Kingdom. Each author has produced an independent piece of work that analyses trends and issues in their subject area, focusing on 2015. The papers enable one to read across the issues, in order to provide a general analysis of health and health care policy, which is lacking in the highly specialised debates that dominate the health world today. They have formed the basis for consultation and discussion as part of the Policy Futures for UK Health Project.

Finally, the Trust is grateful to the members of the PEAG, to Professor Sandra Dawson and Pam Garside of the Judge Institute of Management Studies and to the authors of the 10 technical papers. A particular thanks due to Dr Charlotte Dargie, Nuffield Trust Fellow at the Judge Institute of Management Studies, the author of the Pathfinder report.

John Wyn Owen CB
July 1999

ENDNOTES

1. *Screening in Medical Care: Reviewing the Evidence* A collection of essays with a preface by Lord Cohen of Birkenhead (Oxford: Oxford University Press for the Nuffield Provincial Hospitals Trust, 1968).
2. AL Cochrane *Effectiveness and Efficiency: Random Reflections on Health Services* (London: Nuffield Provisional Hospitals Trust, 1971).
3. T McKeown *The Role of Medicine: Dream, Mirage or Nemesis?* (London: Nuffield Provisional Hospitals Trust, 1976).
4. D Weatherall *The New Genetics and Clinical Practice* (London: Nuffield Provisional Hospitals Trust, 1982).
5. AC Enthoven *Reflections on the Management of the National Health Service: An American Looks at Incentives to Efficiency in Health Services Management in the UK* (London: Nuffield Provincial Hospitals Trust, 1985).
6. S Williams, S Michie and S Pattani *Improving the Health of the NHS Workforce* (London: The Nuffield Trust, 1998).

Each of the papers in the series is available from the Nuffield Trust.

[2] C Dargie *Policy Futures for UK Health: Pathfinder* (London: The Nuffield Trust, 1999). The Pathfinder Report is for wide consultation and invited comment. You can email your comments to policyfutures@jims.cam.ac.uk. You can also send your comments to Dr Charlotte Dargie, Nuffield Fellow in Health Policy, The Judge Institute of Management Studies, Cambridge University, Cambridge, CB2 1AG. You can also find this Pathfinder Report along with other technical papers in the Policy Futures series at the Nuffield Trust website: http://www.nuffieldtrust.org.uk. Please respond with your comments by Friday 19 November 1999.

ABBREVIATIONS

ASH	Action on Smoking and Health
BHPS	British Household Panel Study
BMJ	British Medical Journal
CHD	coronary heart disease
CV	curriculum vitae
DHSS	Department of Health and Social Security
ESRC	Economic and Social Research Council
GPs	general practitioners
HEA	Health Education Authority
HMSO	Her Majesty's Stationery Office
MRC	Medical Research Council
NHS	National Health Service
NIDDM	non-insulin dependant diabetes mellitus
OAM	Office of Alternative Medicine
ONS	Office for National Statistics
OPCS	Office of Population Census Studies
OTC	over the counter
PCG	Primary Care Group
PMF	Public Management Foundation
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

SUMMARY

Trends

- The range in inequality will be much the same. Forms of social polarisation are likely to be strongly entrenched e.g. between the work-rich/time-poor and the work-poor/time-rich.
- The complexities of dual-earning, child-rearing, serially monogamous and 'community caring' couples will still create stressful domestic lives.
- A richer society will not necessarily be a healthier society. For example, there is likely to be increasing alcohol abuse, and increasing workplace flexibility, leading to the collapse of the psychological contract, will also lead to more stress.
- Mental disorders will provide a greater challenge to the health service. The importance of social support will be more widely recognised as part of 'preventative medicine'.
- A consumer-led support for a more holistic approach to health care, manifested perhaps in the growth of alternative or complementary medicine, will increase.

Policy issues

- Should reducing social inequality be seen as a health issue?
- How can government policy concerned with family and employment issues be assessed in terms of their health implications - particularly for mental disorders?
- How can the demand for a more holistic approach to health be accommodated within the National Health Service (NHS)?
- Should there be a shift in research to reflect the growing salience of the psycho-social perspective on social inequalities in health?
- Is a two-tier NHS inevitable?

INTRODUCTION

The relationships between health and lifestyles [1], the overwhelming and crucial importance of what Wilkinson rightly calls 'The Afflictions of Inequality' [2], are firmly established, if not as widely understood as perhaps they should be. This is not for lack of scholarly attention: authoritative accounts are provided by the Office for National Statistics [3], the Department of Health [4] and the King's Fund [5], among others. There is no shortage of rigorous descriptions of inequalities in health. The documentation since the Department of Health and Social Security's 1980 report, *Inequalities in Health* - The Black Report [6] - has been voluminous. Yet, as Professor Sally Maclntyre recently wryly pointed out:

> Much of the literature on the Black Report focused on its description or its analysis rather than on the feasibility or likely effectiveness of its proposed policy solutions (possibly because it was obvious that these proposals were not going to be implemented). [7 p739]

So what is the justification for a further tramp down well-worn paths? Much has already been distilled and well-presented in reports, reviews and scholarly articles and books. Even the most sloppy journalist has no excuse for not producing a challenging and thought-provoking account based on the sources already listed. Where should one look for some value-added benefit for the Nuffield Trust in a field so full of careful and authoritative overviews?

One justification might be that there are potential social changes in the next 15 years that are likely to alter dramatically the conclusions of those studies and reviews already published. Another justification might be that whilst correlations between, say, social class and health are established beyond all doubt, the actual processes and mechanisms underlying such correlations are less well understood.

In brief summary, the argument of this paper is that the likely changes in household arrangements, changes in the labour market and growing social polarisation are likely to make the task of those responsible for the nation's health no easier. Furthermore, the quality of our social relationships in micro-social worlds is coming to be seen as having a vital role in maintaining and achieving better health.

