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Health inequality and social capital: From state to community

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ABSTRACT

In a world of neoliberal imperialist globalisation, there has been a profound growth of social inequalities, between and within nations. This has had a most negative impact on the health and quality of life of large sections of the populations in the developed and underdeveloped worlds. The contention of this paper is that the social production of health inequality, as shaped by neoliberalism, has to be understood in this historical context of the emergence of a new capitalist order which is primarily based on unfettered market with the motives of greed and acquitiveness. This divides societies into very rich and very poor. What a truism of coexistence of great wealth and great poverty/inequality. This offends the notion of a just and equal society.

Even Richard Wilkinson's theory of social cohesion, modelled in the Emile Durkheimian tradition of moral individualism (a system in which the individual willingly performs in accordance with laws and customs of the society), distances itself from a true population perspective. In fact, it creates a smokescreen through its claim as an alternative paradigm, and thereby pushes the task of public health further back. In the Wilkinson model, the real shift has been only that of 'community blaming' in place of individual 'victim blaming'. The attainment of better health status becomes the responsibility of the community as a whole through such measures as better social cohesion and solidarity, and better health is the responsibility of the individual through measures such as behaviour modification, self-help and self-control. In both the cases, the Wilkinson model implicitly suggests that the state has no role to play and there is no space for macro structural change.

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INTRODUCTION

In the crisis ridden phase of imperialist globalisation, the ideology of neoliberalism postulates the reduction of state interventions in the economic and social spheres of life. Neoliberalism deregulates labour and financial markets along with commerce and investment. The neoliberal era is also driven by the intellectual and political hegemony of an individualistic philosophy that claimed that 'there is no such thing as society'[i] (Margaret Thatcher quoted in Altvater 2008:348). Marxian class-based explanations, which expose the social mechanisms of exploitation, have been completely marginalised. Although it has been generally accepted that income inequality leads to health inequality, the causes of income inequality have not adequately been researched. The focus has simply been on establishing an empirical relationship between income inequality and health, or on countering the effects of the former on the latter, rather than countering the cause of income inequality itself. The social production of health inequality has to be understood in this historical context of the emergence of a new drive of capital accumulation led

by international finance capital. The first part of the paper looks at health inequality as present. In the next section, Wilkinson's model of social cohesion (and social capital), which is currently under debate as an alternative to the prevalent paradigm of research in health inequality, is discussed. This paper exposes its inherent affinity to the philosophy of individualism. Prevalent public health policy, which is rooted in the neoliberalism, only serves to perpetuate these inequalities and in doing so, reverses public health logic and history. The last section is conclusion.

HEALTH INEQUALITY AT PRESENT

Health inequality is not a new area of research, but it came into focus very sharply after the publication of the Black Report in the United Kingdom.[1] The Black Report provided an impetus to the resurgence of a new interest in class inequalities in health. The idea was that class divisions and socio–economic inequalities were becoming less important as a consequence of the establishment of the welfare state and the increasing volume of protective and regulatory legislation. It was also based on the understanding that having undergone an epidemiological transition, diseases in the developed world were, in a sense, less dependent on environmental factors, unlike pre-transition communicable diseases.

Since the publication of the Black Report, a plethora of literature has been published on the income and health inequality linkage. A study have noted a steep increase during the last ten years in the number of research articles per month that show social class, socio-economic factors, income, or poverty as descriptors of health inequality.[2] In recent years,[3,4,5]using survey data, have focussed on relative differences particularly in terms of income inequality and health experience. *An Independent Inquiry into Health Inequalities* was commissioned by the incoming Labour Government of 1997 in the U.K. to review the evidence available on health inequalities with the aim of informing and identifying future policy development. The product of this inquiry, the *Acheson Report* referred to as the 'Second Black Report' was to review the findings of the Black Report, but contained no reference to the cost of health services. Instead, the Acheson Report highlighted the need for increased prioritization of family health services, especially those of children and recognized that 'healthcare had a relatively small role to play in addressing social gradients in health'.[6] The report made specific recommendations that steps be taken to reduce income inequalities and improve living standards of poorer households. Michael Marmot, a member of the Acheson Report observes: 'we took the view that as a scientific group we were charged, as stated in our terms of reference, with 'identifying priority areas for future development', not with telling the finance minister at which level to set the rate of taxation and benefits[ii] (Marmot quoted in Exworthy 2002: 181).

