Health Inequalities, Social Cohesion and Social Capital

An Exploration

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This paper claims that the roots and remedies of health inequalities reflected in the major academic debates that culminated with full force towards the turn of the last century, have done little to usher in a radical change in public health discourse. There has been a hesitation to understand health inequalities in a holistic fashion, which has led to the formulation of individual centric remedies and prevention. Even Wilkinson's theory of social cohesion, modelled in the Durkheimian tradition of moral individualism 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. A genuine desire to make people live longer and healthily cannot be dissociated from the larger need to question and reorganise class structures. In the dominant paradigm of public health however, the focus has always been on the individual responsibility for self-care. Relegating to the background, the larger social, cultural and economic context in which lifestyles are adopted, public health policies have continuously harped on behaviour modification.

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I

Introduction

A new bourgeois class nurtured by the neo-liberal ideology emerged at the time of the Industrial Revolution. This economically empowered bourgeoisie broke free from the fetters of feudalism and a new capitalist order evolved. The new social order was equally capable of extending both freedom and unfreedom and of simultaneously reducing one set of risks to human welfare and survival while increasing others. Thus, what brought emancipation and welfare to one set of people, resulted, at the same time, in a degradation of the quality of life experienced by another set of people. The primacy of the individual over society meant that the causes of inequality and deprivation were located within the individual and his capability or incapability to reap the fruits of the capitalist system. Issues of equity and the responsibility of the state to ensure equity were seen as irrelevant and antithetical to the ideology of capitalism.

The social production of health inequality as shaped by neo-liberalism has to be understood in this historical context of the emergence of a new capitalist order. In this neo-liberal era, shaped by the philosophy of Methodological Individualism (hereafter MI), 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 hardly 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. The first part of the paper looks at precisely this proposition. The Black Report brought to the surface the issue of health inequalities and tried to provide an explanatory framework, but the research that ensued in its wake confined itself largely to the descriptive level. In the next section, Wilkinson's model of social cohesion (capital too), which is currently in debate as an alternative to the prevalent paradigm

of research in health inequality, is discussed in detail, exposing its inherent affinity to the philosophy of individualism. The contention of this paper is that income inequalities with their genesis in class structures have led to health inequalities. Prevalent public health policy, which is rooted in the neo-liberal philosophy of MI, only serves to perpetuate these inequalities.

II

Black Report: A Resurgence of the Debate on Health Inequalities

Health inequalities are not a new area of research, but it came into focus very sharply after the publication of *The Black Report* in Britain in 1980.[1] This report is part of a long tradition in Britain of public health interest in socio–economic conditions and health, and of competing explanations for observed differences in health indices by social class. In the second half of the 19th century, Edwin Chadwick, William Farr, John Snow and Engels demonstrated that the poorer sections of the community were more likely to suffer from diseases and early death. The use of social class as a tool to examine mortality differences can be traced as far back as 1887 in the works of Noel Humphreys, who was an Assistant Registrar General. He argued that:

> The time has come… when it is urgently desirable that we should know more of the rates of mortality prevailing in the different strata of society. It is accepted as a fact, and it is apt to be regarded as inevitable, that the death rates of the poor and the rich are divergent; and Medical Officers of Health are constantly expressing their helplessness in dealing with the excess of mortality in their districts partly due to the poverty and partly to the manner of life of the poorer of the working classes. The want of trustworthy statistics of class mortality is therefore generally felt by all who are seeking solutions to some of the most interesting social and political problems of the day, as well as by that smaller class called upon to study vital statistics simply from a public health aspect.[2]

The role of class variation in causing disease and early death was not disputed; but the reasons for this were disputed. In the latter half of 19th century and the early part of the 20th century, there were different kinds of debates between hereditarians (those who believed that people's social positions were consequent to biologically determined inherited natural abilities) and interventionist public health doctors (who believed that "the pestilential material conditions of urban industrial life endured by the labouring masses must be handicapping, independent of inherited constitution").[3] These debates had their counterparts in the United States, where there was a tension between those who saw the poverty/poor health link as being due to inherited (or acquired, behavioural) characteristics, and those who saw it as owing to poor living and working conditions.[4]