My argument is that greater sociological understanding is needed at a micro-level and more vigorous political will and leadership at a macro-level to make the necessary progress.

There may, possibly, be vested interests in recognising these extra-medical and biological considerations. Taking a more narrow focus, whilst there is a common-sense assumption that the way we live affects our health, precise measurement of any one lifestyle factor and its consequent impact on health is

notoriously difficult to achieve. However, the links between smoking and both heart disease and lung cancer are now firmly established [8]. The importance of a mother's diet during pregnancy is also well established as a primary causal factor in the future health of her foetus [9]. However, a recent survey of expert medical and epidemiological opinion in Western European universities about the role of lifestyle on health suggested that these experts were highly cautious in offering unequivocal judgements. Estimates were made of the influence of eight lifestyle factors - smoking, alcohol consumption, exercise, stress, body weight, dietary fat and salt - on the aetiology or course of five disorders: heart disease, high blood pressure, lung cancer, breast cancer and diabetes. Comparatively few lifestyle factors were believed to be unequivocally related to any of the five disorders. Experts from the United Kingdom (UK) and Ireland were generally less likely to endorse lifestyle disease links than those from other European countries [10].

THE IMPORTANCE OF RELATIVE POVERTY

The medical experts may be right. Alternatively, such experts may be less informed about research exploring this area from the perspective of social science. Perhaps the most challenging overview of this complex field is provided in Richard Wilkinson's important book, *Unhealthy Societies: The Afflictions of Inequality* [2]. Wilkinson emphasises the health benefits arising from a more cohesive society, which, he argues, is likely to be more egalitarian:

> The quality of the social life of a society is one of the most powerful determinants of health but this, in turn, is very closely related to the degree of income equality. But that is only the beginning. The indications that the links are psychosocial make these relationships as important for the real subjective quality of life among modern populations as they are for their health. If the whole thing were a matter of eating too many chips or of not taking enough exercise, then that in itself would not necessarily mean that the quality of life which people experienced was so much less good. You can be happy eating chips. But sources of social stress, poor social networks, low self esteem, high rates of depression, anxiety, insecurity, the loss of a sense of control, all have such a fundamental impact on our experience of life that it is reasonable to wonder whether the effects on the quality of life are not more important than the effects on the length of life. [2 p5]

Wilkinson takes a very strong line: 'Because behaviour is socially determined, individuals can only be changed by changing society' [2 p19].

The evidence Wilkinson adduces suggests that it is not absolute but *relative* poverty in society that has a fundamental impact on levels of social and physical health and well being. Thus, it is not simply a question of low income

preventing the purchase of life's necessities. Rather, it is people's feelings of self-esteem or self-worth and of being valued, coupled with close personal relations and wider social networks, which bear so heavily on their health. Those in more egalitarian societies and in less hierarchically structured institutions are likely to have more sense of personal control over what they do and how they present themselves to others. This may help to reduce anxiety, stress or tension. However, one must be very careful not to assume that there was less stress or tension in the past. It must have been very unpleasant living at the time of the Black Death, and the merchants of thirteenth- and fourteenth-century city-states could only dream of the advantages of being insured at Lloyds.

FAMILY, WORK, EMPLOYMENT AND HOUSEHOLD ARRANGEMENTS

The way we live in 2015 will be heavily influenced by a combination of, first, the nature and dynamics of how we live singly or together in households, second, our experience of employment - or unemployment - and the interaction between the two. That, after all, takes up most of the available time in the lives of the economically active. What we consume, what exercise we take and the values we hold are also obviously interconnected with the way we have organised our lives. Finally, as mentioned above, the broader social trend towards greater or less inequality in society is likely to have an even greater overall impact on health than changing domestic arrangements and patterns of employment.

No time for life?

One of the most important trends over the past 40 years, which shows no signs of abating, is the shift away from households dependent on a single or chief earner [11]. The growth of multiple-earner households, now necessary for the maintenance of an appropriate standard of living, has produced a well-documented range of new problems and difficulties. These relate to such matters as maintaining childcare arrangements when both parents are full-time earners and when all four grandparents may also be employed full time and/or live some distance away. This pressure on *time* means that meals are rushed and rarely taken together as a family unit; shopping has to be done on the way back from work (with every incentive to buy convenience food) or done at the weekend, thus reducing time available for leisure and recreation [12]. British Household Panel Study (BHPS) data for 1997 show that most children aged 11 to 15 do not eat a family meal each day. Indeed, 15 percent do not eat a single meal together as a family and a further 27 percent eat only one or two such meals in a week. Sixty percent of men and 45 percent of women employees usually or sometimes work on Saturdays. Twenty-eight percent of men work more than 48 hours each week. Life is, if anything, worse at the top. The days of 'banker's hours' - 10 a.m. to 3 p.m. - have long gone. Surveys report managers in Britain working excessively long hours. One in eight managers works more than 60 hours a week and 40 percent work more than 50 hours. BHPS data for 1996 show that 17 percent of male managers work more than

60 hours a week. Nearly a quarter of all managers take work home several times a week and a further 30 percent one day a week [13]. Time budget studies in the United States of America (USA) provide detailed documentation of what would seem to be a malign social trend [14]. At the other pole, of course, increasing levels of unemployment provide too much 'free time' for unemployed people. There appears to be a growing polarisation between work-rich/time-poor and work-poor/time-rich households [15]. This social trend is unlikely to be reversed, despite growing public awareness of the problem and well-informed pressure groups primarily concerned with publicising the issue[a].

By and large people are not satisfied with the hours they work - either because there are not enough or because there are too many. BHPS data for 1996 show that over half of those working more than 48 hours a week are not satisfied. Of the British workforce as a whole, 10 percent of men worked more than 48 hours a week in 1997.

