Research in Social Stratification and Mobility 55 (2018) 89–98

Contents lists available at ScienceDirect

Research in Social Stratification and Mobility

journal homepage: www.elsevier.com/locate/rssm

Health inequalities in Argentina and Italy: A comparative analysis of the relation between socio-economic and perceived health conditions

Sarti S.[a,*], Rodriguez Espinola S.[b]

[a] *University of Milan, Department of Social and Political Sciences, Italy*
[b] *Observatorio de la Deuda Social Argentina, Pontificia Universidad Católica Argentina, Argentina*

ARTICLE INFO

Keywords:
Argentina
Italy
Health inequalities
Perceived health
Comparative studies

ABSTRACT

In the literature there is a lack of investigation on health inequalities in South America and their differences with respect to those in the developed countries. Since Italy has recorded similar economic trends in recent years and has some similarities with Argentina, we decided to use the Mediterranean country for comparative purposes. Our hypothesis was that, beyond structural differences, health inequalities present similar patterns in these two countries characterized by a capitalist economy. Social groups in advantaged educational and occupational positions exhibit better health than disadvantaged groups. We present some descriptive statistics on the overall situation in the two countries, and we then analyse data stemming from two surveys that collected individual information on social conditions and health statuses (OASD from 2010 to 2015, and "Multiscopo – Health condition and use of health services", ISTAT 2013). The findings show that Argentina and Italy have different levels of wellbeing, mortality rates, and health services. But relative disparities in health seem very similar, confirming the hypothesis of Marmot (2017) about the general form of health inequalities. Manual and precarious workers (in particular unemployed persons) present systematically worse perceived health with respect to higher social classes.

1. The role of socioeconomic conditions on health inequalities

Investigation of the sources of heterogeneity in the population's health is a central topic in social and political sciences. In different ways, health is the main outcome of the impact of social conditions on individual lives. Health is "embedded" in human bodies through many socio-economic disadvantages that individuals cumulate during their lives (Marmot, 2017; Cullati, Rousseaux, Gabadinho, Courvoisier, & Burton-Jeangros, 2014; DiPrete & Eirich, 2006; Spencer & Logan, 2002; Willson, Shuey, & Elder, 2007).

Many scholars explain variability in health by applying structuralist theories. In these approaches, people in deprived or vulnerable social positions have a higher propensity to live and work in worse conditions which increase the chances of poor health due to stress, morbidity and mortality (Bartley, 2003; Drever, Daran, & Whitehead, 2004; Marmot, 2013; Phelan, Link, & Tehranifar, 2010; WHO, 2013; Wilkinson & Marmot, 2003). In particular, these theories pay most attention to socio-economic factors associated with social position (levels of education, labour market organization and material resources such as income, job environment and general working conditions).

This perspective assumes that individuals occupying different "social positions" are differently exposed to physical deterioration (toxic agents, poor housing conditions or dangerous jobs) as well as psychological attrition (stress due to economic worries, unemployment, excessive workload, repetitive tasks, lack of job autonomy). These factors are considered to be important etiological causes of a wide group of illnesses (Cassel, 1976; Cohen, Janicki-Deverts, & Miller, 2007; Navarro, 1986; Phelan et al., 2010; Siegrist & Marmot, 2004).

The influence of the individual's socioeconomic position on his/her health is frequently not direct; rather, it is the product of intermediary factors: material conditions, such as the quality of housing, psychosocial circumstances, including stress and behaviors such as smoking or poor diet. This model incorporates the health system as another social determinant, because, on the one hand, the deterioration or improvement of health status has a feedback effect on socioeconomic status, and on the other hand, the health sector plays an important role in promoting and coordinating action policies on social determinants.

Thus, according to a large body of scientific literature, social position is a decisive factor in determining health conditions. The notion can be operationalized in different ways. However, the most frequently used dimensions are income, occupational status, and educational level. It should also be noted that all these dimensions are closely correlated;

* Corresponding author at: Università di Milano, Dipartimento di Scienze Sociali e Politiche, Via Conservatorio, 7, 20122, Milano, Italy.
E-mail address: simone.sarti@unimi.it (S. Sarti).

https://doi.org/10.1016/j.rssm.2018.04.004
Received 8 January 2018; Received in revised form 5 March 2018; Accepted 13 April 2018
Available online 17 April 2018
0276-5624/ © 2018 Elsevier Ltd. All rights reserved.

we now briefly present the characteristics of each of them.

A large number of scholars tend to investigate inequality by employing income (often in quintiles or deciles) as the only proxy for the social position of individuals. However, income is not able to reveal the dynamics which produce and reproduce the disadvantages that shape social stratification in terms of both material and symbolic advantages, and also, in more specific terms, health status (Goldthorpe, 2010). In particular, to use income (or one-dimensional status scales) would highlight the gradient between the worst socio-economic and health position, but it would prevent recognition of the different levels of inequality attributable to the occupational group and educational life course related to power hierarchy and cultural resources.

Classifying the occupational position in the labour market requires identifying a group of individuals and families that occupy a similar position within the power relations underlying the social division of labour and the market position, and within the related relational and distributive inequalities. Operationally, individuals are classified according to the typical work situation that differentiates them in the relationship of ownership and authority in which they are placed (Erikson & Goldthorpe, 1992). Let us therefore look at some hypotheses about the ways in which power relationships that undergo disparities in labour market would affect health. These explanations are not mutually exclusive, one does not negate the other, but they accentuate different ways in which belonging to one class rather than another may result in a deterioration in the class members' health. By re-adopting the distinction proposed by Bartley (2004) we can briefly consider three main explanatory models: A. the psycho-social explanation; B. the materialistic explanation; C. the accumulation of disadvantages.