In Britain, Stevenson, the Registrar General produced mortality statistics by social class which consistently showed an inverse relation between social position and mortality.[5,6] Social class has been a less popular topic in the United States at least since George III, but mortality statistics show a similar inverse relation between measures of socio–economic status and mortality.[7,8] Both in the United States and Britain, despite overall decline in death rates, socio–economic disparities in mortality rates have been increasing in the last decades of the twentieth century.[9,10] Huge international evidence continues to accumulate documenting the inverse relationship between socio–economic status and health. The Black Report, which is considered a milestone, provided an impetus to the resurgence of a new interest in class inequalities in health. This was of course primarily due to the fact that over this period of

neo-liberal economic reforms globally, income inequalities between and within countries increased sharply.

Prior to the Black Report, it was a widely prevalent notion that contemporary British society was more egalitarian than in the past. The preconceived notion was that class divisions and socio–economic inequalities were becoming less important. This assumption was based on the nature of 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. Thus, the so-called life style diseases were more related, it was believed, to individual behavioural and genetic factors. As a result, social epidemiology was considered less relevant as an explanatory model.

In 1980, the Black Report questioned the prevalent notion of so-called equality. It not only drew attention to very large differences in death rates between occupational classes but it also suggested that these differences were not declining.[11]

Table-1

Mortality by Social Class 1931–1981 (Men, 15-64 Years, England Wales)

Class	1931	1951	1961	1971	1981
Professional	90	86	76(75)	77(75)	66
Managerial	94	92	81	81	76
Skilled Manual & Non Manual	97	101	100	104	103
Semi Skilled	102	104	103	114	116
Unskilled	111	118	143 (127)	137 (121)	166

Source: DHSS (1980) Table 3.1, as in Wilkinson (1986) Class and Health, Research and Longitudinal Data (Tavistock Publication) London and New York.

Notes: 1) To facilitate comparisons, figures shown in parentheses have been adjusted to the classification of occupations used in 1951. Men, 20–64 years, Great Britain.

2) Figures are SMRs - which express age–adjusted mortality rates as a percentage of the natural average at each date.

From the above table, it can be seen that the mortality differentials, as measured by age-standardized death rates for occupational classes, have increased since the sixties. Of these, absolute mortality rate increase is observed to be highest for unskilled labourers.

The Black Report, has been summarised by Macintyre into three main components: a *description* of differences between occupational classes in mortality, morbidity and use of health services, trends in these over time, and comparisons with other industrial countries; an *analysis* of likely explanations for these inequalities; *recommendations* for further research

and for a broadly based strategy to reduce health inequalities or to reduce their consequences.[12]

The descriptive component of the report, as stated earlier found higher level of mortality and morbidity among lower occupational and social classes. The most interesting part of the report, however, was the set of explanations offered for the social class differences in mortality.

Explanations for Social Class Differences in Mortality

Macintyre has shown that the report divided possible explanations for health inequalities into four main categories: artefact explanations; theories of natural and social selection; materialist or structural explanations; and cultural or behavioural explanations. There are two versions of each of these types of explanations; the "hard" version and the "soft" version.

Artefact Explanations: The report itself considers the artefact explanations, noting the following:

> This approach suggests that both health and class are artificial variables thrown up by attempts to measure social phenomena and that the relationship between them may, itself be an artefact of little causal significance.[13]

This view of class inequalities is the "hard" version of explanation where there is no real relationship between class and health. Indeed many proponents of this view may well argue that social class itself is an abstraction, not easy to define and more difficult to measure empirically. Therefore, according to this view, the association between health and class arises due to some statistical problems. The Working Group (which compiled the Report) modified and further explained:

> Accordingly, the failure of health inequalities to diminish in recent decades is believed to be explained to a greater or lesser extent by the reduction in the proportion of the population in the poorest social classes.[14]

This explanation, the "soft" one, takes into cognisance social class inequalities in health, but does not attempt to analyse the cause of such inequalities. The implications for health of different material and social experiences of individuals, classes, and local communities were yet to be disentangled and exactly quantified. Indeed this shortcoming in the capacity to analyse the reasons for the unequal distribution of health in populations represented, and continues to represent, a major research challenge for all the sciences concerned with health.

