between the groups, it was suggested that this could be resolved using health intervention that match recipients’ educational level.

One main problem with health education is that it is mostly designed by – and therefore for those with high SES, and so is less accessible or less believable to those of lower SES.

Also, Blair (1993) suggests that language in particular is important to accessing healthcare. The language used by doctors (high SES) may be incomprehensible to those of lower SES. Also, doctors tend to factor in mental state as opposed to the mantra of many people of low SES who simply see diseases and disorders as ‘something to be fixed’ in the body.

In conclusion, the main factors affecting health behaviour are perceived control, age and income background. This shows that clearly the government needs to adopt a more universal approach to health care in that it should be adaptable to each individual or at least on a group basis as the current approach is maladaptive and based on a ‘standard’ model. Although, these factors may be insignificant compared with the seemingly obvious fact that we as humans act irrationally and emotionally most of the time i.e. ignoring statistics and believing case studies such as ‘my gran smoked and drank a lot and lived until she was 98’. This inherent irrationality which can be crucial to our survival (intuition) may prevent suitable health behaviour.