Explorations in Economic History 48 (2011) 376–388

Contents lists available at ScienceDirect

Explorations in Economic History

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

Wealth and health in 19th Century Sweden. A study of social differences in adult mortality in the Sundsvall region

Sören Edvinsson [a,*], Marie Lindkvist [b]

[a] Centre for Population Studies, Umeå University, SE 901 87 Umeå, Sweden
[b] Department of Statistics, Umeå University, SE-901 87 Sweden

ARTICLE INFO

Available online 24 May 2011

JEL classification:
I10
I14
N33

Keywords:
Social inequality
Mortality
Sundsvall region
19th century
Lifestyles
Gender

ABSTRACT

The present article analyses social inequality in mortality in the 19th century Sundsvall region, an area that experienced rapid industrialization after 1850. The purpose of the study is to investigate whether there were social differences in mortality in this context and whether these differences increased during the industrial break-through. The expected advantages for higher social classes could not be confirmed in this environment. Instead, the best survival was found among those belonging to the agricultural sector. We found a strongly gendered pattern, with much higher mortality for and small health differences among men, while the results indicate increasing social inequality in female mortality during industrialization. The spatial pattern of mortality was pronounced and living with a partner had a strong impact on survival, particularly for men. We finally discuss the role of gender and class expectations in relation to lifestyles for the social patterning of mortality.

© 2011 Elsevier Inc. All rights reserved.

1. Introduction

According to an old Swedish proverb, "It is better to be poor and healthy than rich and ill". However, a humorous reformulation of the proverb – "It is better to be rich and healthy than poor and sick" – is closer to actual conditions. Being wealthy leads to better health and prolonged survival, as has been well documented in many studies around the world. Social position is perhaps the most central variable in determining health. Some scholars have even argued that socio-economic status per se is a fundamental cause, implying that certain groups will maintain their disadvantage even if the proximate causes are changed (Link and Phelan, 1995). This underlines the importance of analysing social differences in health, particularly what causes these differences as well as possible changes in health inequalities over time. Furthermore, this topic has strong implications for our understanding of the mortality decline, for example the role of improved nutrition (McKeown, 1976).

There is ample evidence that lower social position determines health outcomes in modern times and that these differences even appear to be increasing (Kunst, et al., 2004; Mackenbach, et al., 1997). When the Black Report for England reported on health inequality around 1980, it created a great controversy, illustrating how politically sensitive these questions can be (Whitehead, 1998). The fundamental question for research is what creates health inequalities. It involves both effects of material conditions as well as psychosocial aspects of the social position, sometimes referred to as a status syndrome (Marmot, 2004). Some scholars also suggest that societies with a larger income distribution, i.e. larger economic differences, are less successful when it comes to population health (Wilkinson, 2005).

Social inequalities in health became an issue during the 19th century. Physicians, researchers and social reformers such as Villermé, Chadwick and Engels documented the many times horrible conditions of the impoverished population at the time. They

* Corresponding author. Fax: +46 907866958.
E-mail addresses: Soren.Edvinsson@ddb.umu.se (S. Edvinsson), Marie.Lindkvist@stat.umu.se (M. Lindkvist).

0014-4983/$ – see front matter © 2011 Elsevier Inc. All rights reserved.
doi:10.1016/j.eeh.2011.05.007

pleaded for political reform in order to combat poverty. In the words of the famous Prussian physician, researcher and social reformer Rudolf Virchow: "Medicine is a social science, and politics is nothing else but medicine on a large scale" (Ackerknecht, 1948, p. 142). This awareness of higher mortality among the socially disadvantaged, however, did not lead to immediate political reforms. Instead, the poor were often blamed for their own situation. A common theme in the political discourse was the immoral behaviour of the poor, their abuse of alcohol and their indifference in matters relating to their health. Authorities and political debaters were very much concerned about the quality of the population, a concern that led to initiatives by some upper-class reformers to educate and civilize the lower classes. Others, on the other hand, recommended strict control of the presumably dangerous classes and even interference with reproduction in the lower classes.