Natural/Social Selection: The Report's "natural selection" model, as Macintyre noted, has its roots in the Darwinian view of natural selection and social class as espoused at the beginning of this century by hereditarians such as Galton:

> Occupational class is here relegated to the status of a dependent variable and health acquires the greater degree of causal significance. The occupational class structure is seen as a filter or sorter of human beings and one of the major bases of selection is health, that is, physical strength, vigour or ability.[15]

This view implies that contrary to the "hard" version of the artefact explanation, there is a real relationship between class and health, but health determines class position and not vice versa. In other words, this implies that those who are unhealthy remain poor and not that those who are remain unhealthy, turning the causal explanation upside down. "Natural" here has two interesting connotations: "natural" meaning biologically based (as in "the natural world"), and "natural" meaning morally neutral, something about which there is no inequality or unfairness (male/female differences in life expectancy are often seen as being "natural" in both these senses).[16] This "hard" version of selection thus "explains away" observed inequalities in health by occupational class as being nothing meriting social concern or collective intervention.

Materialist/Structural Explanation: This explanation emphasises "the role of economic and associated socio–structural factors in the distribution of health and well being".[17] As the Working Group noted, this position is frequently misunderstood partly owing to confusion between "materialist" and "material" factors. The "hard" version is that physical, material conditions of life, which are determined by occupational class position, produce class gradients in health and death, and that relative deprivation in income and wealth produces relative deprivation in health and longevity. This treats the main correlate of the occupational classification, and the one that directly influences health, as being income and wealth, as implied in Titmuss's 1943 description on the basis of the occupational class classification.[18]

The "soft" version is that the conditions of life, which are determined by occupational class position, and which may influence health and longevity, include psychological as well as physical factors, and social as well as economic capital.

Occupational class is multifaceted in "advanced" societies and apart from the variables most readily associated with socio–economic position – income, savings, property and housing– there are many other dimensions, which can be expected to exert an active causal influence on health. People at work for instance, encounter different material conditions and amenities, levels of danger and risk, degree of security and stability, association with other workers, levels of job satisfaction and physical and material strain. These other dimensions of material inequality are also closely associated with another determinant of health, namely education.[19]

As Macintyre suggests, this view is reflected in the Working Group's emphasis on education, and is similar to Stevenson's basis for developing the social class classification, i.e. that culture as well as wealth or poverty contribute to class differences in mortality.

Cultural/Behavioural Explanation: The "hard" version of this explanation is as follows:

> A fourth approach is that of cultural or behavioural explanations of the distribution of health in modern industrial society. These are recognisable by the independent and autonomous causal role, which they assign to ideas and behaviour in the onset of disease and event of death. Such explanations, when applied to modern industrial societies, often focus on the individual as a unit of analysis emphasizing unthinking, reckless or irresponsible behaviour or incautious life style as the moving determinant of poor health status. Explanation takes an individual form.[20]

This recalls both views about irresponsibility commonly expressed in debates about infant mortality around the turn of the century, and about personal responsibility for health prevalent in the mid 1970s.[21,22] However, the Working Group then discussed a more socially (rather than individually) based model of health related behaviours:

> Others see behaviour, which is conducive to good or bad health as embedded more within social structures; as illustrative of socially distinguishable styles of life, associated with, and reinforced by, class. [23]

Noting this, the Group further discusses the role of the education system in reinforcing and maintaining the class structure of Britain.[24]

In the "hard" version of explanation, there are class gradients in health and length of life but there is more emphasis on health damaging behaviours (smoking, poor diet, inappropriate use of health services etc.) The idea enshrined in such an explanation is that the genesis of health inequalities can be explained in terms of individual behaviour and its class location.