The end of a 'job for life'

A second major trend is the end of the traditional career or job for life. This has led to 'the privatisation of the CV and a short-term instrumentalism, encouraged as much by employers as employees. The putative breakdown of the so-called 'psychological contract' between workers and their employers is not conducive to the development of trust [16]. There is a resentment against 'greedy institutions' [17], and short-termism is arguably bad for people's characters [18]. Dex's analysis of the BHPS suggests that up to three-quarters of all households may have had some experience of flexible work [19]. Couple households with children were the most likely household types to include a flexible worker - usually the wife or mother. It does not follow that workers are *objectively* more insecure (as evidenced by higher rates of job change): indeed the reverse may be the case. However, *feelings* of insecurity appear to be increasing. In one survey in 1994, 41 percent said that they were concerned about the possibility of being made redundant or becoming unemployed over the next 12 months [20 p137]. Taking full-time paid employees only, BHPS data for 1997 show, despite the moral panics in the quality press, that satisfaction with job security increases with moving up the social class scale. Thus 20.5 percent of unskilled workers were not satisfied with their job security, compared with 11 percent of professional occupation.

Insecurity and short-termism in employment is matched with less domestic security. Rates of divorce have steadily risen in every age group since 1960. These increases have been greatest for younger marriages, particularly for those in their twenties. It has been estimated by John Haskey that the proportion of couples married in 1994/5 who might expect to celebrate their silver wedding is now below half [21 p36]. Given that over half of all divorcing couples have children under 16, and given that about two-fifths of

[a] New Ways to Work (309 Upper Street, London, Nl 2TY) provides excellent publicity and fact sheets on the issue.

all marriages are remarriages, the growth of step-children and other step-kin is unsurprising. In 1991 there were around half a million step-families containing dependent step-children in Great Britain, with around one million dependent children, both step-children and natural children, living in such families [22].

Stressful household work strategies

Domestic and workplace instability could be documented at length. Those with young children who also have some distance to travel to work are undoubtedly stretched and stressed. BHPS data show that about two out of five workers spend more than an hour travelling to and from work each day. The complications and responsibilities flowing on from previous marriages can generate acute time squeezes. This has been described as daily role stress, since multiple roles are associated with increased stress - particularly for women when there is a child in the house. One research report, whilst recognising that the stress spill-over effects between job and home are pervasive, concluded that the 'roles occupied by married women are more strongly associated with the psychological functioning of their husbands than of the women themselves' [23 p113]. If one relates this finding to the changing employment position of women, then there could be a plausible link between this and neurotic disorders amongst men. Women make up 85 percent of the part-time workforce. The number of self-employed women in the UK is rising steadily and it has been calculated that women held 38 percent of all professional jobs in the early 1990s; these jobs are projected to grow more rapidly than any other occupational group [24 table 4]. This gender switch in the market, added to the other trends already mentioned, is likely to have a significant impact on health:

> The common neurotic psychiatric disorders, mostly depression and anxiety, have a prevalence of about fifteen percent in the UK. They are associated with fifteen-thirty percent of all absence due to sickness, and lead to as much or more disability than many other chronic medical disorders. A study published in 1993 put forward evidence that the prevalence of neurotic disorder is increasing in the UK. [25 p605]

There appears to be a clear association between low standard of living and the prevalence of neurotic psychiatric disorder. Since the UK has experienced one of the largest increases in income inequality over the past 20 years, this would be likely to have adverse consequences for the mental health of the population [25]. Attempts to measure change in stress levels using the General Health Questionnaire scores in the BHPS shows that those aged 45 to 54 experienced the greatest rise in stress levels [26]. This is likely to be influenced by the complex social trends outlined above.

An influential American study, attempting to account for 'the unprecedented increase in clinical depression' since the 1960s in America and other developed economies, suggests that 'the rage to consume' contributed to the

problem. Increasing rates of mood disorders in Britain and the USA suggest that a malign self-reinforcing cycle may be developing [27 p523]. It is hard to provide robust evidence to support the view that, beyond a certain level, material affluence makes you ill; on the other hand, Wilkinson's work cited above certainly suggests that health is related to levels of relative inequality.

Single-person households

One of the most striking social trends since 1961 has been the growth of households containing just one person living alone, the proportion of which has doubled over the period. In 1996, 27 percent of all households consisted of one person living alone, of which 41 percent were under the age of 60. Households consisting of a lone parent with dependent children comprised a further 7 percent. Thus a third of all households did not have more than one adult living in them. In 1996, families headed by a lone parent formed 21 percent of all families with dependent children, the majority of lone parents being lone mothers [28 pi 1] (see figure 1).

The usual gross weekly income was considerably lower among lone-parent families than among either married or cohabiting couple families. Thus, in 1996, 33 percent of families with a lone mother and 27 percent with a lone father had a gross weekly income of £100 or less, compared with 3 percent of married and 6 percent of cohabiting couple families [28 pi2] [29]. This is one element in the growing problem of children in poverty. The other main element is households with children in which no adult is in employment.

Turning now from households to the proportion of people living alone, the proportion of those living alone is fairly stable at about 14 percent. Interestingly, there has been a growth in the proportion of men aged 25 to 44 who live alone - 11 percent of this age group are doing so. Increasing longevity has resulted in more people over the age of 75 living alone. They are most likely to be women - 58 percent of all people living on their own are elderly women, particularly those over 75 [28]. This general reduction in social support amongst a growing proportion of the population will be one of the most significant social changes of the next 15 years.

Coping with stress

Smoking

In 1996, 29 percent of men and 28 percent of women smoked, compared with 51 percent and 41 percent in 1974. Men and women aged 20 to 24 (43 percent and 36 percent respectively) were more likely than any other age group to smoke cigarettes [28 pl51]. In 1994/5, the BHPS carried questions on smoking amongst children aged 11 to 15. The biggest single factor that seemed to explain children's 'internal' reasons for smoking is their psychological well being. Children who score poorly on life satisfaction or self-esteem are far more likely to smoke. A further important factor is whether parents do or do not consider smoking to be a serious matter affecting health. Parents or siblings can provide a powerful role-model effect. Interestingly, a

child aged between 11 and 15 is more likely to smoke if an elder sibling (aged over 15) lives in the house, whether or not that sibling smokes. The implication is that smoking is associated with more 'adult' behaviour and younger siblings attempt to compensate for their age inferiority [30].