We lack, however, substantial knowledge about how socio-economic position influenced health and mortality in historical contexts, especially the development of this influence (Bengtsson and van Poppel, 2011-this issue). Some results indicate that geography had a greater impact than did socioeconomic position and that social differences only appeared at some point in time when access to more resources could be used to buy better health. When in time this shift occurred and whether the pattern was the same for all age groups and for both sexes is, however, unclear. This is the topic of the present paper. We investigate whether the rapid industrialization, with profound changes in the living conditions, taking place in a Swedish district – the Sundsvall region – during the late 19th century worsened the health of the working class or the lowest social strata in society and whether social health inequalities increased during this specific historical period.

Here, we argue that even in this society of great social inequality, the spatial aspect still had a strong impact on health and that social differences influenced mortality differently depending on gender and age groups. Not all age groups were affected in the same way and there were clear differences between men and women, in particular in relation to the impact of social class. We furthermore suggest that social advantages were not automatically turned into general health advantages, and that we need to take into consideration not only the material aspects of class but also lifestyle characteristics. We need to understand the class and gender aspects of lifestyles in relation to health and to consider the different expectations and status demands in different social groups.

2. Analysing social inequality in mortality

Let us first reflect on how social differences in health and mortality are constructed. A starting point is the assumption that differential access to resources has impact on survival. Consequently we should not expect contradictory patterns of survival when it comes to access to vital goods. The main categories of resources are often referred to as different kinds of capital. Bourdieu defined three major interrelated groups of capital – economic, cultural, social capital. Economic capital increases access to both social contacts and knowledge and education, and vice versa. Economic capital refers to the possession of money and valuables. Cultural capital can take different forms, formal education being the most important. Social capital is related to belonging to a group and having a social network. The socioeconomic position created by these forms of capital takes the shape of different lifestyles through what Bourdieu called habitus, a class-specific way by which forms of practice are produced (Hoffmann, 2008, pp 31ff; Bourdieu, 1984). Bourdieu's method of integrating lifestyle into the class dimension makes it an interesting approach for health studies.

Why do we expect different access to resources to influence health and mortality? Conceptually, it is possible to identify both indirect and direct ways in which this would have an effect. Indirect ways imply that access to resources enables persons to live a life with fewer health risks compared to those with less access. Wealthy people live in better houses and in environments with a better infrastructure. They can afford both better and more food and are less affected by crises. Affluent groups will thus be healthier even if they do not act consciously to improve their health. Direct ways refer to conscious measures that people take to improve their health, for example through medication and health care or by adopting a health-promoting lifestyle. To accomplish this, some prerequisites need to be fulfilled:

- There must be something available to buy that can improve health or avoid death and disease.
- There must be knowledge about access to these possibilities and how to use them.
- There must be a desire to invest in improved health.
- It has higher priority than other competing and perhaps conflicting values.

The indirect ways did not necessarily mean that people with more resources had an advantage, though usually this was the case. They were well fed and they did not live in cold, damp and overcrowded dwellings, as did the poor in society. However, the demands of belonging to a higher social class often meant residing in urban places, places that usually were unhealthier than rural environments. The traditions of or expectations placed on upper class families could also be detrimental to health.

Furthermore, if nothing could be "bought" or if it was easily available for all, then more economic resources mattered less. Preston and Haines argued that lack of knowledge explains the small social differences in child mortality in the US in the early 20th century. Even the most knowledgeable groups in questions regarding health – the physicians – could not prevent equally high mortality among their children as among others (Preston and Haines, 1991). The degree to which pre-20th century health knowledge served as a protection from disease is a question still open for debate. Regarding the will to use resources to promote health, we should not take it for granted. Conflicting values may cause people to choose actions damaging for health, but considered right depending on the demands of their social role. The preferences must be understood within the realm of the group-specific habitus and how this comes into practice in lifestyles.

Download English Version:

https://daneshyari.com/en/article/5069110

Download Persian Version:

https://daneshyari.com/article/5069110

Daneshyari.com