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STRATIFICATION, CLASS AND HEALTH: CLASS RELATIONS AND HEALTH INEQUALITIES IN HIGH MODERNITY

GRAHAM SCAMBLER AND PAUL HIGGS

Abstract This paper starts from a critique of the dominant and largely empiricist paradigm within which sociologists have approached the relationship between social class and health. Referring to the transformational model of social activity and the relational model of society advanced by Bhaskar, the nature and reality of class relations and the preconditions for their theorisation are discussed. A neo-Marxist theory of class relations owing much to Clement and Myles is outlined. The relevance of this theory for a revised and more sociological consideration of health inequalities is then explored and some pointers offered for future empirical enquiry. The authors contend that this theory may throw some light too on the theoretical and political timidity medical sociologists characteristically show in their current research on health inequalities.

Key words: class as a 'real' phenomenon, health inequalities, operationalisations of class, revised agendas for studying health inequalities, theories of class relations.

In many respects dialogues and debates about social class have assumed a new salience and vigour in sociology in Britain and kindred societies as the twentieth century fades. This is due primarily to an increasing polarisation between those who insist on its continuing relevance – typically to understanding high or late modernity or processes of postmodernisation – and those who postulate a decline in its explanatory power – typically in relation to processes of postmodernisation or the advent of a new epoch of postmodernity. While there is some consensus around the pace of recent change, there is considerable dissensus about its nature and, if the views of some proponents of postmodernism are taken into account, about how, and even if, change might profitably be investigated (see Lee and Turner 1996).

It is not our object in this paper to comprehensively review analyses of social change in the last quarter of the twentieth century, or to set out and defend a particular stance on the modernity/postmodernity dichotomy. Rather, we shall engage with these literatures only when the statement and elaboration of our main thesis requires it. This thesis is that class retains its sociological potency and promise as a means of understanding the social world, but that fundamental revisions in the way we approach and theorise class are indicated. It follows that we reject any postmodern insistence on 'the deconstruction of class as a theoretical object'; nor do we accept the – understandable but premature – judgement that recent economic and political change has now secured 'the end of class as a historical subject' (see Hall 1997).

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In the first section we explain and detail the context in which our thesis was initially formed, namely, around the putative relationship between class and health (see Higgs and Scambler 1998). In the second, drawing on the work of Bhaskar, we consider the persistently neglected issue of the ontology of class. In the third, we offer some criticisms and suggest ways of revising established approaches to theorising and operationalising class. And in the fourth section, we attempt to show how our 'revised' understanding of social class might help illuminate the rather static, 'system-driven' (Scambler 1996) – and perhaps even 'degenerating' (Lakatos 1972) – research programme on health inequalities currently attracting most state and other funding in Britain (see Bartley *et al.*, 1998).

Social Class, Inequality and Health

The awareness of health inequalities in Britain, and of the salience of what have come to be called 'socio-economic factors' for understanding and accounting for them, dates at least from the seventeenth century. If the stresses on occupation, and later social class, are essentially twentieth-century phenomena, they certainly had nineteenth-century antecedents. For example, the General Register Office, founded in 1837, almost from its inception used data from occupation on death certificates and census information on numbers in each occupation to examine mortality rates amongst different groups of workers. Using these data, William Farr subsequently drew out some of the effects of particular industrial hazards. He also began to develop life tables based on the survival chances of different population groups, the use of which soon spread (Leete and Fox 1976).

It was not until 1911, however, that Stevenson constructed a means of grouping occupations into, initially, five social classes, plus three industrial classes, namely, textile workers, miners and agricultural workers, and utilised it to study infant mortality. The three industrial classes were integrated into the five main social classes by the time of the 1921 Census. These five classes were based on the inference of social position (mainly but by no means exclusively a matter of wealth or poverty, culture also having been taken into consideration) from occupations. Since then, allowing for the absence of a census in 1941 and for numerous revisions, data from successive decennial supplements have been used to examine the extent and nature of putative links between class and health (see Whitehead 1997; MacIntyre 1997).

