



## Social class differences in health behaviours among employees from Britain, Finland and Japan: The influence of psychosocial factors

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### ABSTRACT

This study aims to examine social class differences in smoking, heavy drinking, unhealthy food habits, physical inactivity and obesity, and work-related psychosocial factors as explanations for these differences. This is done by comparing employee cohorts from Britain, Finland and Japan. Social class differences in health behaviours are found in the two western European countries, but not in Japan. The studied psychosocial factors related to work, work–family interface and social relationships did not explain the found class differences in health behaviours.

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### 1. Introduction

Key health behaviours, including smoking, drinking, food habits and physical activity, as well as obesity, are important determinants of major public health problems worldwide. Health behaviours are monitored in many countries in order to establish where health risks are larger and where smaller (Murray and Lopez, 1997; Ezzati and Lopez, 2003; Harper and Lynch, 2007). In each country, health behaviours are shaped by social, psychosocial, economic and cultural forces. People in lower socioeconomic positions typically share unhealthier behaviours than their counterparts in higher positions (Blaxter, 1990; Macintyre, 1997; Jarvis and Wardle, 1999; Cockerham, 2007). Health behaviours also provide explanations for socioeconomic health inequalities as emphasised since the Black Report (Townsend and Davidson, 1982; Laaksonen et al., 2005, 2008a; Mackenbach et al., 2008).

International comparisons can pinpoint where socioeconomic differences in health behaviours are larger than elsewhere, and thus suggest where reducing differences is the most feasible. Comparisons also contribute to our understanding of the limits and generalisability of explanations obtained in particular

national contexts only. Our study examines cohorts from Britain, Finland and Japan. An earlier study used the same British cohort while comparing socioeconomic differences in biological risk factors, such as smoking, drinking and obesity with male employees from Japanese industry (Martikainen et al., 2001). Associations between psychosocial working conditions and health behaviours in Britain, Finland and Japan have been examined in the same cohorts as in this study (Lallukka et al., 2008). We extend the scope to social class differences in health behaviours and their psychosocial explanations, and include both women and men from Britain, Finland and Japan.

#### 1.1. Socioeconomic differences in health behaviours

Among various health behaviours, socioeconomic differences in smoking are the clearest and can be found in most European countries (Cavelaars et al., 2000; Mackenbach et al., 2008). However, in the Mediterranean countries these differences tend to be non-existent or even reverse among women, who in higher socioeconomic positions are more often smokers than their lower position counterparts. Elsewhere in Europe as well as in Russia and some of its neighbouring countries, socioeconomic differences in smoking are equally prevalent and have widened over time among women, but narrowed among men (Giskes et al., 2005; Helasoja et al., 2006; Cockerham et al., 2006b). Among male

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industrial employees from Japan, socioeconomic differences in smoking were modest (Martikainen et al., 2001). Another Japanese study found income differences in smoking in particular among women (Fukuda et al., 2005).

In contrast to smoking the socioeconomic picture for heavy drinking is equivocal. Although heavy drinking among Japanese male industrial employees was more prevalent in the lower socioeconomic groups, the pattern among British male employees was rather the reverse (Martikainen et al., 2001). Similar reverse differences have been found among Baltic women. However, in a Japanese study, heavy drinking was slightly more common among low-income women than in other women (Fukuda et al., 2005). Russia and some of its neighbouring countries witness high levels of heavy drinking in lower socioeconomic groups (Cockerham et al., 2006a, 2006b).

Studies on food habits have typically examined vegetable use. Those in higher socioeconomic positions use more vegetables across most western European and Baltic countries as well as Russia and some of its neighbouring countries (Prättälä et al., 2009; Cockerham et al., 2006a, 2006b). However, in the Mediterranean countries, where vegetable consumption is high, socioeconomic differences are rather non-existent. According to a study comparing twelve European countries those in higher socioeconomic positions consumed more cheese, whereas for milk, socioeconomic differences were non-existent (Sanchez-Villegas et al., 2003). A Japanese study showed some socioeconomic differences in food habits (Fukuda et al., 2005).

In most European countries as well as Japan those in lower socioeconomic positions are less physically active; these differences are larger among men than women (Rütten et al., 2001; Gidlow et al., 2006; Demarest et al., 2007; Fukuda et al., 2005).

