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Social class, employment status and inequality in psychological well-being in the UK: Cross-sectional and fixed effects analyses over two decades

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ABSTRACT

A body of academic research has shown a social class gradient in psychological well-being. Some recent work has also suggested that the gradient is worsening over time, though the evidence is mixed. We focus on two straightforward research questions: Is there a class gradient in mental health? Has this gradient changed over time? We answer these questions with attention to two specific causal pathways: *employment status* and *unobserved heterogeneity*. We use two data sources: repeated cross-sections from the Health Survey of England (HSE) and longitudinal data from the British Household Panel Survey (BHPS). The combination of pooled OLS regression (with HSE) and fixed effects analysis (with BHPS) allows for a robust analysis of the relationship between class and psychological well-being. We argue that employment status is a confounder in the analysis of class inequalities and show that, along with unobserved heterogeneity, these two pathways go a long way to explain the class gradient. The effects of employment status are substantive and, unlike social class, cannot be explained away by unobserved heterogeneity. We conclude that employment status deserves greater prominence in the debate as both a pathway by which the class gradient transpires, and as another 'dimension' of inequality in its own right. Our overtime analysis suggests that skilled and unskilled manual workers had higher psychological well-being in the 1990s but by 2008 were closer to the average. Class inequalities do not appear to be widening.

1. Introduction

Tackling socio-economic inequalities in health has become one of the priorities in UK government health policy and a key challenge for monitoring inequalities is to accurately identify population groups where health problems cluster (Marmot et al., 2010). Yet empirical evidence on the health gradient remains mixed and the nature of the social determinants of health 'unresolved' (Eckersley, 2015). Several studies have found a 'health gradient' whereby incrementally better outcomes are seen for those higher up the socio-economic and occupational ladder (World Health Organisation, 2008). This field of study has been extended to include well-being and mental health where the gradient has been replicated (e.g. Stansfeld et al., 2003; Chandola and Jenkinson, 2000; Maheswaran et al., 2015; Katikireddi et al., 2012; Jokela et al., 2013). Further, several studies have suggested that these inequalities in mental health may be worsening over time. Maheswaran et al. (2015), for example, showed that the difference between those at the top (in professional and managerial jobs) and those at the bottom (unskilled manual) of the occupational social hierarchy grew between 1997 and 2009. Katikireddi et al. (2012) have similarly shown that the gap between those with low and high educational attainment grew between 1991 and 2010. In contrast, while Jokela et al. (2013) report a social class gradient in mental health, they find no evidence of a change over time in social class inequalities. Moreover, Foverskov and Holm (2016) cast doubt on the nature of the relationship arguing that the gradient emerges in cross-sectional and random effects studies due to unobserved confounding factors such as childhood disadvantage (Ferraro et al., 2016).

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Eckersley (2015) argues that, for the last few decades, research into social determinants of health seemed to tell a simple and coherent story - that any socio-economic hierarchy would directly reflect a health gradient. Therefore, different dimensions of socio-economic status – income, class, education – have been taken as good indicators for identifying clusters of mental health problems. However, the substantial differences between these dimensions indicate complexity in the social determinants of health (Eckersley, 2015). In this paper we focus on social class as a specific dimension; however, we will go on to argue that economic activity status and the uneven distribution of employment function as a further dimension of inequality of mental health.

This paper comes down to two straightforward questions: First, is there a social class gradient in mental health in the UK? Second, did the social class gradient in mental health increase over time? We address these questions with attention to two alternative pathways: firstly, employment status as a time-varying (measured) confounder correlated with both class and mental health, and, secondly time invariant unobserved heterogeneity (unmeasured confounder). We do this by using a combination of cross-sectional and panel data. With the second question, we aim to reconcile the evidence from previous studies showing that class inequalities are becoming larger over time (Maheswaran et al., 2015) in contrast to those showing stable inequalities (Jokela et al., 2013).