Over a third of people who had ever smoked regularly began before they were aged 16. There is a direct relationship with social class. Men in the unskilled manual group were more than four times as likely to smoke as those in households where the socio-economic group of the head of the household was classified as professional (45 percent compared with 11 percent respectively). Since 1994 there has been an increase in the proportion of women who smoke cigarettes, particularly among the age group between 25 and 34 [28 p153]. BHPS data demonstrate that there is a correlation between greater job insecurity and a higher incidence of smoking. It has been claimed that around one in five of all deaths can be attributed to tobacco and about half of all regular cigarette smokers will eventually be killed by their habit. Passive smoking is also dangerous: 17,000 children under the age of five are admitted to hospital every year because of the effects of passive smoking [8].

Alcohol abuse

Drinking alcohol is unquestionably an established part of contemporary lifestyle. In 1994, 27 percent of men and 13 percent of women were drinking above the then-recommended sensible limit [31 p10]. It is suggested that this level of drinking poses a progressive risk to health [31 p7] [32]. It has been estimated that the cost to industry in terms of sickness absence due to alcohol was about £1,059 million in 1992; between 8.8 and 14.8 million working days are lost to industry each year through alcohol-related illness. In 1994, the UK industry spent £114.8 million in the advertising of alcoholic beverages. England and Wales have one public house for every 554 adults aged 16 and over. An estimated 130,000 children under the age of 16 drink alcohol in pubs in an average week in England [31] [28 pp 180-97].

A World Health Organisation (WHO) report summarising the relationships between alcohol and social harm concludes: 'Adverse consequences in areas of life such as friendship, health, happiness, home life and employment opportunities all increased monotonically with increasing consumption' [33 p13].

A recent survey from the Medical Research Council (MRC) National Survey of Health and Development demonstrated that divorce and separation were associated with increased anxiety and depression and increased risk of alcohol abuse [34]. There is also substantial evidence that work cultures and occupational norms can promote collective and even intense drinking for social purposes. However, since teamwork may serve to buffer the negative effects of a drinking climate on co-workers, alcohol abuse may be reduced by focusing on the social relations of the workplace and highlighting the importance of teamwork over interpersonal rivalry and competition [35].

Diet

This topic has been well covered in recent reports, particularly by the Department of Health's Low-Income Project Team for the Nutrition Task Force [36]. Diets of low-income households have less variety and poorer nutrient profiles compared with the rest of the population. 'The association between poorer diet-related health and low income is underpinned by a physical and commercial environment that makes access to health diets a particular problem for low income households' [36 p6]. There are many practical policy options listed in this report that are not repeated here. It is claimed that nutritional medicine is a neglected and underfunded field, that appropriate diet can play a crucial role in the prevention of cancers and that certain early stages of cancer may be reversible with dietary measures. There appears to be a consensus on the elements of a diet most conducive to health, which would include whole grains, vegetables, fruits, legumes, seeds and nuts and pure water. These are not necessarily expensive items, but nor do they get the commercial advertising support available for 'junk', fast and sugar-rich foods [37].

Car ownership and exercise

Higher levels of physical activity are associated with lower all-cause mortality in populations. For example, sedentary people have been found to have between 1.2 and 3.6 times the colon cancer risk of the most active.

> A positive association has been found between exercise and a decreased level of mild to moderate depression; it may also be useful as an adjunct to professional treatment for severe depression. Regular, particularly rhythmic, exercise has been found to reduce anxiety, with the greater reductions seen in people who are both unfit and highly anxious. [38 p11]

For England and Wales, it has been estimated that if the whole population exercised regularly the following could be avoided:

- Just under a third of all coronary heart disease (CHD) incidents
- One-quarter of stroke incidents
- Just under one-quarter of non-insulin dependant diabetes mellitus (NIDDM) in over-45-year-olds
- Just over half the hip fractures in over-45-year-olds.

A merged sample of 6,583 adults aged 16 to 74 provided information on levels of exercise by age and sex. Twenty-nine percent of men and 28 percent of women were categorised as sedentary. There is a marked fall-off in taking exercise as people get older. Over half of men and women aged 65 to 74 do not take regular exercise. The Health Education Authority (HEA) report again provides a number of sensible and practical suggestions to facilitate a greater amount of regular exercise amongst the population. However, when asked their reasons for not taking more exercise, over 40 percent of men and women

claimed that they did not have sufficient time. This is further evidence of the impact of the time squeeze on health mentioned above [39].

The growth of car ownership and the increasing use of cars since the mid-century has been very dramatic. The growth in distances travelled has increased four-fold since 1960, and three-quarters of all shopping journeys are made by car [40 table 12.2]. By contrast, the distance walked per person per year has substantially fallen from 1985/6 to 1994/6. This decline is most marked among men and women in their teens and twenties. The fall-off is greatest among young girls aged 11 to 15 and young women aged 21 to 29. This may be a reflection of fears for personal safety amongst these groups [40 table 12.4].

The growth of out-of-town shopping centres and other aspects of the consumption society are not conducive to good health. One of the regrettable social trends of recent years is that material 'prosperity' and 'development' are often at the expense of healthier lifestyles [40 table 12.6].