The soft version is that certain health damaging behaviours have a social class gradient and that this contributes to the social class gradient in ill health and early death. Smoking, poor diet, lack of recreational exercise etc. are more prevalent among the lower occupational class groups and these behaviours compromise health. In this "soft" version, behaviours do not explain away class differences, but contribute to them, and push the explanatory task further back to ask why such behaviours are persistently more common in poorer groups.

III

Recommendations for Policy

The Working Group gave third priority for "preventive and educational action to encourage good health", involving both collective action (e.g. banning tobacco advertising, and creating safer conditions of work) and individually directed health education ("we recommend that a greatly enlarged programme of health education, with a particular emphasis on schools, should be sponsored by the government").[25] They have emphasised "the health effects of such aspects of what can be regarded as individual behaviour as smoking, diet, alcohol consumption and exercise"[26], which suggests that they were not completely rejecting the role, such behaviours might play in the genesis or maintenance of inequalities.

It was probably both politically and scientifically important for the Working Group to pre-empt possible rejections of significance of observed inequalities in health by raising and, then rejecting, the "hard" version of the artefact, selection and behaviour explanations. All these had so far been used to justify the lack of public policies to reduce inequalities in health. The debates in the late 19th century and early 20th century between the hereditarians and environmentalists, or between the latter and those who attributed high infant mortality rates to defective maternal behaviour, lived on into the 1970s and 1980s. The Working Group, which took an essentially environmentalist position, was doubtless correct in assessing that it had to tackle these potential criticisms head on.

However, despite the provisional or general nature of the evidence then available, the Black Report drew unequivocal conclusions about the direction of that evidence. They found that material deprivation played the major role in explaining the very unfavourable health record of the poorer sections of the population (especially of the partly skilled and unskilled manual groups making up more than a quarter of the entire population), with biological, cultural, and personal life-styles factors playing a contributory role. This conclusion carried a powerful implication for the construction of policy. The elimination or reduction of material deprivation, and not just the organisation of more efficient health care services, had to become a national objective for action in England. Low wages and minimum social security

and child benefits had to be raised as part of a strategy to lift low incomes. Poor housing and environmental conditions had to be tackled.

IV

Empirical findings on health inequalities

Since the publication of the Black Report, a wealth of literature has been published on the income and health inequality linkage. Lynch and Kaplan[27] 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. Although the relevance of class analysis (e.g. pragmatic, functionalist, neo-Weberian, or neo-Marxist) is still debated in epidemiology (along with other forms of research on social inequalities such as those due to gender, race or ethnicity, age, migration, or sexual orientation), the growing evidence of an increasing polarization of the United States' social structure in terms of gradational measures of class (i.e. income, wealth),[28,29] has become difficult to ignore.

In recent years, Townsend and Davidson[30], Acheson[31], Whitehead[32], using survey data, have focussed on relative differences particularly in terms of income inequality and health experience. These studies reveal that relative income distribution in developed societies is positively correlated with negative health outcomes - the "egalitarian wealth thesis" (Wilkinson[33], Blane, Brunner, and Wilkinson[34]). The use of survey data has, however, been critiqued as revealing everything about health inequalities without revealing very much at all.[35] While these 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, they explain little about why or how this happens nor do they expose any underpinning dynamics, which may determine health inequalities.[36]

Many other researchers have come up with a number of empirical studies supporting the negative correlation between income and mortality. Rogers[37] used data for fifty-six countries to find an association between income inequality and infant mortality, life expectancy at birth and at the age of five, after considering Gross National Product. Flegg[38] investigated fifty-nine countries mainly developing ones and found that income distribution was related to infant mortality after controlling a variety of factors. Pampel and Pillai[39] questioned the relative importance of income inequality. They found some association with infant mortality among eighteen developed countries and showed that it was not a statistically significant determinant, when they adjusted for a number of other factors. Le Grand[40] 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 Gross Domestic Product (GDP) and public and private expenditure on health care.