A) The basic principle of the psycho-social explanation, which is the one most frequently adduced by scholars, is that the social positions undergo a more systemic stress state, as defined by Aneshensel (1992), so as to produce a weakening of immune defenses and lesser psychological protection from risk behaviors (Cohen et al., 2007). One of the first scholars to advocate this approach was Karasek (1979), who defined job strain as the tension between job demands and decision-making autonomy (job decision latitude/control). High stress results in a high workload associated with poor decision-making autonomy. According to Wilkinson (2002), the hierarchy of power and the existence of inequality systems increase the stress load to the disadvantage of lower social positions. Therefore, membership of a disadvantaged class should be considered a real health risk factor: "We needed to theorize social status as a psychosocial risk factor, and the biology tells us that this means theorizing it as a source of chronic stress "(Wilkinson, 2002: 539).

In regard to the psycho-social explanation, to be mentioned in particular is Siegrist's approach (Siegrist, 1999; Siegrist, 2000), which focuses on the imbalance between efforts and rewards. This approach is inspired by Homans' theory of exchange, for which a person's way of acting is influenced by past experiences, that is to say, how it was rewarded earlier. The "usure du travail" would result in a deficit in the balance of 'reciprocity'. In other words, people frustrated with their social roles in terms of the ability to obtain material, symbolic and relational resources (work income, family roles, self-esteem, etc.) suffer from a social reward deficit. Disfigurement would cause so much distress and suffering as to affect the efficiency of the neurobiological system through a high and persistent state of stress.

B) The materialistic explanation attaches importance to the material living conditions of the members of the lower classes. They rely on lower income and wealth resources, so that they have *de facto* limited access to resources that can safeguard their health: for example, they may lack money to pay for medicines or health care, or they may live in inadequate housing without heating or drinking water or a sewerage system; or more trivially they may lack the daily caloric intake required for a healthy life. The role of the materialist explanation is particularly evident in health inequalities in international comparisons, for example when comparing rates and different causes of infant mortality in particularly disadvantaged nations, such as sub-Saharan or less developed countries, compared to the most industrially advanced ones (WHO, 2015). Another aspect to which the materialist explanation attaches great importance is the higher exposure of disadvantaged class members to unhealthy environments, as exemplified by workers in certain industrial sectors such as construction, where employees are most exposed to work accidents (Karjalainen & Niederlaender, 2004).

C) The third explanation refers to the model of the life course (Sarti & Zella, 2016; Cullati et al., 2014; Kuh & Ben-shomo, 1997) and takes into account the fact that being located at the bottom of the social hierarchy produces initial disadvantages that accumulate over time (disadvantages that may be already present during pregnancy, Turkheimer, Haley, Waldron, D'Onofrio, & Gottesman, 2003; Tucker-Drob, Rhemtulla, Harden, Turkheimer, & Fask, 2011). More than an alternative to the two previous hypotheses, this one attempts to shed light on the processes that produce and reproduce inequalities in health. In this regard it should be noted that the selection effects cannot be aprioristic, so that subjects who are less likely to develop worse health conditions (anxiety, lack of self-esteem, various illnesses, etc.) are also those that most easily ascend the social leadership scale to occupy top positions. From the point of view of empirical evidence, however, it should be noted that such selection effects are considered modest (Aittomäki, Martikainen, Laaksonen, Lahelma, & Rahkonen, 2012; Mulatu & Schooler, 2002).

Another fundamental dimension of socioeconomic stratification is education, which is a reliable predictor of health and is closely associated with wellbeing, unhealthy lifestyle, morbidity, and mortality (Dupre, 2008; Eikemo, Huisman, Bambra, & Kunst, 2008; Ross & Mirowsky, 1999; Kitigawa & Hauser, 1973; Ross & Wu, 1996). Education is such a good predictor that models using education as control variable see a weakening of the effects of the occupational class. Explanations of the role of education in health partially overlap with those of the occupational position (they are also closely linked). Highly-educated individuals tend to obtain better employment (healthier, less stressful, more autonomous) (Della Bella, Sarti, Lucchini, & Bordogna, 2011; Brunner & Marmot, 2006; Wilkinson & Marmot, 2003); they earn more; they can afford better housing and living standards (such as more physical activity, better diet, etc.) (De Irala-Estévez et al., 2000; Mancino, Lin, & Ballenger n, 2004; Mclaren, 2007); they can count on more valuable social relations (with doctors or informed people). Moreover, more cultural resources furnish better knowledge of medicine and easier use of healthcare services, including preventive medicine (Herzlich & Adam, 1994). Unfortunately, only expensive longitudinal data (panel surveys) enable the study of life courses dynamically.

With this theoretical frame in mind, in what follows we investigate the social inequalities in health in Argentina and Italy. We first consider the general difference in several aggregated health indicators in the two countries. We then detail the health inequalities using data from individual surveys that enable account to be taken of specific socio-economic statuses based on occupational and educational conditions and the associated health statuses.

Argentina and Italy are modern countries with different levels of industrialization, educational attainment, wellbeing, mortality and health care. But the general organization of society is quite similar: they are democratic countries with capitalist economies. Moreover, the two countries have a cultural proximity, since a large number of Argentinians have Italian forebears, and, more importantly, they have experienced a similar macroeconomic trend in recent years. The two economies were hit hard by the global crisis that began in 2007 in the USA, with a relative impoverishment of wealth per capita.

In this regard, it is interesting to compare the pattern of social inequalities in health in the two countries, which have similar labour market organizations but different levels of wealth. More in general, they may be used as a case study of the structural differences between South American and European societies.

Download English Version:

https://daneshyari.com/en/article/7409877

Download Persian Version:

https://daneshyari.com/article/7409877

Daneshyari.com