THE RISE OF COMPLEMENTARY MEDICINE

There is little dispute that there has been a dramatic increase in those using various forms of complementary medicine. A recent survey in the British Medical Journal (BMJ) referred to research from the University of Sheffield suggesting that 10 to 12 million visits are made to complementary therapists at a cost of £15 to £40 per consultation [41 p131]. A market research survey by Mintel estimated that in early 1997 the market for complementary or alternative medicine was worth some £72 million, having 'shown excellent growth over the last five years driven by consumer interest in natural health issues, greater confidence in self-medication and widening distribution' [42][a]. The report goes on to point out that 'educating and drawing new consumers into the market by offering products in a form similar to mainstream medicines is vital to maintaining market growth' [42]. In terms of effective marketing it is claimed that 'the holistic aspect of complementary medicine is vital in terms of maintaining a point of difference over conventional remedy suppliers' [42].

Evidently the question of rigorous testing of efficacy is not at the front of the minds of marketing specialists. Happily for them, the market is not restricted to 'curative remedies' but, as consumers are becoming more interested in *preventive health care*, they are turning to alternative remedies. These are being aggressively marketed to be sold in parallel with conventional over-the-counter (OTC) medicines. The proposed marketing strategy is now to move from niche-marketing into mass-marketing status in the early years of the next century. One indication of this is that licensed herbal medicines have moved out of the health food shop niche. Between 1992 and 1996 the proportion sold in that area declined by 11 percent with growth of 5 percent in chemists and 6

[a] Page numbers for this and the following direct quotes in this paragraph are not available.

percent in middle grocers. Chemists such as Boots have now taken over from health food shops as the main distribution channel.

There is a dispute amongst the medical profession about the acceptance of alternative medicine. A front-page article by the health editor in the *Independent* on 17 September 1998 referred to recent highly sceptical reports in *The New England Journal of Medicine* in which the editors strongly regret the apparent uncritical acceptance of alternative medicine by medical schools, hospitals and the public: 'there is only medicine that has been adequately tested and medicine that has not' [43]. Just a few weeks later, the same journalist quoted the British government's chief medical officer who, in the September 1998 issue of *The Lancet,* said he saw an increasing role for alternative medicine 'because it is what people want and people definitely benefit from it' [44].

According to the Consumer's Association, 40 percent of general practitioners (GPs) offer their patients complementary therapy and 75 percent of fund-holding practices would like to see complementary medicine available on the NHS [45]. One of the few serious academic studies of complementary medicine suggests that the main users tend to be middle-class, middle-aged females who turn to complementary therapists because they are disillusioned with doctors. Since the length of the average consultation with a GP lasts just seven minutes, Professor Furnham, author of the study, suggests that 'people are very happy to pay for the time, touch, the whole person approach and a nice surgery. Satisfaction depends on the patient, the problem and the practitioner. But it is surprisingly higher than it is for orthodox medicine' [46]. This, despite the very limited amount of robust evidence that these remedies are efficacious.

The Research Council for Complementary Medicine claims that 45 percent of those who visit a complementary practitioner are male - a higher proportion than can be found in general practice [47]. Men's greater interest in complementary medicine is due to a concern with stress or stress-related problems, according to the principal of the Institute of Traditional Herbal Medicine and Aromatherapy [47].

All the indications are that complementary and alternative medicine will continue the trajectory of growth to 2015. An American study has estimated that the *per capita* supply of alternative medicine clinicians (chiropractors, naturopaths and practitioners of oriental medicine) will grow by 88 percent between 1994 and 2010, while conventional physicians will grow by 16 percent. This should be compared with an increase of 124 percent in the number of alternative medicine clinicians. The most dramatic change of projected supply in America from 1994 to 2010 is an increase of 230 percent in the number of oriental medicine practitioners [48].

Another source claims that in 1990 a third of all Americans sought alternative care, consisting of over 400 million office visits - more than to all conventional primary care physicians [49].

These American figures are probably hugely inflated. More rigorous research in the UK found that in 1981 complementary consultations averaged 6.5 percent of general practice consultations in that year. A more recent study suggests that the complementary practitioners undertook four million consultations a year [50]. Elsewhere in Europe, studies suggest that between a third and a half of the adult population have used complementary medicine at some time [51]. Bearing in mind that all studies indicate that patients using complementary medicine or unconventional therapists tend to be those with relatively more education and higher incomes, future growth in the UK seems highly likely [52].

FRIENDS, PERSONAL COMMUNITIES AND HEALTH

There is now substantial evidence showing that social support is related to surviving postmyocardial infarction. More generally, evidence is accumulating that 'first, social factors might be determinants of disease and, second, this might influence a *broad range of disease* outcomes' [53 p245]. Arguably, friends and friend-like relations are becoming more salient in contemporary society. People are exercising more choice in deciding on those family members with whom they make most contact, depending on how well they get on with them. Friends are taking on various caring and supportive functions for the elderly and sick and for mothers with young children. This may be because mothers are tied by their own employment and thus not able to help their daughters with their young children. Or it may be that geographical and social mobility have made it more difficult for traditional supports to be maintained. Whatever the reasons, and they are many and complex, these informal ties are becoming of greater practical and scholarly interest [54].

In a recent unpublished report for the HEA, an attempt was made to explore the relevance of social capital to health promotion. The idea was to compare areas that were defined as being 'healthier' with those defined as 'less healthy'. The authors recognise the crucial importance of informal networks of friends, neighbours and relatives in accounting for some of the differences observed [55]. New research, part-funded by the Economic and Social Research Council (ESRC), aims to explore the role and significance of friends over the life course, using the idea of a social convoy to describe the way personal communities change and fluctuate through the different stages of life [56].

These new ideas may come to be increasingly significant for life in 2015. First, whilst there is a well-established link between social contexts and health, it is not yet clearly understood how and why certain personal communities are more effective than others are. If those precisely defined as 'friend-rich' are healthier and recover more rapidly from certain illnesses than the 'friend-poor', it would be vital to know more of the processes and mechanisms

involved. It may be argued that certain personality types are more likely to be 'friend-rich' than others but that simply pushes the analysis back a stage to define the conditions that produce secure 'attaching-type' personalities. Furthermore, if certain types of *society* are healthier (and friendlier) than others, where the levels of inequality are reduced, then maybe a more comfortable, less competitive and more relaxed social environment generates less stress and anxiety (recognising, of course, the ambiguity of these terms). Hence, it is necessary to do more research on micro-social ties, which would initially be largely qualitative, before embarking on larger quantitative surveys. The team working for the HEA has made a useful start.