The question of why health inequalities exist has led to a considerable extent of work, drawing upon survey data and theories to consider a range of other variables as disparate as crime statistics and voting behaviour.[41] The integration of these survey data with psychosocial theories has emerged as one of the most popular and dominant methodological approaches.[42] In 1990s, Wilkinson and other investigators in Europe and the United States built an original research programme on social inequalities in health.[43]

V

Wilkinson's Model of Social Cohesion

The main thrust of the programme's empirical studies involves correlations between national mortality and morbidity rates and national measures of income inequality (e.g. Gini

coefficient or the per cent share of total household income received by the least well-off 50 per cent of the population), which are typically strong[44,45] (Correlations range between 0.6 and 0.8). A second aspect of this research programme is the attribution of the effects of income inequality on population health, to the breakdown of social cohesion (e.g. cooperation, reciprocity, trust, civic participation), in the Durkheimian tradition of social anomie. Wilkinson contends that income inequality produces social disorganisation (or lowered social cohesion) which leads to lower average national health status. Although the relationship between income inequality and health is backed up by many empirical studies, the role of social cohesion as mediator of this relationship is mostly an 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). Recent work by Kawachi and colleagues[46,47] provides some empirical support for the idea that social cohesion (i.e., organization membership) mediates the effects of income inequality on health.

Wilkinson is however, sometimes equivocal about the direction of causality between income inequality and social cohesion. In places, he suggests that it is possible that social cohesion produces lower income inequality or that some form of highly cohesive community might "not permit" high levels of income inequality. Wilkinson also suggests that income inequality may directly produce both lowered social cohesion and lowered longevity, i.e. social cohesion might not be the mediator between income inequality and health status, but instead one of the results of income inequality.

Wilkinson draws upon Putnam's concept of "social capital" to show how it is possible to improve the quality of life in general and health status in particular by increasing the social cohesion within the community. Putnam says:

> By "social capital", I mean features of social life – networks, norms, and trusts – that enable participants to act together more effectively to pursue shared objectives…. To the extent that the norms, networks, and trust link substantial sectors of the community and span underlying social cleavages – to the extent that the social capital is of a bridging sort – then the enhanced cooperation is likely to serve broader interests and to be widely welcomed.[48]

An important contribution of Wilkinson's model of "Income Inequality and Social Cohesion" is that it provides a sociological alternative to former models, which emphasize poverty, health behaviour (such as smoking, overweight, drinking alcohol, using drugs, and being sedentary,[49,50] in particular among the poor[51]) and cultural aspects of social relations as determinants of population health. Most research on income and health in United States, prior to Wilkinson's model of social cohesion, primarily focussed on effects of poverty on personal attributes such as culture of poverty, genetic or racial inferiority, low self-esteem, lack of "values", inability to delay gratification[52,53] 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.[54] Further, Wilkinson's analysis of developed capitalist countries that have gone through the epidemiologic transition (e.g. Europe, Japan, The United States, Canada, Australia) show that population health is strongly associated with the distribution of income, even after taking into account average disposable personal income, absolute levels of poverty, smoking, racial differences and provision of health services.