The vagueness of the recommendations gave large scope for interpretation even as it has been translated into individualized policies. In short, while the Inquiry can identify that in less egalitarian societies, those at the bottom of the social order are more likely to experience ill health or even behave in certain ways, it says little about why or how this happens; nor do they expose any underpinning dynamics, which may determine health inequalities.[7]

Many other researchers have come up with a number of empirical studies supporting the negative correlation between income and mortality. A study of fifty-six countries finds an association between income inequality and infant mortality, life expectancy at birth and at the age of five, after considering Gross National Product (GDP).[8] A study investigated fifty-nine countries - mainly developing ones-and found that income distribution was related to infant mortality after controlling for a variety of factors.[9] Another study reported that the share of national income going to the bottom 20 per cent of the population was related to average age at death in a group of seventeen developed countries after controlling for the GDP and public and private expenditure on health care.[10]

The question of why health inequalities exist has led to a considerable amount of empirical work and of a great deal of theorising. The empirical evidence that has been mobilised and studied is truly vast and goes from survey data to a range of other variables

as disparate as crime statistics and voting behaviour[iii] (Wilkinson quoted in Marmot and Wilkinson 1999). The integration of these survey data with psycho-social theories has emerged as one of the most popular and dominant methodological approaches[iv] (Elstad quoted in Bartley, Blane and Davey-Smith 1998). Indeed in the 1990s, 'the psychosocial hypothesis became conventional wisdom'[6] as Richard Wilkinson and other investigators in Europe and the United States, built an original research programme on social inequalities in health.

WIKINSON's MODEL OF SOCIAL COHESION

Richard Wilkinson in his 1996 book, *Unhealthy Societies* contends that income inequality produces social disorganisation (or lowered social cohesion), which leads, in turn, to lower average national health status. Although the relationship between income inequality and health is backed by many empirical studies, the role of social cohesion as a mediator of this relationship is a relatively untested hypothesis. Wilkinson arrives at this explanation after reviewing a large body of research on social relations and health across several disciplines, including epidemiology, sociology, political science, anthropology, and behavioural neuroscience.

Contemporary seminal social theorists who placed social capital in a theoretical context were: Glenn Loury, Pierre Bourdieu and James Coleman. Economist Glenn Loury[11] identified social capital as a potential explanation for variations in characteristics of human capital, where an individual or group's place in society was affected by social forces. French Sociologist Pierre Bourdieu[12] emphasized reciprocality and institutionalization of relationships as being important; he also advocated social status as a central element of social capital, as opposed to trust. And American Sociologist James Coleman[13] staunchly upheld that social capital belonged to social structures—not individuals. Though, they produced quite distinct formulations of the concept of social capital.

Wilkinson draws upon Robert Putnam's concept of 'social capital' from his 1993 book, *Making Democracy Work* on regional governments in Italy[14], where he tried to continue with the legacy of James Coleman but Putnam in his later book *Bowling Alone*, however, has sharply distinguished his position from that of Coleman and has shown how it is possible to improve the quality of life in general, and health status in particular, by increasing social cohesion within a community.[15]

Wilkinson's model of 'Income Inequality and Social Cohesion' provides a sociological alternative to former models, which emphasize poverty, health behaviour and cultural aspects of social relations as determinants of population health. Most research on income and health prior to Wilkinson's model of social cohesion, primarily focussed on the effects of poverty on personal attributes such as the so-called culture of poverty, genetic or racial inferiority, low self-esteem, lack of 'values', inability to delay gratification[16,17] etc. However Wilkinson's study on income inequality confirms that behavioural risk factors (e.g. smoking) are minor determinants of the social gradient in mortality.[18] Further, Wilkinson's analysis of developed capitalist countries that have gone through the epidemiologic transition (e.g. Europe, Japan, The United States, Canada, Australia) shows that population health is strongly associated with the distribution of income, even after taking into account the age structures of population, their mortality patterns, average disposable personal income, absolute levels of poverty, smoking, racial differences and the provision of health services.

Nevertheless, Wilkinson's model suffers from some serious drawbacks. Policies flowing from this model therefore need to be regarded with some caution. One of the strongest criticisms of Wilkinson's model has been made by Muntaner and Lynch.[19] They argue:

> *The model ignores class relations, an approach that might help explain how income inequalities are generated and account for both relative and absolute deprivation. Furthermore, Wilkinson's model implies that social cohesion rather than political change is the major determinant of population health. Historical evidence suggests that class*

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formation could determine both reductions in income inequality and increases in social cohesion. Drawing on recent examples, the authors argue that an emphasis on social cohesion can be used to render communities responsible for their mortality and morbidity rates: a community level version of "blaming the victim".