Secondly, if convinced of the general importance of this area, the policy makers will need evidence of change in these micro-social worlds. Is society getting more or less 'friendly', and what are the likely trends to 2015? At present we have only indications but these do seem to suggest that with increasing divorce, more mobility and a flexible labour market, people are turning more to friends to provide continuity and support. Children leave home, parents die or separate, partners come and go but some friends can provide continuity in social support throughout the life course.

Finally, with accumulating evidence related to the first two issues, how should policy makers consider intervention to ensure more effective health promotion? How, in a phrase, can we encourage a more friendly society? Some may recoil from what may appear to be unsavoury social engineering. However, if a good society is a healthier society, how can society be made 'better'? One way, clearly, is to encourage more *trust.* If people are endlessly competing with each other as parents, employees and consumers they will be more divided and less secure. There is, indeed, a 'politics of attachment' and some politicians are coming to recognise this [57].

There may, therefore, be a new paradigm emerging which would merit long and detailed exploration in the coming 15 years. The sudden surge of interest in the slippery concept of 'social capital', the re-evaluation of 'community care' and the widespread acceptance of the importance of 'social networks' all suggest that policy makers and practitioners are seeking a new approach. The problem of why poor people in a more egalitarian society are healthier than poor people in an inegalitarian one cannot be resolved by economic policies alone. If there is something about the *quality* of people's relationships that has so far remained elusive, but which has great practical relevance, then clearly further research is needed. Only when there are clear and precise ways of describing personal communities can it be rigorously determined whether any putative trends are likely to be benign or malign.

CONCLUDING DISCUSSION

Social trends and lifestyle contradictions

The relationship between social trends and health is not, of course, a direct one. Thus, for example, divorce by itself does not add to ill health, but if

divorce produces lone parents with dependent children in poverty, then that may lead to poor diet and hence poor health. Divorced people might be lonelier, smoke and drink more and claim they are stressed. The causal chains are complex. Similarly, in 1996, men who were single in a household headed by an employer/manager or intermediate non-manual worker or who had a household income at the upper end of the range were likely to drink more than 21 units a week [28 p183]. Both poverty and affluence can contribute to health-threatening behaviour.

Modern lifestyles are full of contradictory tendencies: on the one hand, as people get more educated, they become more aware of the benefits of healthy living, modify their styles and modes of consumption and take more care of their bodies. On the other hand, more wealth provides more opportunity to overindulge in smoking, drinking or drugs. The growth in alternative or complementary medicine is again two-sided: on the one hand, it encourages an understanding of the complex relationships between mind and body. People can feel more in control of their own health and real or imagined reductions in symptoms may follow. On the other hand, there are clear dangers in expecting untested remedies to deal with serious conditions. However, whichever way one considers it, if people define themselves as better from certain conditions as a result of a consultation or alternative therapists, then they will be better - at least in their minds.

The anxieties of a 'risk society'

There seems to be evidence that with increasing material affluence people do not necessarily feel happier. Whether or not there has been, as some claim, 'an unprecedented increase in clinical depression since the mid-1960s' [27], surveys show consistently that people claim to be more 'stressed' or anxious. A classic indicator of such malaise is the suicide rate. There has been recent debate about the increase in the male suicide rate (aged 15 to 24) which is five times higher than the rate of women of that age category. One theory is that the erosion of 'traditional notions of masculinity' may be related to the growth of feminism and the restructuring of the labour market which has led to fewer of the traditional 'masculine' jobs. Furthermore, it has been speculatively suggested that about half of the increased numbers of male suicides is attributable to the increase in men who remain or are made single [58].

It may, therefore, be argued that a combination of increasing marital instability (divorce), unemployment and feelings of insecurity at work are affecting the health of the population and show no signs of going away. Furthermore, sociologists such as Ulrich Beck and Anthony Giddens claim that we are living in a 'risk society' where we become anxious about the state of our food - genetically modified or chemically adulterated - about environmental pollution, global warming, dangers of travel and a host of other real or imagined dangers and disasters [59].

The challenge of poverty and health inequalities

However, perhaps the greatest danger of all is that generated by poverty. Comparing data based on the family expenditure surveys of 1979 and 1991, it is unhappily the case that the proportion of households in poverty *doubled* over the period [60 p287]. This, of course, is a relative measure and therefore reflects the substantial increase in inequality in the income distribution of the UK over this period. Furthermore, there is evidence that over this same period the *lowest income groups have experienced an absolute fall in income.* As mentioned above, lone-parent families have been particularly at risk, as are couple households with two or more children or where both adults are economically inactive. Unless this trend of increasing child poverty is dramatically reversed, the consequences for the future health and well being of the British population will be much worse than it could be (see table 1).

The policy implications are clear and must not be fudged. Without clear government policies to reduce levels of relative inequality the situation will not improve. As a first step the Office for National Statistics should devise a set of indicators of social inequality which should be published regularly in the same way as are statistics relating to inflation or unemployment. The government should be judged by its success in reducing the range of inequality and if this involves some fiscal redistribution, so be it. With so much incontrovertible evidence from the Black Report through to the present, it is surely time that a government committed to improving the nation's health should take the social dangers of inequality seriously [7]. One way to meet criticism would be to accept the importance of poverty indicators and to co-ordinate government departments' policies in a combined effort to reduce levels of inequality.

BHPS data for 1997 give further evidence, if such is needed, of the continuing health divide. Those men who reported poor or very poor health in the previous 12 months ranged from 2.8 percent of managerial and technical workers to 7.4 percent of unskilled workers (in the case of unskilled women the proportion rose to 8 percent). Taking men and women together, 83 percent of professionals reported being in good health over the previous 12 months, compared with 71.5 percent of unskilled occupations. No society can rest easy with itself with such enduring inequalities of health.