Obesity is closely related to food habits and physical activity and shows large and consistent socioeconomic differences among European women but less so among men (Roskam and Kunst, 2008; Mackenbach et al., 2008). Similar differences were also found among British male employees, but among male industrial employees from Japan, obesity was rather more common in the higher socioeconomic positions (Martikainen et al., 2001).

### 1.2. Towards explanations for socioeconomic differences in health behaviours

So far comparative studies of socioeconomic differences in health behaviours have reported descriptive findings, but the reasons for socioeconomic differences remain poorly understood. Theoretically psychosocial factors provide potential explanations for socioeconomic differences in health behaviours (Emmons, 2000; Chin et al., 2000; Stansfeld and Marmot, 2002; Cockerham, 2006; Siegrist and Rödel, 2006). If for example lower socioeconomic groups disproportionately suffer from high psychosocial strain due to overexertion, fatigue and conflicting situations this might contribute to smoking, drinking, unhealthy eating and sedentary behaviour as coping strategies. Higher socioeconomic groups in contrast may possess resources to better cope with psychosocial strain without engaging in unhealthy behaviours (Almeida et al., 2005). However explanatory studies are few and practically lacking in an international comparative setting. A comparative study made efforts to explain socioeconomic differences in smoking among Danish and Swedish employees by Karasek's (1979) psychosocial job strain model but without success (Andersen et al., 2008).

We focus on psychosocial factors as explanations for socioeconomic differences in health behaviours in an international comparative setting. For this purpose we develop a comprehensive explanatory framework extending from psychosocial factors

related to work to the interface between work and family, and to non-work-related social and family relations. Firstly we include Karasek's (1979) job strain model, as well as working overtime. These have previously shown some, although limited, associations with health behaviours (Johnson and Lipscomb, 2006; Kouvonen et al., 2007; Lallukka et al., 2008). Secondly we include conflicts between paid work and family life. So far very little is known about how these conflicts might be associated with health behaviours (Roos et al., 2007; Lallukka et al., 2009). Thirdly we include marital status and social relations as these have shown associations with health behaviours (Laaksonen et al., 2003; Smith and Christakis, 2008). A broad framework encompassing a variety of psychosocial factors effective in different environments allows us to quantify the explanations of each type of factors as well as to assess their joint effects on the socioeconomic differences in health behaviours.

## 2. Context and purpose of the study

Both health research and health promotion equally benefit from a better understanding of the nature and reasons for the existing socioeconomic differences in health behaviours. While many studies confirm socioeconomic differences across various behaviours there is heterogeneity in the differences as shown by variation between countries and genders.

Earlier international comparisons have primarily covered European countries. Our study on social class differences in four key health behaviours and obesity uses employee cohorts from Britain, Finland and Japan, exemplifying affluent societies not only from western Europe but also East Asia. These three countries share similarities and dissimilarities in social structural and cultural arrangements, welfare provision and allocation, family structures as well as employment participation among women and men. Britain approximates a liberal welfare state model, Finland a Nordic social democratic model and Japan a liberal-traditional hybrid model (Esping-Andersen, 1990, 1997; Uzuhashi, 2003). Labour markets, gender relationships and family models are likely to be more traditional in Japan, which may give rise to some deeper social divisions in Japan than in western Europe, with structural, material and psychosocial consequences (Uzuhashi, 2003; Martikainen et al., 2004). The national context in each country lays the substratum shaping the factors behind socioeconomic differences in health behaviours. We examine key psychosocial factors related to work, interface between work and family and further social relations as potential explanations for social class differences in health behaviours. These factors are highly relevant for employee populations and have previously been studied for health-related outcomes in comparative settings (Sekine et al., 2006; Lallukka et al., 2008; Andersen et al., 2008).

This study aimed first to examine social class differences in smoking, heavy drinking, unhealthy food habits and physical inactivity as well as obesity among female and male public sector employees from Britain, Finland and Japan; and second to assess whether work-related, work-and-family-related and non-work-related psychosocial factors explain the observed social class differences in health behaviours and obesity.

## 3. Data and methods

### 3.1. Data sources

Three cross-sectional employee cohorts were used: (1) The London-based Whitehall II study (WHII), Britain; (2) The Helsinki Health Study (HHS), Helsinki, Finland and (3) the Japanese Civil

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