Since income inequality, an indicator of social stratification is a strong predictor of mortality and morbidity rates, a model of social inequalities in health should address the social mechanisms that generate income inequality in the first place.[20] In Wilkinson's analysis, it is the receipt of income that is important, not the way income is generated. In this way, the model linking income inequality, social cohesion, and health is based on how income is used to consume various social goods rather than on how income results from particular production relations.[18] David Coburn,[21] in his critique of Wilkinson's model notes:

There is a particular affinity between neo-liberal (market-oriented) political doctrines, income inequality and lowered social cohesion. Neo-liberalism … produces both higher income inequality and lowered social cohesion. Part of the negative effect of neo-liberalism on health status is due to its undermining of the welfare state. The welfare state may have direct effects on health as well as being one of the underlying causes of social cohesion. The rise of neo-liberalism and the decline of the welfare state are themselves tied to globalisation and changing class structures of the advanced capitalist societies. More attention should be paid to understanding the causes of income inequalities and not just to its effects because income inequalities are neither necessary nor inevitable.

David Coburn further observes:

The absence of any concept of 'the social' in neo-liberalism is related to the neo-liberal practice of universalising market characteristics to all areas of human existence. Even 'the self' comes to be viewed in terms of 'its' usefulness in the market as an instrument of 'economic' advancement. Social development or even 'social capital' becomes individual 'human capital'. The neo-liberal vision is individualistic rather than collectivist or communitarian. There is a stark divide between collectivist views of society (including the notion that goods can be held 'in common') and market ideology. Thus, the first act of many contemporary neo-liberal regimes has been to 'privatize state organisations or functions' and those that might be said to have been included in 'the commons'. (ibid.141-142)

The omission of class analysis seriously limits Wilkinson's model. Class analysis provides a more encompassing framework than the 'income inequality and social cohesion model'. The task of class analysis is precisely to understand not only how macro structures (e.g. class relations at the national level) constrain micro processes (e.g. interpersonal behaviour) but also how micro processes can affect macro structures (e.g. via collective action). The theories of social stratification and class analysis seek to explain how relational positions in a social system (social formation in neo-Marxian terminology) generate income inequalities.[22] Different positions in production relation (e.g. moneylender, property owner, manager, and worker) generate various sources of income and wealth (e.g. much greater income can be generated from the position of manager than that of worker). Although any class location can receive low income e.g. there are many poor business owners,[23] high income and wealth are overwhelmingly associated with capital ownership in capitalist economic systems.[24]

Marxian class-based explanations are preferable because they expose the social mechanisms of exploitation in a way that income distribution models cannot. In this way, Marxian class analysis of the labour process goes even deeper than Weberian class analysis, as the former links exchanges in the labour market and production through the concept of exploitation, while the latter keeps labour market

exchanges and production separate.[22] Such a Weberian approach is evident in dominant social epidemiology, where research into the health effects of work stress and work organization is conceptualized as independent of social class.[25] Thus Wilkinson's model:

> *Presents itself as an alternative to materialist structural inequalities (class, gender, and race) and invokes a romanticized view of communities without social conflict that favours an idealist psychology over a psychology connected with material resources and social structure. The evidence on social capital as a determinant of better health is scant and ambiguous. Even if confirmed, such hypotheses call for attention to social determinants beyond the proximal realm of individualized socio-psychological infrastructure. Social capital is used in public health as an alternative to state-centred economic redistribution and party politics, and represents a potential privatization of both economics and politics.*[26]

The problem of disregarding class structures in society and the consequent undermining of the role of the state and political change have already been discussed. What needs to be emphasised along with it is that firstly, as Muntaner and Lynch observed, the concept of social cohesion itself has serious problems, both conceptually and empirically. For instance, Nazi Germany was a very cohesive society with a strong sense of togetherness and even a denial of class divisions. So, social cohesion, *per se* cannot be chosen as an ideal goal. Moreover, the enormous decline in health indicators in the former Soviet Union cannot be attributed to only a collapse of its social cohesion. Furthermore, societies and communities can be highly cohesive, while reproducing exploitative relations.