The most authoritative and influential collation of the evidence for such links has been the 'Black Report' (DHSS 1980), followed by Whitehead's (1987) 'The Health Divide: Inequalities in Health in the 1980s'. The former concluded that the association between class and health is real not artefactual, and that it may be most satisfactorily explained in terms of material factors, although cultural and behavioural factors and, to a lesser degree, social

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selection are also salient. Whitehead's enquiry, together with most later reviews, like Davey Smith *et al.*'s (1990) revisitation of the findings of the Black Report '10 years on', have claimed that class-related health inequalities have increased through the 1980s and are likely to continue to do so (see also Black 1993).

The publication in 1997 of the fifteenth decennial supplement represents the latest statement of evidence on 'health inequalities' and, because of this, warrants more detailed consideration (Drever and Whitehead 1997). The authors select for emphasis some of the most 'striking findings' on 'patterns and trends', including the following (see Whitehead and Drever 1997). First, there continue to be 'serious, not trivial, differences in risk of death across society persisting into the 1990s' (Whitehead and Drever 1997:225). According to the Office of National Statistics Longitudinal Study, for example, life expectancy at birth is 75 for men in classes I and II, compared to just under 70 years for men in classes IV and V. The equivalent figures for women are 80 and 77. Infant mortality rates for births inside and outside marriage showed an almost two-fold difference between classes V and I for 1993–95.

Secondly, the question of whether social differentials in mortality have widened or narrowed over the past twenty years varies by age group. Infant mortality data – that is, from births inside marriage – indicate both a decline in mortality for all classes and a reduction in the ratio between the rates for classes I and V from the late 1980s to 1993–95. But there is evidence of a relative widening in the mortality differentials for men of working age: the all-cause mortality rate of men in class V was nearly double that of men in classes I and II in 1970–72, and had increased to an almost three-fold difference by 1991–93. For women aged 35 to 64, the Longitudinal Study indicated a narrowing and then a widening of the differential between manual and non-manual classes from the late 1970s to 1986–92, a trend confirmed when housing tenure was substituted as an indicator.

Thirdly, the widening of mortality differentials across classes has sometimes been the result of a general improvement in mortality rates for all classes, though at a more rapid rate for some; and sometimes the product of a stagnation in, or worsening of, the mortality rates for one or more classes at the same time as improvements were occurring in the rates for others. In illustration of the former, the life expectancy for women aged 65 in manual classes did not improve between 1977 and 1991, while it increased by approximately ten months for women in classes I and II. An example of the latter involves boys aged 10–14; there was an increase in mortality rates for the sons of men in class V between the early 1980s and the early 1990s, little change for the sons of men in class IIIM, and a marked decline for the sons of men in non-manual classes.

Fourthly, critical age groups can be identified when health inequalities between classes are especially large. Over the age-range 20–64, all-cause mortality is nearly three times higher for men in class V than for men in class

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I; but for the age-range 30–34, it is four and a half times higher. For some major causes of death the mortality gap is even more marked, and again younger men appear the most vulnerable. For suicides and undetermined injury, for example, while overall there is a four-fold difference in mortality between classes V and I, at younger ages the differential is seven to eight-fold. This reduces to a five-fold difference at age 35–39, and to a two-fold difference by age 55. For accidents, a five-fold difference between classes V and I at age 25–34 increases to a seven-fold difference by age 40–44, and then levels off. The authors add here that this means that at ages when mortality is generally low, 'a large proportion of young lives are cut short by the high mortality associated with less advantaged classes' (Whitehead and Drever 1997:228). At age 25–34, about half the deaths are from accidents, suicide or homicide.

Finally, there is evidence that in the 1990s the link between class and mortality was echoed in a link between class and self-reported chronic illness and several major diseases and causes of disability. However, while the trend has been for mortality to decline overall, and for most classes, the prevalence of self-reported morbidity has tended to increase, both overall and for each class. Data also indicated class gradients in most, but not all, 'health-damaging' and 'health-promoting behaviour' in line with the trends in mortality and morbidity.

Data like these are clearly indicative of enduring and patterned health inequalities. But it seems apparent to us that they remain paradigmatic of a type of research programme devoted to documenting and accounting for health inequalities which has proved far too seductive for far too long to far too many medical sociologists. Our argument is not that there is no sociological return on the programme of research or 'social accounting' conducted by those such as members of the Office for National Statistics, but rather that sociology should long ago have initiated and developed its own *distinctive*, if in many ways complementary, research programme.

