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Original Research

Social and health-related correlates of intergenerational and intragenerational social mobility among Swedish men and women

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SUMMARY

Objective: To explore the pattern and determinants of inter- and intragenerational occupational mobility among Swedish men and women.
Study design: A Swedish 14-year prospective longitudinal study (response rate 96.5%).
Methods: Detailed information on 546 men and 495 women regarding their occupation, health status, health-related behaviour, psychosocial environment at home and school, material recourses and ethnicity prior to mobility were available at 16, 21 and 30 years of age. Odds ratios and 99% confidence intervals were calculated using logistic regression to determine social mobility.
Results: The results indicated that being popular at school predicted upward mobility, and being less popular at school predicted downward mobility. Additionally, material deprivation, economic deprivation, shorter height (women) and poor health behavioural factors predicted downward mobility. Among this cohort, being less popular at school was more common among subjects whose parents had low socio-economic status. Occupational mobility was not influenced by ethnic background.
Conclusions: Apart from height (women), health status was not associated with mobility for men or women either inter- or intragenerationally. Unfavourable school environment was a consistent predictor of mobility for both genders. The results indicate that schools should be used as a setting for interventions aimed at reducing socio-economic health inequities. Targeted school interventions that are designed to assist higher educational attainment of socio-economically disadvantaged youth would help to break the social chain of risk experienced during this time, and thereby alter their life course in ways that would reduce subsequent social inequities in health and well-being.

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Introduction

The health selection hypothesis has been one of the most controversial explanations of class inequalities in health,[1,2] claiming that it is individuals' health which determines their social position. According to the hypothesis, social class differences in health occur due to healthy people moving up the social hierarchy and unhealthy people moving down. The balance of evidence on health and mobility suggests that direct selection according to health is not the predominant explanation for health inequality.[2–9] Recent studies have indicated that social mobility does not create or widen social class differences in health but rather constrains these differences.[7,10–13] The narrowing of health inequality is suggested to be mainly due to the fact that upwardly mobile people tend to have better health than those in the class they left behind but poorer health than those in the class they join, and *vice versa* for downwardly mobile people.[7,10–14] Hence, increasing social mobility is viewed as a desirable policy to reduce health inequality.[13] In light of this, more insight is needed regarding what determines social mobility in a particular social context.

In general, social mobility can be inter- or intragenerational. Individuals' occupational movement between generations (i.e. parents' occupation to subject's own occupation) is referred to as 'intergenerational mobility' and movement within a generation is referred to as 'intragenerational mobility'. Most social mobility is likely to occur at younger age groups (i.e. intergenerational stage).[2] Height has been most commonly used in mobility research as a health indicator, because short stature is a well-established risk factor for cardiorespiratory disease and death among men and women.[15–18] The relevance of height to subsequent social mobility among men and women[7,11,19–21] has been widely studied, although most studies only consider intergenerational mobility. Collectively, studies suggest that taller people are more likely to be upwardly mobile and shorter people are more likely to be downwardly mobile. Using other health indicators such as self-reported health, serious chronic illnesses, psychological distress, etc., studies have indicated that adolescents' health has a direct but modest effect on the chances and direction of mobility,[3,5,11,21] while other studies have shown no effect.[8,9] With exceptions,[5,11,21] these studies rely on measures of health which are concurrent to mobility, thus making it difficult to establish the direction of causality. Nonetheless, the reason for the modest effect of health status on mobility could be that chronic disorders in adolescents are rare. This has led to the idea of indirect selection which implies that other adolescent background characteristics rather than health are accountable for both subsequent social mobility and adult health. The most relevant characteristics are material deprivation,[7] psychosocial environment at school[22] and health-related behaviours,[23] which are linked to educational attainment and hence the direction of social mobility. However, these previous studies only focused on men,[7] combined men and women in the analyses,[22] used limited indicators,[7,22,23] or only addressed mobility at one transition (inter- or intragenerational).[7,22,23] Ethnic background is an important aspect related to mobility.[24,25] Social mobility is reported to be difficult for US immigrants, particularly the first generation compared with the second or next generation (those with at least one foreign-born parent), due to language barriers in addition to trying to adjust to the new environment and culture.[24] A similar mobility pattern among ethnic groups was also reported from Sweden.[25] However, the aspect of ethnicity in health selection research is receiving less attention.

What appears to be lacking is prospective longitudinal analyses in determining social mobility among both men and women, and at both inter- and intragenerational stages. Detailed data on health and other characteristics prior to mobility are available for the Northern Swedish Cohort, born in 1965, providing a unique opportunity to address the above-mentioned shortcoming. Previous studies on this cohort have indicated that material resources, psychosocial environment at home and school, and health-related behaviours in early years are associated with adult educational attainment.[26,27] As direction of mobility is strongly associated with level of education, these similar factors could also influence adult occupational mobility; however, this has not been investigated previously. The aim of the present study was to use this cohort data to identify which factors – specifically, health behaviour, psychosocial environments at home and at school, material recourses as well as health-related measures and ethnicity – had a significant effect on the direction of inter- and intragenerational social mobility among men and women.

Methods

Data and subjects

The analysis is based on a 14-year prospective cohort study. The baseline survey was conducted in 1981, when all 16-year-old ninth-grade school pupils (575 boys and 506 girls) in Luleå, an industrial city in northern Sweden, completed questionnaires in the classroom. The questionnaires were constructed from previously validated questionnaires.[28,29] The same questionnaire was then used in the follow-ups at 18, 21 and 30 years of age; the response rate was 96.5% (i.e. 547 men and 496 women). Full details of the study design are reported elsewhere.[30] In brief, among the subjects lost to follow-up (28 men and 10 women), five died (three men and two women). The baseline background characteristics did not differ between the responders and the non-responders. Survey data from 16, 21 and 30 years of age, school records and teachers' interviews at 16 years of age were analysed in the present study. In total, 65 form teachers were interviewed with previously validated questionnaires.[31,32] In Sweden, form teachers usually have regular contact with the pupils, teach at least one major subject, co-ordinate class work, and have main responsibility for contact with parents. The form teachers had known the pupils for at least 6 months. The study was approved by the ethics committees of Uppsala University and Umeå University. The study subjects gave informed consent before participation.

Health-related and health behavioural measures

Four different health-related measures were determined for each age group. An index of chronic symptoms was