Secondly, current indicators of social cohesion use middle-class standards of collective action, which working class communities might not be able to meet. An erroneous characterisation of working class communities as non-cohesive could be used as a justification of paternalistic or punitive social policies. For instance, Christopher Hamlin has shown that the public health successes in the first half of the nineteenth century Britain were not the result of social capital nor indeed due of the actions of supposedly enlightened business men like Joseph Chamberlain, but the result of social conflict, including class conflict.[27]

Thirdly, it hardly needs remarking that the social capital/social cohesion formulations of Wilkinson and colleagues, is remarkably analogous to the 'the culture of poverty' hypothesis popularised by Oscar Lewis.[28] The 'culture of poverty' intended to apply only to market-organized social structures with poorly developed public systems of health, welfare and income maintenance. Lewis argued that human existence in any given environment involves a process of biological and social adaptation which gives rise to the elaboration of a structure of norms, ideas and behaviour. This culture overtime acquires an integrity and stability because of the supportive role it plays in helping individuals to understand and cope with their environment but, through its influence on socialization practices and the like, it also comes to have an important autonomous influence in the social consciousness of individuals. The integrity of the culture ensures its autonomous survival even the material base from which it emerged has changed or been modified.Consequently, the implication of social capital/social cohesion hypothesis for public health is that, communities may be seen as responsible for their crime rates[29] or aggregated health rates, an idea that justified the privatisation of health services, such as managed care.[30] After all, if they are not an integral part of theories of health inequalities and are so difficult to change, then perhaps an achievable alternative is to retreat to mass psychotherapy for the poor to change their perceptions of their place in the social hierarchy.[31]

The problem with subjectivity as an explanation for health inequality is not only that it has little empirical evidence but also that it may not yield

egalitarian public health policies.[32,19] Policy outcomes that arise may not be the ones desired by any proponent of the social capital/psychological environment approach to health inequalities or for that matter, by any one in the broader public health community.

Finally, the idea of social cohesion championed by so many communitarians in the USA often falls into the trap of narrow associationism. Alexis de Tocqueville in *Democracy in America* displayed a sharp and critical view, for example, when reflecting on the individualism and self-sufficiency that is so dear to communitarians. 'Individualism', he wrote, 'is a mature and calm feeling, which disposes each member of the community to sever himself from the mass of his fellows and to draw apart with his family and his friends, so that after he has thus formed a little circle of his own, he willingly leaves society at large to itself.[33] This sentence highlights the perils of narrow associationism, or a negative effect of social capital that is largely absent from current public health and social policy debates. Thus, social capital may become only an extended (in the sense of a narrow association of few individuals like family and friends) version of individualism.

CONCLUSION

The idea of social cohesion which appears to challenge the dominant neo-liberal praxis in public health is, in reality, an extension of 'moral individualism'. The stress on community participation serves only to shift the focus away from the state to the community and thereby curb any demand for structural change that could reorganise society and address the issue of income inequality that lies at the root of health inequality. Individualism continues to hold sway in the new garb of social capital. Under the new model, the real shift has been only that of 'community blaming' in place of individual 'victim blaming'. The attainment of better health status becomes the responsibility of the community as a whole through such measures as better social cohesion and solidarity. The state has no role to play and there is no space for macro structural change. Thus, a meaningful discourse on public health is part of a political exercise and the search for an alternative holistic vision must retain its political and social content, which has also been a striking legacy of public health.

REFERENCES

1. Department of Health and Social Security (1980): Inequalities in Health: Report of a Working Group, Chaired by Sir Douglas Black (London: Department of Health and Social Security).
2. Lynch, J and GA Kaplan (1997): 'Wither Studies on the Socio-economic Foundations of Population Health?', American Journal of Public Health, Vol. 87:1409-1411.
3. Townsend, P, N Davidson and M Whitehead (1992): Inequalities in Health: The Black Report and Health Divide, (London: Penguin).
4. Acheson, D, et al (1998): Independent Inquiry into Inequalities in Health, (London: Stationery Office).
5. Whitehead, M (1988): The Health Divide, (London: Penguin).
6. Asthana, S and J Halliday (2006): What Works in Tackling Health Inequalities, Pathways, Policies and Practice through the Lifecourse, (Bristol: The Policy Press University of Bristol).
7. Popay, J, G Williams, G Thomas and AC Gartell (1998): 'Theorizing Inequalities in Health: The Place of Lay Knowledge', in M Bartley, D Blane and G Davey-Smith Eds (1998): The Sociology of Health Inequalities, Sociology of Health and Illness Monograph Series (Oxford: Blackwell).
8. Rogers, GB (1979): 'Income and Inequality as Determinants of Mortality: An International Cross-Section Analysis', Population Studies, Vol. 33: 343-51.
9. Flegg, AT (1982): 'Inequality of Income, Illiteracy and Medical Care as Determinants of Infant Mortality in Underdeveloped Countries', Population Studies, Vol. 36: 441-58.
10. Le Grand, J (1987): 'Inequalities in Health: Some International Comparisons', European Economic Review, Vol. 31:182-91.
11. Loury, G (1977): 'A Dynamic Theory of Racial Income Differences', in P.A. Wallace and A. LeMond Eds Women, Minorities, and Employment Discrimination, (Lexington, MA: D.C. Heath).
12. Bourdieu, P (1986): 'The Forms of Capital', in J Richardson Ed Handbook of Theory and Research for the Sociology of Education, (Westport CT: Greenwood Press).