Medical sociologists have largely failed to do so for three strongly related reasons (which are, in turn, simultaneously underpinned and exacerbated, we believe, by their historical proximity to medicine and the increasing 'McDonaldisation' and systemic 'colonisation' of their endeavours (see Ritzer 1993; Scambler 1996, 1998). First, they have been overly passive in their pursuit of social statistical and epidemiological agendas and initiatives, for example, in relation to the pioneering studies of civil servants, Whitehall I and II (Marmot *et al.* 1991; Marmot and Davey Smith 1997). Marmot's (1986) observation that the research interests – and therefore presumably agendas – of social epidemiologists, public health physicians and sociologists are substantively different has, it seems, struck a chord with few sociologists. Secondly, they have generally relied on concepts and measures of class, such as the Registrar General's, arguably utilised more credibly by social statisticians and epidemiologists, which are too crude and inadequately theorised

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for sociological purposes. And thirdly, they have tended to deploy deeply flawed 'abstracted' (Wright Mills 1970) or 'systematic' *empiricist* (Willer and Willer 1973) methodologies, one effect of which has been to severely limit the sociological return on their research investment.

Sociologists' contributions to the study of health inequalities, in other words, have been insufficiently sociological. They have typically adopted the reductionist perspective of social epidemiology, trying to *explain class away* by means of empiricist manoeuvres – of the kind commended in the nineteenth century in J. S. Mill's 'canons of scientific enquiry' and refined by social statisticians, but long since subjected to compelling critique (see Willer and Willer 1973) – featuring so-called 'class-constitutive' or 'class-associated' factors, such as educational attainment, facets of employment, marital status, family size, household income, housing tenure and patterns of lifestyle and behaviour. Only rarely has class been adequately theorised and taken seriously *as a phenomenon in its own right.*

Ontological Issues

Sociologists working in the health domain and elsewhere are unexceptional in their propensity to neglect matters of ontology. In the brief account that follows we draw on the rich evolving arguments of Bhaskar, although we cannot do any justice to their density or originality here. In his early work, Bhaskar (1978) identified what he termed the 'epistemic fallacy'. He was referring to the pervasive but fallacious tendency to define or analyse statements about being in terms of statements about our knowledge (of being). His 'transcendental realism', forged in relation to the natural world, proffered a solution. In the spirit of Kant, he argued that for the natural sciences to have developed as they have, the natural world *must* have a set of *specifiable* ontological properties. The merits of such a transcendental thesis continue to be debated. What concerns us here are the 'transformational' and 'relational models' – of social activity and society respectively – that Bhaskar (1989a) went on to develop out of his transcendental realist perspective to accommodate the social world.

Reacting primarily against Weber's 'voluntarism' and Durkheim's 'reification', he contends that people do not create society since it always pre-exists them. Rather society is an 'ensemble of structures, practices and conventions' that individuals reproduce or transform (but which would not exist unless they did). 'Society does not exist independently of conscious human activity (the error of reification). But it is not the product of the latter (the error of voluntarism)' (Bhaskar 1989a:76). Bhaskar asserts a real ontological difference, if also a mutual ontological dependence, between *people* and *society*, the latter being defined, after Marx, in terms of a 'network of relations' (hence the relational model of society): 'people are not relations, societies are not

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conscious agents' (Collier 1994:147). In the same vein as Giddens (1979), Bhaskar writes (1989a:34–5):

> society is both the ever-present *condition* (material cause) and the continually reproduced *outcome* of human agency. And praxis is both work, that is, conscious *production*, and (normally unconscious) *reproduction* of the conditions of production, that is society. One could refer to the former as the *duality of structure*, and the latter as the *duality of praxis*.

People do not work to reproduce the capitalist economy any more than they marry to sustain the nuclear family. Bhaskar continues (1989a:35):

> yet it is nevertheless the unintended consequence (and inexorable result) of, as it is also a necessary condition for, their activity. Moreover, when social forms change, the explanation will not normally lie in the desires of agents to change them that way, though as a very important theoretical and political limit, it *may* do so.

Bhaskar (1989b:81) elsewhere offers a helpful summary statement of the connection between the transformational model of social activity and the relational model of society which is worth quoting at length:

> the relational conception does not of course deny that factories and books are social forms. But it maintains that their being *social*, as distinct from (or rather in addition to) material, objects, consists only in the relationships between persons or between such relationships and nature that such objects causally presuppose or entail. The *social* conditions for the structures that govern the substantive activities of transformation in which human beings engage (and which constitute the immediate explanation of these activities) can thus only be relations of various kinds: between people and each other, their products, their activities, nature and themselves. If social activity is to be given a social explanation it is in this nexus that it must be found. It is thus in the enduring relations presupposed by, rather than the actual complex motley of, particular social forms, that on this conception, sociology's theoretical interest lies.