2. Theoretical background

2.1. What is social class?

Our conceptualization of class in this study is that of occupation based class. The occupation in which one is or has been employed is a reflection of one's place in the socio-economic system; it influences various dimensions of economic advantage and disadvantage: earnings, earnings stability, career prospects, risk of unemployment, and access to the labour market more generally. Thus class is largely concerned with the allocation of economic advantage and disadvantage as well as reflecting the nature of the employer-employee relationship (Goldthorpe, 2000). Nonetheless, we argue that the occupation-based approach to class applies to those *outside* as much as to those *inside* the labour market. Firstly, this is because class defines long-term career prospects and directly influences the risks of exiting and re-entering the labour market, with higher percentages of the lower classes retired early, outside the labour market for long-term health conditions, or to look after home and children (Popham and Bambra, 2010; Goldthorpe, 2000; Whelan, 1994; Arber, 1987). Secondly, it has been shown that occupation-based status continues to have an effect on health after the employment has ended (van Rossum et al., 2000). Finally, occupational class is likely to shape people's perceptions about their position and status in a society in relation to others (Ridgeway, 2014) and such perceptions of one's status can affect mental health also when out of the labour market either temporarily or permanently.

2.2. Social class and mental health

From a 'social causation' perspective four types of explanation for the class mental health relationship can be distinguished. First, social class could exert its influence on mental health via conditions of the work environment. The specific psychosocial stressors thought to have a causal effect on mental health include 'job strain', which comprises the elements of high demands and low autonomy, and effort-reward imbalance (Stansfeld and Candy, 2006). The extent to which individuals can exercise autonomy in their day to day job, for example, has been found to explain part of the variance in the mental health gradient (Marmot et al., 1997). However, the link between these psychosocial stressors and social class is itself is not as strong as might be assumed. For example, high levels of demand are found in higher grade positions, while lower grade jobs might be associated with lower demands but may be monotonous with little room for autonomy (Stansfeld and Candy, 2006). The second social causation pathway is based on economic insecurity and the level of, and access to, resources. Lower social class occupations are characterized by lower incomes, higher income volatility, job insecurity, and fewer long-term economic prospects (Goldthorpe, 2000), which are likely to create a 'common element of economic insecurity' leading to negative mental health consequences (Rohde et al., 2016). The third pathway is that of health behaviours including exercising, eating habits, smoking and alcohol consumption. Although these factors might be more intuitively associated with physical than mental health, they have been shown to explain the class-mental health relationship when included in multivariate analyses (Chandola and Jenkinson, 2000). The fourth is the psychosocial explanation whereby the social environment and perceptions of one's place in the hierarchy can directly influence health outcomes (Marmot, 2004). Those occupying positions lower in the social hierarchy are subject to greater levels of psychiatric distress directly resulting from perceiving oneself to be of low status.

In contrast to the social causation hypotheses the health selection hypothesis suggests reverse causality – that health determines social class (Foverskov and Holm, 2016; Dahl, 1993). From this perspective membership in a lower social class does not cause the worse mental health, but worse mental health makes people more likely to be in the lower-classified occupation.

2.3. The role of employment

The social causation and the health selection hypotheses are not mutually exclusive but they both assume a causal relationship between social class and mental health. However, we need to consider the problem of endogeneity – that some third variable might be driving this relationship between class and mental health. Much of the evidence on the effect of class on health outcomes in the UK has been from studies of civil servants working in Whitehall; for those in such (mostly) white-collar jobs, incremental increases of common mental disorder are seen with each drop in job grade (Stansfeld et al., 2003). However, there are also important differences to note for those who are not in paid employment. Particularly in contrast to being unemployed, employment itself, of any class or grade, appears to be beneficial. Work provides 'a daily experience of collectivity' (Jahoda, 1982: 24), which includes opportunity for inter-personal contact, as well as social status, opportunities for skill use and control, and feelings of goal achievement and worth (Gallie, 2004). In contrast to the unemployed, the class differences in mental health of those in employment tend to be small (Richards, 2015). A number of studies have shown that the health gradient appears to be stronger for women and for those in older age groups (Fryers et al., 2003; Chandola and Jenkinson, 2000), two groups with lower than average participation in the labour market, thus suggesting that employment status might be partly accounting for the social class effect.

The social causation pathways of working conditions, economic security and access to resources, health behaviours, and perceived status are also relevant to people who are not currently working. Job strain and unequal effort-reward balance, but also income and prospects, may be factors that determine the likelihood of one dropping out of the labour market for long-term illness, early retirement, or to stay at home to look after children. It is therefore not surprising that Dahl (1993) suggests that neglecting the non-