It may still be argued that increasing prosperity and projected economic growth will make arguments about inequality irrelevant by 2015. There is also a naive fallacy that, because everyone is equal under the surgeon's knife, equality of treatment will lead to a more egalitarian outcome in terms of the health of the British population. There is also a view that greater managerial competence and technological advance will confound the pessimists and produce better health and outcome in the future.

Certainly the *World Health Report 1998* does offer what it describes as 'a cautiously optimistic' vision of the future up to 2025. However, whilst there have been dramatic improvements over the past 50 years, 'they have not led to

a corresponding reduction in morbidity and disability or improvement in the quality of life. Available data indicate that disability-free life expectancy at birth has not significantly increased' [61 p205].

Furthermore, it is not clear that with all the expected managerial and technological advances much impact will be made on the limiting growth of mental disorders. Again, to quote the WHO Report, 'More working days are lost as a result of mental disorders than physical conditions.' The Report goes on to note that 'people with depressive disorders have reduced levels of survival. The management of affective disorders, dementia, schizophrenia, post-traumatic stress, epilepsy and alcohol and drug abuse consumes a great amount of health care resources' [61 p92].

It is thus unhappily the case that an NHS primarily concerned with physical conditions may be ill-equipped to deal with mental disorders on the scale that is necessary. Those with optimistic scenarios of a richer, healthier future perhaps do not recognise clearly enough that the price of a wealthier future might be an increase in stress and mental disorder. The growth of the demand for alternative medicine may be a reflection of this.

Politicians fear that egalitarian goals will be unachievable and/or unpopular. However, if they are equally afraid of the electoral consequences of the rising costs of the NHS it might be cheaper in the long run to educate people in the social benefits of a more egalitarian society [62]. If the government could convince electors that we would *all* be better off in a healthier (and probably happier) society, some progress could perhaps be made. Without the political will, the trends appear to indicate a worsening of social polarisation - and therefore health - between now and 2015.

Doubts about technological and managerial 'fixes'

The futurologists with an over-great faith in the combination of economic growth and the technological fix are not always ready to accept that socially damaging levels of inequality are likely to persist. Clearly no one can be sure about future government policies and what redistributive programmes may be eventually planned and implemented. One attempt to produce two alternative scenarios for the year 2008 has been put forward by the Public Management Foundation (PMF) [63]. As a result of this careful exercise in futurology, the two quite different predictions of the future can be compared, to see whether either or both of them expected some decline in social exclusion and inequality. In the first scenario, there is some ambiguity, since it is considered that social exclusion will still exist in 2008, despite the general benefits of prosperity: 'Long-term unemployment - like the poor - has proved an obstinate problem on the social and economic agenda' [63 p7]. The second scenario, however, offers an even gloomier prediction for 2008: 'the gap between rich and poor which was supposed to have narrowed has begun to widen again, leaving Britain one of the least cohesive societies in Western Europe' [63 p13].

It appears, then, that informed specialist opinion, whether of the more optimistic or the more pessimistic variety, comes up with broadly similar conclusions. Unless something new and dramatic emerges, the most *reasonable* expectation in both scenarios is that the patterns of inequality that create the health divide in Britain will still be there in 2008.

The inevitability of a two-tier NHS?

The forces for a two-tier health service seem likely to grow. The time-squeezed salariat may find it more convenient to pay for special treatment in the evenings or at weekends. NHS workers may, as it were, save themselves during the day for their more lucrative work with more articulate and demanding patients in the evenings or other pay times. Increasingly, perhaps, nurses and other auxiliary health practitioners will take on more responsibilities in the 'health shops'[a]. This may have the latent function of reducing status barriers between doctors and others, and whilst this may lead to criticism from doctors that there is a lower level of NHS provision, paradoxically this may not necessarily be the case. Nurses and other auxiliary health workers, free from the closed-shop restriction of doctors, may, on the one hand, be trained to think and work more holistically. On the other hand, being less expensive, they may be able to expand their numbers so that the health-shop patients get longer consultations and more focused attention. The managerial and technological high fliers also working in the pay sector will price their time and equipment highly. For many of the emerging health problems, such as those triggered by life-style stress, it may not follow that the more people pay the better the treatment they receive. Similarly, in many spheres where early diagnosis is of the greatest importance, the more relaxed pace and holistic approach of nurses and other auxiliaries may be more effective. Certainly the 'worried well' may come to prefer health shops, recognising that the overheads involved in private consultations with doctors in smarter surroundings all add to the cost. Of course, I am not suggesting that the two-tier split is simply between doctors and nurses; I am suggesting that if some 'out of hours' payment system emerges, people may initially be more ready to pay for a doctor than a nurse.

The importance of dilemmas based on a conflict of values

There are fundamental choices forcing society that cannot be evaded. Sometimes these are summarised as being between a 'Wild West' model, looking more towards the USA, or a 'Nice North' model looking towards Scandinavia. This is a gross over-simplification, of course, but it reflects a clear set of value choices that are often hidden in management-speak. To make these choices in terms of different sets of values would, of course, generate much debate and controversy. For those who want to avoid this, it is easy to turn to futurologists to cover the issues with swathes of techno-speak and

[a] The suggestion that nurses might replace GPs as the gatekeepers to care has been described as 'The biggest transformation of the NHS in its 50 year history' *{Independent,* 14 April 1999, reporting on the Prime Minister's speech to Primary Care Group [PCG] workers in Birmingham on 13 April 1999). The old GP fundholding scheme was replaced by PCGs on 1 April 1999.