Society as the condition of action and society as its outcome both then belong to the subject-matter of sociology. And society as an object of enquiry is necessarily 'theoretical' in the sense that it is necessarily unperceivable: it cannot be empirically identified independently of its effects. In this respect it is of course no different from many objects of natural scientific enquiry. Where it does differ, however, is that it not only cannot be empirically identified independently of its effects, but it does not *exist* independently of them either (Bhaskar 1989b:82).

This does not stop sociology being 'scientific' in the same sense as the experimental sciences of the natural world, but it can only be scientific 'in *ways* which are as *different* from the latter as they are specific to the nature of societies' (Bhaskar 1994:93). Crucially, the objects of sociological investigation only manifest themselves in 'open systems', that is, in systems where 'invariant empirical regularities' do not obtain. This means that sociology –

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due to an absence of spontaneously occurring, and the impossibility of creating (for example, through laboratory experiments), 'closures' – is denied, in principle, decisive test situations for its theories. This in turn means that the criteria for the rational confirmation and rejection of theories in sociology cannot be *predictive*, and so must be *exclusively explanatory* (Bhaskar 1989b: 83).

Bhaskar's contribution to our understanding of these issues is a major one justifying more attention than it has received here (see also Bhaskar 1986, 1991, 1993); but sufficient has been said to facilitate the kind of rethinking of social class we are proposing.

Theorising Class

Revealingly, Bhaskar (1989b) attributes to Marx an earlier articulation of both a transformational model of social activity and a relational model of society, which he combines of course with an additional premiss of historical materialism, namely, that it is material production that ultimately determines the rest of social life. While it is not part of our brief here to defend this 'additional premiss', we do want to explore and support an explicitly neo-Marxist and relational conception of social class.

We agree with Gubbay (1997) when, adopting Crompton's (1993) distinction between *nominal*, *weakly relational* and *strongly relational* class schema, he concludes that the neo-Weberian rationale underlying much of the research of Goldthorpe and his colleagues on the 'Nuffield Programme' must be regarded as weakly relational *at best* (in fact, Goldthorpe has recently been at pains to deny that the construction of his scheme has *any* theoretical antecedents (Goldthorpe and Marshall 1992); and that the evolving neo-Marxist research programme of Wright and associates has shifted from being strongly to being weakly relational. It often seems, indeed, that the actual empirical categories generated by current neo-Weberian and neo-Marxist analysts are all but indistinguishable.

Adapting Bhaskar's Kantian transcendentalism, it seems apparent to us that, given the 'social patterning' consistently revealed by past and recent empiricist and empirical research – deploying a mix of nominal, weakly relational and, far more rarely, strongly relational class schema (see, for example, Adonis and Pollard 1997) – there *must* exist *real class relations* hinging on the ownership/control of the means of production. There are clearly limits to the extent to which we can lend substance to this thesis here, but fortunately some relevant work has been done by others. We are particularly indebted to Clement and Myles (1997) who, out of their participation in the 'Comparative Project on Class Structure and Class Consciousness' launched at the turn of the 1980s by Wright, have elaborated a 'minimalist' neo-Marxist perspective on class closer to (but not identical with) Wright's early (strongly

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relational) theory than to his later (weakly relational) 'principal assets' model (see Wright 1985).

Building on the insights of Carchedi (1977), they emphasise that classes are formed at the point of production and reproduced throughout social life. Central to class formation are the 'criteria of real economic ownership of the means of production and the appropriation of surplus value and/or value through control and surveillance of the labour of others' (what Carchedi refers to as the 'global function of capital'). The exercise of control and surveillance in relation to the labour process is distinct from the accomplishment of 'co-ordination and unity', which is part of 'creating surplus value/labour' (in Carchedi's terms, part of the 'global function of the collective worker') (Clement and Myles 1997:12).