13. Coleman, J (1988): 'Social Capital in the Creation of Human Capital', American Journal of Sociology, Vol. 94: S95-120.
14. Putnam, RD (1993): Making Democracy Work: Civic Traditions in Modern Italy, (New Jersey: Princeton University Press).
15. Putnam, RD (2000): Bowling Alone: The Collapse and Revival of American Community, (New York: Simon and Schuster).
16. Lynch, J, et al (1998): 'Income Inequality and Mortality in Metropolitan Areas of the United States', American Journal of Public Health, Vol. 88: 1074-80.
17. Muntaner, C, J Nieto and P O'Campo (1997): 'Additional Clarification Re: The Bell Curve: On Race, Social Class, and Epidemiologic Research', American Journal of Epidemiology, Vol. 146: 607-08.
18. Wilkinson, RG (1996): Unhealthy Societies: The Afflictions of Inequality, (London and New York: Routledge).
19. Muntaner, C and J Lynch (1999): 'Income Inequality, Social Cohesion, and Class Relations: A Critique of Wilkinson's Neo-Durkheimian Research Programme', International Journal of Health Services, Vol. 29: 59-81.
20. Muntaner, C and PE Parsons (1996): 'Income, Stratification, Class, and Private Health Insurance: A Study of the Baltimore Metropolitan Area', International Journal of Health Services, Vol. 26: 655-71.
21. Coburn, D (2000): 'Income Inequality, Social Cohesion and the Health Status of Populations: The Role of Neo-Liberalism', Social Science and Medicine, Vol. 51: 135-46.
22. Wright, EO (1997): *Class Counts, Comparative Studies in Class Analysis*, (New York: Cambridge University Press).
23. Muntaner, C and J Stormes (1996): 'Social Class and Behaviour', Psychological Report, Vol. 79: 379-82.
24. Edwards, RC, M Reich and TE Weisskopf (1986): The Capitalist System, (Englewood Cliffs, New Jersey: Prentice-Hall).
25. Karasek, RA and T Theorell (1996): Healthy Work: Stress, Productivity and the Reconstruction of Working Life, (New York: Basic Books).
26. Muntaner, C, J Lynch and G Davey-Smith (2001): 'Social Capital, Disorganized Communities, and the Third Way: Understanding the Retreat from Structural Inequalities in Epidemiology and Public Health', International Journal of Health Services, Vol. 31: 213-37.
27. Hamlin, C (1998): Public Health and Social Justice. In Age of Chadwick 1800-1884, (Cambridge: Cambridge University Press).
28. Lewis, O (1967): The Children of Sanchez, (New York: Random House).
29. Sampson, RJ, SW Raudenbush and F Earls (1997): "Neighbourhoods and Violent crime: A Multilevel Study of Collective Efficiency", Science, Vol. 277: 918-924.
30. Stoto, MA (1999): 'Sharing Responsibility for the Public's Health', Public Health Report, Vol. 114: 231-35.
31. Proudfoot, J and D Guest (1997): 'Effects of Cognitive Behavioural and Training on Job-Finding among Long Term Unemployed People', Lancet, Vol. 350: 96-100.
32. Muntaner, C, J Lynch and G Oates (1999): 'The Social Class Determinants of Income Inequality and Social Cohesion', International Journal Health Services, Vol. 29: 699-732.
33. Tocqueville, A de (1998): Democracy in America, translated by H Reeve (Wordsworth Classics of World Literature).

Notes

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[i] Margaret Thatcher quoted in E Altvater (2008): 'The Roots of Neoliberalism', in L Panitch and C Leys Eds *Socialist Register 2008*, *Global Flashpoints: Reactions to Imperialism and Neoliberalism*, (New Delhi: Leftword Books).

[ii] Marmot quoted in M Exworthy (2002): 'The 'Second Black Report'? The Acheson Report as Another Opportunity to Tackle Health Inequalities', *Contemporary British History*, Vol. 16: 175-197.

[iii] Wilkinson quoted in MG Marmot and RG Wilkinson Eds (1999): *Social Determinants of Health*, (Oxford: Oxford University Press).

[iv] Elstad quoted in M Bartley, D Blane and G Davey-Smith Eds (1998): *The Sociology of Health Inequalities*, *Sociology of Health and Illness*, Monograph Series (Oxford: Blackwell).