



The Status Syndrome: How Social Standing Affects Our Health and Longevity by Michael Marmot, Henry Holt and Company, 2004.

Michael Marmot is Professor of Epidemiology and Public Health at University College, London and also Director of the International Center for Health and Society. Marmot is best known for his work on the health and mortality differences among British civil servants; this research is sometimes referred to as the Whitehall studies. The main finding in these studies is that "the higher the status in the pecking order, the healthier they (British civil servants) are likely to be." Similar studies have been conducted in a variety of social settings around the world and the finding that "health follows a social gradient" has been widely replicated. The Status Syndrome is a breezy conversational discussion of how and why various forms of social rank have the effects on health and mortality they appear to have; by necessity, the discussion involves lengthy efforts to untangle factors which correlate with health outcomes and establish causal mechanisms. Not surprisingly, this turns out to be a difficult task even for a bold theorist like Marmot.

Marmot acknowledges that most educated people intuitively grasp why health outcomes in poor neighborhoods or communities differ from health outcomes in their relatively affluent counterparts. It may not be as intuitively obvious, however, why health and mortality outcomes follow a social gradient and are highly sensitive to even small differences in social rank. Marmot's interpretation of these health differences is that "Autonomy -- how much control you have over your life -- and the opportunities you have for full social engagement and participation are crucial for health, well being and longevity. It is inequality in these that plays a big part in producing the social gradient in health."

The extent of these differences is striking. "Travel from the southeast of downtown Washington to Montgomery County, Maryland. For each mile traveled, life expectancy rises about a year and a half. There is a twenty - year gap between poor blacks at one end of the journey and rich whites at the other," Marmot states. There are also large national differences in life span which Marmot believes have social causes (Japanese men live 20 years longer on average than Russian men), though the relationship of these differences to social rank are arguable to say the least. Nevertheless, Marmot asserts that the social gradient in health and mortality has been found in other European countries, including Scandinavian countries as well as Japan, Australia and New Zealand.

Income level is one common way of determining social rank; educational level and occupational prestige are other common ways. NPR listeners may have been surprised to hear recently that Academy award winners live 4 years longer on average than the

(often) wealthy and famous losers. One's position in an organizational chain of command is another form of social ranking. One Scandinavian study found the social gradient in health and mortality for university faculty, though Marmot fails to mention American or English studies of this type.

Marmot takes on alternative explanations for the social gradient in health one by one like a boxer wading through pesky but outgunned opponents with knockout punches. He asserts that health habits such as smoking, diet, exercise level account for about a third of the social gradient in health, i.e., persons low in social rank tend to have poorer health habits. Furthermore, Marmot claims, even when researchers control for smoking, diet and exercise levels, the social gradient in health outcomes remains. Other alternative explanations Marmot considers include genetic differences, the material hardship associated with poverty, material differences in national life styles and degree of income inequality.

Income inequality in the United States is related to mortality rates, e.g., "Comparing states and metropolitan areas, the higher the degree of inequality, the higher are the mortality rates." However, some researchers (e.g., Deaton) claim that income inequality is not an important influence on mortality rates once African American ethnicity is included in the analysis; states with high levels of income inequality also have relatively high percentages of African Americans in the population. The question for researchers is which factor, i.e., ethnicity or income inequality, is more important for health outcomes. Marmot thinks that both income inequality and ethnicity "indicate the degree to which people have the opportunity to participate fully in society ..." "A society that excludes high proportions of its population from full social participation is one that does not value all its people equally highly. Such a society is likely not to provide the conditions that favor good health."

Marmot then turns his attention to possible social causes of health outcomes and to his favored explanation of differential health outcomes, i.e., "being low in the social hierarchy means having less control over your life." He plausibly argues that "Sustained, chronic and long term stress is linked to low control over life circumstances." Marmot presents research on protective factors in high stress environments as establishing the importance of "five characteristics, control, predictability, degree of support, threat to status and presence of outlets that modulate the impact of a psychologically threatening stimulus." Marmot's argument is that stress related to lack of control over life circumstances leads to higher rates of heart disease, arteriosclerosis and major and minor mental health disorders. He is particularly concerned about "the high risk of depression in low -status women who had little control over things at home." Depression, in turn, is correlated with higher rates of heart disease.

Some of the most interesting information in this book concerns mortality differences among nations. The Japanese live about 4 years longer than Americans, a huge difference in aggregate mortality statistics. "An American boy of fifteen has a 60 percent higher chance of dying before his sixtieth birthday than a Japanese boy of fifteen, according to Marmot."Abolishing coronary heart disease from the whole population

would add about three to four years of life expectancy." Marmot claims that the Japanese don't have particularly good health habits; half of adults in Japan are smokers for example. Marmot thinks the cohesive nature of Japanese society accounts for their longevity; if so, Americans are paying a heavy price for our society's individualistic culture.

The average life span of Russian men has decreased by seven years since the collapse of Communism and is now among the lowest life spans in the world. Russian men, on average, live 15 fewer years than males in the European Union, Marmot states. Income inequality makes a difference in national mortality rates. "When we compared countries of Central and Eastern Europe, the greater the increase in income inequality between 1989 and 1996, the greater the increase in mortality rates."

Marmot comments that "Infant and child mortality are the health indicators most sensitive to material deprivation." The chances that a male baby will die before age five in Japan is 5 per 1000..." At the other end of the spectrum there is Sierra Leone, where the chance of death before age five is 292 per thousand for boys and 265 for girls." "In Russia, the corresponding figures were 23 for boys and 17 for girls." Marmot interprets these statistics as indication that the increase in male mortality rates in Russia and Eastern Europe is due to social causes, not poverty or other material conditions. Marmot goes on to discuss research confirming that "people (in these countries) who had less control over their lives had worse health." "We found the link between income inequality and poor health was low control, Marmot asserts." All roads lead to Rome.

Marmot states that "All societies have rankings because individuals are unequal in a variety of ways; but not all societies have the same gradient in health." "What matters is the degree to which inequalities in rankings lead to inequalities in capabilities - being able to lead the lives they most want to lead. Central to those capabilities are autonomy and social participation," Marmot asserts. Marmot acknowledges that "some determinants of health exert their influence regardless of social position. Improvements in environment and health behaviors will benefit the health of everybody whether high status, low or in between." However, these factors do not explain the health gradient, according to Marmot.

Marmot concludes that "The social gradient was not only a way of coming to understand the importance of autonomy and social engagement; it demonstrated that these factors are distributed unequally in society." "There are social forces at work that lead to social groups lower in the hierarchy having worse health than higher groups," he states. "A more just distribution of capabilities -- control and social engagement -- will lead to a more equal distribution of health. The aim should be to focus on the conditions for good health. These will be material, yes, but more, they will have to do with self realization: control over life in the sense of being able to lead the life we most want to lead."

This is book with implications for the organizational culture of bureaucracies, for social work practice with low income populations and even for the definition of social justice. It is possible to argue with Marmot's conclusions about findings from health research at

many points, and most scholars will want to see the data on which his arguments are based. It is also a lively engaging book written for educated persons who are not professional scholars; and its main themes touch on matters important to practically everyone.