This distinction between control and surveillance on the one hand and co-ordination and unity on the other is pivotal. While the latter are essential for any large-scale system of production, the former follow from the need to 'impose discipline' on workers in the interests of extracting surplus value and/or surplus labour from them. And this extraction of surplus value and/or surplus labour is particular to maintaining the *capitalist-executives*, who have 'specific powers that are called real economic ownership' (Clement and Myles 1997:13). The work of control and surveillance represents an extension of real economic ownership and in advanced capitalist societies like Britain becomes 'the task of a complex, hierarchically organized ensemble of people who collectively perform what used to be the function of the individual capitalist' (Carchedi 1977:70). These collective tasks of capital have come to be the responsibility of people who are themselves separate from real economic ownership, the *new middle class*.

The main criterion for the capitalist-executive class is real economic ownership, 'by which we mean the power to direct production to specific purposes and dispose of its products' (Clement and Myles 1997:14). This involves command over *strategic* decision-making. Individuals are members of the new middle class if they make *tactical* decisions about administrative processes affecting others or if they exercise control and surveillance over the labour power of other employees, including the right to discipline those workers. Those who (only) co-ordinate and lend unity to the labour process, 'and are therefore productive of surplus labour and/or value', do not belong to the new middle class but are rather associated with collective labour.

The *old middle class* owns its own means of realising its labour. Its members work 'outside' the dominant relations of production. While the classic petty bourgeoisie owned its own property and enjoyed independence from the capitalist class,

> 'a more intensive analysis of the fate of the old middle class under advanced capitalism reveals that many members retain their formal ownership of their means of production and possession of their immediate labour process but have often lost

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Figure 1
Class Relations in Clement and Myles

	Command Labour Power of Others: Yes	Command Labour Power of Others: No
Command Means of Production: Yes	**Capitalist-executive**	**Old middle class**
Command Means of Production: No	**New middle class**	**Working class**

Source: Clement, W. and Myles, J. 1997. *Relations of Ruling: Class and Gender in Post-industrial Societies*. Montreal: McGill-Queen's University Press.

> control over real economic ownership (thus becoming dependent commodity producers, experiencing proletarianization without becoming proletarian).
> (Clement and Myles 1997:15)

Clement and Myles (1997:14) stress that in their construction of their typology they are 'discussing classes in relation to one another'. And the 'primary' relationship is between the capitalist-executive class and the *working class*, that is, the class that has no command over the means of production, the labour power of others, or its own means of realising its labour. The working class has only its labour power to sell; it is the subject of capital as mediated by the new middle class. The relations between the four classes identified by Clement and Myles are summarised in Figure 1.

It is not necessary to detail here how Clement and Myles operationalise class since this is documented in their book. They 'add complexity' to their minimalist construction of social classes as their comparative analysis unfolds. There are, however, two general elaborations to their basic schema that we would make. The first concerns the linkage between their capitalist-executive class and what might, after the manner of Wright Mills (1959), be termed a *power elite*. Scott (1991:151) writes: 'Britain is ruled by a capitalist class whose economic dominance is sustained by the operations of the state and whose members are disproportionately represented in the power elite which rules the state apparatus'. He goes on to assert three preconditions for the existence of a 'ruling' capitalist class: first, a power bloc dominated by a capitalist class; secondly, a power elite recruited from this power bloc, and in which the

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capitalist class is disproportionately represented; and thirdly, mechanisms which ensure that the state operates in the interests of the capitalist class and the reproduction of capital. If a power bloc is to endure, it must attain 'consciousness' and 'coherence' and a capacity for 'conspiracy': 'it must evolve some awareness of common interests and concerns, it must achieve some degree of solidarity and cohesion, and its leading members must be capable of pursuing some kind of coordinated policy of action to further these interests' (Scott 1991:122; see also Scott 1997). *We maintain that an appreciation of the nature and role of Britain's power elite is crucial for understanding health inequalities and much else besides.*

Our second elaboration has to do with the alleged existence of an 'underclass' in Britain, consisting of a sizeable 'outsider' (Bradley 1996) or 'surplus population group' (Esping-Anderson 1993) materially, and perhaps culturally, adrift. The emergence of such a group has been variously attributed to the growth of long-term unemployment; the decline in industrial jobs; women's changing labour market position; the collapse of working-class communities; and attempts to dismantle the welfare state (Bradley 1996:50). The debate about how to theorise this group continues: for example, Marshall and colleagues (1995) argue against the identification of an underclass on the grounds that the opinions of those involved do not differ significantly from those of the lowest social classes, while Morris and Scott (1995) protest, rightly in our view, that this is an unsatisfactory way of refuting the existence of an underclass.