However, Wilkinson's model, in spite of providing a sociological alternative to the strictly individualistic models of health inequality, suffers from some serious drawbacks and the policies flowing from the model need to be regarded with caution. One of the strongest criticisms of Wilkinson's model has been given by Muntaner and Lynch. 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 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." [55]

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.[56] 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.[57] David Coburn, 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.[58]

Wilkinson does accept that the image of society carried by the neo- liberals is that of voluntaristic "possessive individualism".[59] Wilkinson captures the idealised market in the notion of a "cash and keys" economy:

> Increasingly we live in what might be called a "cash and keys" society. Whenever we leave the confines of our own homes we face the world with the two perfect symbols of the nature of social relations on the street Cash equips us to take part in the transaction mediated by the market, while keys protect our private gains from each other's envy and greed… Although we are wholly dependent on one another for our livelihoods, this interdependence is turned from being a social process into a process by which we fend for ourselves in an attempt to wrest a living from an asocial environment. Instead of being people with whom we have bonds and share common interests, others become rivals, competitors for jobs, for houses, for space, seats on the bus, parking places… [60]

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". Privatization in fact means the individual ownership of what were once possessions or functions of the state as representative of society, or of those things that were previously viewed as the possession of everyone (including natural products, land etc.). The implication of targeted programmes in the neo-liberal regime is that the problem lies with individuals and families and not with the

structure of opportunities within society. In fact, Wilkinson remarks: "Indeed, integration in the economic life of society, reduced unemployment, material security and narrower income differences provide the material base for a more cohesive society".[61] But, unfortunately these issues are not raised in the Wilkinson's model. The "starting fact" for Wilkinson's model is that by some process (which he does not discuss) income is distributed unevenly and that this has consequences for health. Where Wilkinson differs from the aggressive individualistic agenda of the neo-liberal ideology is that he shifts the onus of welfare and good health from the individual to the community. This only facilitates the capitalist state's marginalisation from the sphere of ensuring welfare to its citizens. In the world of Wilkinson, in fact, the state absolves itself of all responsibility without even the sense of guilt that an aggressive individualistic policy might have bred. Thus, the main contribution of the social cohesion approach (read also social capital) to the psychosocial perspective is that it takes components of individual-centred approaches and develops them at the macro level.[62]

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 structure (e.g. class relations at the national level) constrains 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.[63,64] Different positions in production relation (e.g. moneylender, property owner, manager, and worker) generate various sources of income (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[65]), high income and wealth are overwhelmingly associated with capital ownership in capitalist economic systems.[66]

Central to Marxian class analysis is the concept of exploitation that provides a social mechanism for explaining how income inequalities are generated. The "classical" or "traditional" view of exploitation is of particular interest here because of the body of empirical tests to which it has been submitted.[67] Classical Marxism starts with a theory of value, the Labour Theory of Value, which leads to a theory of exploitation. In Marxian terms, class is defined as the process of producing, appropriating, and distributing surplus labour.[68] Labourers perform a certain amount of labour that is sufficient to produce the goods and services required to maintain their current standard of living (necessary labour). Nevertheless, labourers perform more than this necessary labour (surplus labour), which might be retained by labourers or, alternatively, might be appropriated by non-labourers (exploitation). Exploitation, thus, occurs when the class process involves appropriation of the surplus labour of labourers by non-labourers.[69]

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 the Weberian class analysis as the former links exchanges in the labour market and production through the concept of exploitation, while the Weberian class analysis keeps labour market exchanges and production separate.[70] Such a Weberian approach is evident in dominant social epidemiology, where research into the health effects of work stress and work organisation have been conceptualised as independent of social class.[71] Thus Wilkinson's model:

> …presents itself as an alternative to materialist structural inequalities (class, gender, and race) and invokes a romanticised 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 privatisation of both economics and politics.[72]

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. 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.

Thirdly, the social capital/social cohesion formulations of Richard Wilkinson and colleagues, is very much similar to the "the culture of poverty" hypothesis popularised by Oscar Lewis[73]. The culture of poverty turns upon the poor themselves holding their dearth of community ties and community heritage (i.e., social capital) as the main causes of their poor health status. Perceptions and subjectivity become all important, because it is not objective inequalities that ultimately determine the well-being of populations, rather, the subjective response to those inequalities, which affected individuals and groups can control. Consequently, one implication of the social capital/social cohesion hypothesis for public health is that, communities may be seen as responsible for their crime rates[74] or aggregated health rates, an idea that justified the privatisation of health services, such as managed care.[75] Another possible direction may be to take a step back from the structural sources of health inequalities.[76] 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 place in the social hierarchy.[77] Functionalist sociologist Warner revealed this idea in his book *Social Class in America*:

> The lives of many are destroyed because they do not understand the workings of social class. It is the hope of the author that this book will provide a connective instrument, which will permit men and women better to evaluate their social situation and thereby better adapt themselves to social reality and fit their dreams and aspiration to what is possible.[78]

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.[79,80] 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.