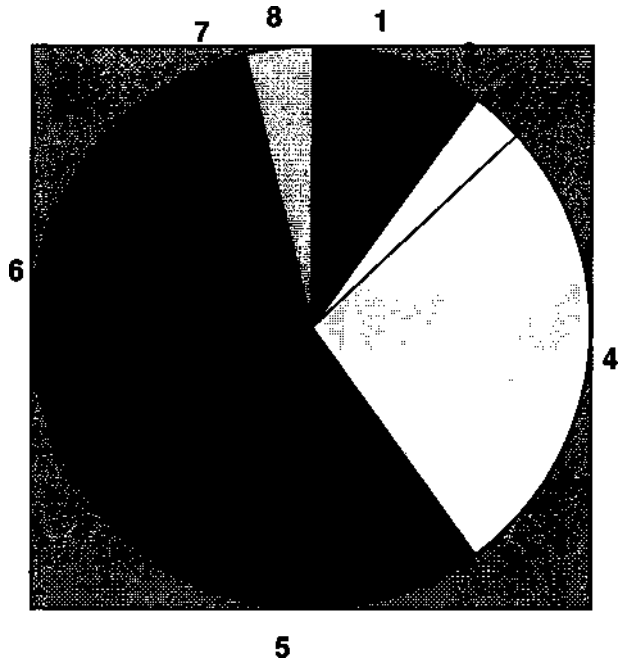
putative managerial reorganisation. Hence, we get 'the tyranny of an imagined future over the present', in Michael Young's memorable phrase. The futures industry must be controlled by its stakeholders. Predictions in the past have failed because of a lack of imagination and a lack of concern with human values. The projected collapse of work and the growth of a leisure society predicted in the 1970s is an excellent example. Are we now, a quarter of a century later, living in 'Athens without the slaves', as Prime Minister Harold Macmillan put it. The same is likely to apply to over-optimistic scenarios about the effects of changing lifestyles on health.

The underlying dilemmas will not go away. It is better in a democratic society for politicians and policy makers to face them, recognise them and come to terms with the limitations of their levers of change. Over-inflated expectations of managerial or technological fixes can do more harm than good. It may be that relatively modest goals, such as encouraging and enabling stronger social support through personal communities and training more and better-paid nurses, will do more for the health of Britain than other seemingly more dramatic measures. Building a more secure and trusting society cannot be achieved easily or quickly. In some ways it is a Utopian concept. However, the growth of a more stressful, competitive, unequal consumerist society does not do much good for the overall health of Britain. In the same way that people are becoming more aware of a holistic approach to their individual bodies, this could provide the basis for an encouraging and more holistic and balanced approach to society.

Resentments against long hours, insecurity, burdensome travelling and the reduction of quality time are not at present generalised to a desire to change the way society is organised. That could come. A younger generation more concerned with the quality of life may be increasingly resistant to the workaholic culture. Perhaps the most important drive towards a healthier Britain in 2015 will be a value shift towards a more balanced life [64].

FIGURES

Figure 1 Households by type of household: Great Britain, 1996



KEY
1. Lone parent with dependent children (7%)
2. Lone parent with non-dependent children only (3%)
3. Other (3%)
4. One person only (27%)
5. Married couple with dependent children (23%)
6. Married couple with no children or non-dependent children (30%)
7. Cohabiting couple with dependent children (3%)
8. Cohabiting couple with no or non-dependent children (4%)

Source: ONS Living in Britain: Results from the 1996 General Household Survey (London: ONS, 1998) [28 p11]

TABLES

Table 1 Households in poverty[1]

Type of household	1979			1991		
	% of all households	*%in poverty*	*% of all households in poverty*	*% of all households*	*% in poverty*	*% of all households in poverty*
Single-person households	11.3	15.9	19.0	17.2	25.1	22.8
Couple households with no others	19.3	3.2	6.5	17.7	7.0	6.5
Couple with 1 or 2 dependent children	39.8	5.7	23.9	28.5	13.0	19.5
Couple with 3+ dependent children	9.3	20.5	20.2	6.2	27.1	8.9
Other couple households	9.0	2.7	2.6	10.2	5.5	3.0
Lone-parent households	6.1	37.7	24.4	9.7	61.2	31.1
Other households	5.2	6.0	3.3	10.5	15.1	8.3
All working-age households	100.0	9.4	100.0	100.0	19.0	100.0

Source: Family Expenditure Survey Micro Data Set 1979 and 1991. Reproduced from N Buck 'Social and economic change in contemporary Britain: The emergence of an urban underclass?' in Enzo Mingione (ed.) *Urban Poverty and the Underclass* (Oxford: Blackwell, 1996) [61]

1. Households in poverty are defined as below 50 percent of median equivalent income (working-age households only).

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> Differences in status produce contempt from those above and fright and insecurity among those below...Smaller social inequalities are...associated with better social relations i.e. more trust, more security, more social support, more self esteem and self-respect, and more sense of belonging; and also with less financial insecurity and fewer feelings of being materially disadvantaged. Democratic, participatory styles in social organisations, from the family to the political system, ensure self-respect and feelings of being appreciated by one's surroundings, and have therefore additional health-enhancing effects.

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59. U Beck *Risk Society* (London: Sage Publications, 1992) and U Beck, A Giddens and S Lash *Reflexive Modernisation* (Oxford: Polity Press, 1994).

60. N Buck 'Social and economic change in contemporary Britain: The emergence of an urban underclass?' in Enzo Mingione (ed.) *Urban Poverty and the Underclass* (Oxford: Blackwell, 1996).

61. WHO *World Health Report 1998* (Geneva: WHO, 1999).

62. This situation could be widely endorsed by those in the NHS and the private health sector; see Catharine Howarth, Peter Kenway, Guy Palmer and Cathy Street *Key Indicators of Poverty and Social Exclusion* (London: New Policy Institute, 1998).

63. Public Management Foundation 'The future for public services 2008', pamphlet, 1998.

64. See R Pahl *After Success: Fin de Siecle Anxiety and Identity* (Cambridge: Polity Press, 1995).