Bauman (1998a:66) points out that the term 'underclass' invokes 'an image of a class of people who are beyond and outside hierarchy, with neither chance nor need of readmission; people without role, making no useful contribution to the lives of the rest, and in principle beyond redemption'. The facility to adapt such a 'label' for use to 'stigmatize poor people, whatever their actual behaviour', has been documented by Gans (1995:2) in the United States. We agree with Novak (1996) who, while generally commending Wright's (1995) neo-Marxist class analysis of poverty (see below), upbraids him for deploying the idea of an underclass, partly because it is ideologically tainted, but for other more compelling reasons too. First, it lacks precision, frequently subsuming such oddly heterogeneous assemblies as the long-term unemployed, single mothers, (working-class) criminals, welfare recipients, drug users, black people (in the United States), and so on. Secondly, there seem to be no attitudes, values or behaviours which are distinctive to its putative membership. And thirdly, and most importantly, it is theoretically as well as empirically flawed. As Bauman indicates, the term underclass suggests a group literally underneath the class structures of society. But as Novak (1996:190) argues, class position, 'at least in the Marxist sense', is not decided by whether someone is 'employed or unemployed, poor or poorer'; rather 'the unemployed, the old, the sick, the "economically inactive" constitute part of the working class'. Chronic and long-term unemployment and its associated immiseration is a periodic feature

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of capitalist economies, and it is as yet premature to discern a qualitatively different phenomenon towards the end of this century warranting the use of the concept of an underclass.

Our own preferred option is consistent with Novak's critique of Wright, and is to refer not to an underclass but to a recently, and – one must for the time being presume – temporarily, *displaced segment of the working class*, consisting overwhelmingly of people who have only their labour power to sell but who find themselves, as a by-product of new – post-industrial, post-Fordist or 'flexible' – forms of work organisation in globalising markets, unable to secure a wage in the present and for the foreseeable future.

Theory, Class and Health Inequalities

We have argued that, in Bhaskar and Crompton's allied senses, social class is most appropriately understood relationally. What implications does this have for the sociological documentation and explanation of health inequalities? If the argument is sound, it follows that class can be seen, in Bhaskar's terms, as a real and enduring phenomenon in what has often been cast as the 'disorganised' capitalism of high modernity (Lash and Urry 1987), but which might perhaps be more appropriately defined as a 'reorganized' capitalist formation (see Ashley 1997). Because social systems are open and not amenable to spontaneous or experimental closure, however, class can only be known and studied indirectly through its effects.

Self-evidently, the dominant publicly funded research programme on class and health inequalities in Britain fails to address the ontology of class and is largely reliant on nominal class schemas such as the Registrar General's. While it is not our wish or intention here to offer a critique of social epidemiology and its practitioners' class analyses, it is our contention that sociologists should be offering something different, and that they are only rarely doing so. It is not of course that there has been *no* return for sociology from the considerable investment in the prevailing – often statistically sophisticated, but essentially empiricist – research programme, but rather that alternative, more genuinely sociological and less undertheorised, research strategies promise a *better* sociological yield.

We have maintained elsewhere that not only do sociologists need to develop a more comprehensive and distinctively sociological *macro-perspective* on health inequalities, but more flair, innovation and precision are required in empirical research methodology (Higgs and Scambler 1998). This is emphatically *not* a matter of deploying more abstruse statistical techniques of abstracted or systematic empiricism in the hope of some fortuitous inductive return. It has rather to do with harnessing quantitative and – increasingly urgently – qualitative methods to test and refine macro and derivative middle-range theories of linkages between class relations – accessible only through

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their effects in open systems – and health inequalities. Theoretical sophistication is as important as, and should inform rather than issue from, sophistication in the collection, processing and analysis of data.

More substantively, the neo-Marxist stance we have advocated here has a number of implications for sociology's contribution to the study of health inequalities in Britain. For reasons of space, we shall focus on explanations of health inequalities and then, more briefly, the reproduction of health inequalities, and the promulgation and effectiveness or otherwise of policies designed to ameliorate them.