Fourthly, in spite of its severe limitations, Wilkinson's model should be appreciated for having addressed the lack of research on the psychological effects of inequalities. There is a substantial scholarship on the psychology of racism and sexism, but little research has been done on the effects of class ideology (i.e., classism). This asymmetry could reflect that in most wealthy democratic capitalist countries, income inequalities are perceived as legitimate,

while gender and race inequalities are not.[81] While Wilkinson uses Sennett and Cobb's classic *The Hidden Injuries of Class*[82] for his argument about his psychology of inequality, he fails to mention Sennett's new volume[83], which stresses the erosion of control over labour process even among persons of relatively high income (e.g. the rise of non-standard work arrangements, lack of control due to mechanisation). Attitudes about the causes of social inequalities, cast in terms of reductionist biological hypothesis (e.g. the inheritance of intelligence) or idealist lay psychology (e.g. self, effort, morality, responsibility, will power) pushes back the task of explaining health inequalities.[84]

Fifthly, Wilkinson is correct in stressing the need to explain the social psychology of health inequalities. Nevertheless, Wilkinson's social psychology neglects precisely the impact of social (economic, political, and cultural) relations on individual behaviour. A similarity can be noticed in his approach and interpersonal social psychology that was criticised by British Psychology more than twenty years ago.[85,86] That approach to social psychology was abandoned because it focussed on interpersonal behaviour without analysing the social relations that determine it. Populations are not just unrelated heaps of individuals, whose patterns of connections can be ignored. However, over simplified models of the pattern of connections among people may mask, not reveal, determinants of population health. For instance, strong links among individuals can both increase and decrease the risk of certain health outcomes. Tight connections among infants in a day-care centre may increase their risk of otitis media. In one context, strong friendships and networks of peers can increase the risk of smoking, drinking, or use of illicit drugs, while in others, they may decrease the risk of suicide. The way in which individuals and groups get connected to form friendship networks, neighbourhoods, communities and populations are very important in the public health perspective. The concept of social capital, in its present form, cannot provide an adequate basis to understand how these connections may be linked to population health. It appears that social capital has been under-theorized in its public health usage and that it is time to engage in serious debate about its definition, measurement, and application in public health research and practice. Discussion so far has rarely moved beyond the level of "bonding" social ties– the informal and more intimate connection between family members, friends, and neighbours. These are surely important, but it is also important to consider the bridging connections (to broader social networks) and linking social connections (to social institutions) that help to determine which individuals and groups have access to and control over resources and their health. This calls for a broad framework of appreciating the formal and informal connections among population subgroups, and how these individuals and groups are linked to social institutions (e.g. class based parties) and the state.

Sixthly, 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."[87] 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.

VI
Conclusions

It should be emphasised that the idea of social cohesion, which appears to challenge the dominant neo-liberal praxis in public health, is in reality, an extension of Durkheim's concept of "moral individualism". In effect, there is danger of its becoming a ploy in the hands of the bourgeoisie to perpetuate the status quo while creating an illusion of an alternative system. The stress on community participation serves only to shift the focus away from the state 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. Thus, methodological individualism, which has so far dominated the public health sphere, still 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, 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 state has no role to play and there is no space for macro structural change.

The public health researcher needs to seriously consider these issues. A fact that emerges through the discussions in this paper is that the growth of individualism and mechanicalism in public health, like in other social sciences cannot be traced without reference to the historical transition of political and social systems. 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.

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