Explanations of Health Inequalities

In his discussion of sociological approaches to poverty in the United States, Wright (1995:99), despite his questionable deployment of the idea of an underclass, neatly epitomises the value and trenchant ramifications of the kind of theory of class relations we are advocating:

> adding a class analysis perspective to the analysis of poverty is not just adding another variable to a laundry list of factors in a multivariate model. It changes the way we think about the political dynamics at stake in attempts to do something about the problem. Specifically, since a class analysis of poverty argues that there are significant numbers of privileged people with a strong, positive material interest in maintaining poverty, significant advances towards reducing poverty in the United States must place the problem of power and struggles over power at the centre of the political agenda.

Needless to say, Wright's point has no less applicability to the understanding of poverty in Britain. And if poverty is one presently acknowledged *risk factor* for health in Britain, there are countless others, the distribution of many – perhaps even most – of which cannot be adequately or sufficiently explained without recourse to relations of class. Such risk factors range from (rarely emphasised or studied) global to local ecological/environmental concerns, through aspects of material deprivation and work and housing circumstances, to (frequently emphasized and studied) 'individual' behaviours such as rates of exercise, choices of diet, drinking and smoking (see Francome and Marks 1996).

It is our contention that, for sociologists at least, *all* such risk factors for health should be examined in relation to, and explanations of health inequalities framed in terms of, social structures. This requires going beyond the 'post-Black Report' recognition that a clear demarcation between materialist/structural and cultural/behavioural explanations of health inequalities is unsustainable (which has underpinned research geared to uncovering psychosocial and other 'pathways'), to an acceptance of the view that the proper objects of study for sociologists are beneath-the-surface relations, in the present context crucially including those of class, perceivable and examin-

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able only through their effects. *The focus for medical sociologists interested in class and health inequalities should therefore be the nature and extent of the embeddedness of – frequently, it seems, causally-linked chains or webs of – risk factors for health in relations of class.* Although there remains in our view a compelling case for the study of class relations here, this is not of course to deny or under-estimate the salience of other relations, for example, those around status and command (Scott 1996), as well as those of gender (Arber 1997; MacIntyre and Hunt 1997) and ethnicity (Nazroo 1997a, 1997b).

What kinds of studies of class relations and health are we commending here? Consider, for example, the increasingly well documented association – at least at the level of national comparisons and comparisons of the fifty US States – between inequality of income distribution and health (see Wilkinson 1989, 1992, 1996; Lynch and Kaplan 1997). Arguably it is an association of particular significance in contemporary Britain where, according to the Luxembourg Income Study, there were notably large increases in income inequality (more than 30 per cent) (and in child poverty rates (more than 30 per cent)) between 1967 and 1992 (Smeeding and Gottschalk 1996). It is an association too which is attracting renewed attention, if of a predictable kind. There is an expanding body of predominantly empiricist – and some empirical – research; and beyond this, from some authors, an injunction to generate 'comprehensive conceptual models' around such issues as: (a) the identification of factors along the causal pathway linking income distribution and health; (b) how inequitable income distribution relates to health outcomes that have different 'latency periods' (such as cardiovascular disease versus suicide); (c) how to understand the separate and joint effects of absolute income and income distribution; and (d) how to understand differences in the association of inequality in income distribution and health 'between the young and old, the rich and the poor, men and women, or between racial and ethnic groups' (Lynch and Kaplan 1997:310).

In similar vein Marmot and Davey Smith (1997) affirm the need for research, like the Whitehall I and II Studies, which deepens our understanding of the factors which mediate between macro-economic phenomena like income inequality and individual ill health. 'Such investigations', they write (p. 294):

> must be centrally concerned with the manner in which different exposures accumulate and interact over the life course. It is probably here that the general nature of health inequalities can be understood. It is probably through the social clustering of advantage and disadvantage throughout life that the marked social patterning of many causes of ill health is produced.

To reiterate the earlier analysis, our contention is that given the 'marked social patterning of many causes of ill health', which have – together with congruent social patterning in rates of morbidity and mortality and in many domains other than health – been consistently documented in terms of

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nominal, weakly and strongly relational class schema, there must exist real class relations resting on the ownership/control of the means of production. Thus macro-economic factors such as income inequality, like poverty, cannot be grasped independently of an adequate theory of relations of class. Such a theory would necessarily subsume changes in global capitalism and in linkages between the adaptive behaviours of members of the power elite and capitalist-executive and the emergence of post-industrial, post-Fordist, flexibly specialised and 'feminised' employment practices; between such employment practices, which disproportionately disadvantage – through job insecurity, underemployment and casual employment, as well as through chronic unemployment – the working class and, most markedly, its displaced segment, and growing income inequality; and between growing income inequality and those forms of material deprivation, together with their concomitant patterns of diminished cultural capital and risk behaviour, known to be associated with poor health and reduced longevity (see Ferrie 1997).

The point to stress is that it is not just that a sociological theory of class relations, reaching back crucially to the ever-adaptive behaviours of members of the power elite and capitalist-executive, is required to understand enhanced income inequality, *qua* health risk; but that such a theory, with the same long reach, is also required to understand and account for the 'individualised' cognitions (such as 'modest' definitions and expectations of health and well being) and behaviours (such as eating habits, smoking and alcohol and illicit drug consumption) most prevalent in the working class and its displaced segment, *qua* health risks (see Chamberlain 1997). Indeed, the relatively high rates of morbidity and mortality common in the working class and its displaced segment can themselves be interpreted with plausibility as – indirect and largely unintended – consequences of the actions of members of the power elite and capitalist-executive.

As Elias and Scotson (1994:171) rightly insist, 'in the last resort, the crucial test for the fruitfulness or sterility of a sociological theory is the fruitfulness or sterility of empirical enquiries stimulated by and based on it'. It is evident that research methodologies beyond mere empiricism are needed to convincingly interrogate the neo-Marxist approach to class and health inequality advocated here by means of an examination of the multiple interrelated hypotheses issuing from it. Much of the complexity inherent in such an interrogation is due to the fact, rehearsed earlier, that the true objects of sociological enquiry only manifest themselves in open systems, that is, in systems where invariant empirical regularities are not to be found. This suggests the need for a subtle 'triangulation' of methods (Denzin 1989), with less emphasis than is the case in the current empiricist research programme on quantitative studies and more on qualitative ones. Arguably, for example, the optimum way to further an understanding of real class relations and of any direct or, more likely, indirect explanatory linkages with those of people's circumstances, experiences, orientations and behaviours that bear on their

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health is through imaginatively conceived and highly focused small-scale qualitative investigations of their life histories. Falling outside the current dominant research programme, such studies remain exceptional (see Chamberlain 1997; Blaxter 1997).

The Reproduction of Health Inequalities

If the distribution of social and individualised risk factors for health can only be fully comprehended in terms of an adequate theory of class relations – necessarily incorporating analyses of power, contradictory or incompatible class interests, and so on – then so can their reproduction. Stated more generally, in as far as those risk factors that contribute to the production of health inequalities can only be properly explicated in terms of their embeddedness in class relations, so can their reproduction. This carries the implication that what is required from medical sociology in this area – *perhaps, above all else* – is an account of the obdurate character of the relations between what Clement and Myles call the capitalist-executive, and especially of the power elite, and the working class, together with a fuller appreciation of the roles of the two 'hybrid' intermediate classes, the new and old middle classes. Such an account would of necessity also clarify the role of the state in light of its apparent incapacity to bridge the gap between the rhetoric of endless – if heterogeneously – 'pro-egalitarian' White Papers and the sponsorship and pursuit of policies consistent with the production and reproduction, even deepening, of health inequalities.

It is worth emphasising once more the disconcertingly neglected but *pivotal* influence of the power elite. This elite is infused, as Scott (1991, 1997) convincingly shows, by core members of the capitalist-executive who, dependent on an increasingly global system of impersonal capital resulting from the growth in institutional property holdings, have acquired a new global mobility. In his discussion of the 'human consequences' of globalisation, Bauman (1998b:9) graphically and appositely characterises them as 'absentee landlords, mark II'. Scott (1991:89–90) maintains that these core members (who in his terminology constitute the ruling capitalist class) are composed of entrepreneurial capitalists, 'passive' rentiers and executive capitalists, together with an 'inner circle' of 'finance capitalists with directorships in two or more very large enterprises in the system of impersonal capital'. He estimates the size of this group in Britain at 0.1 per cent of the adult population, some 43,500 individuals. We would contend that it is the (largely unintended) consequences of the actions of these core members of the capitalist-executive that supply the conditions necessary for both the production and the reproduction of health inequalities.

Bauman (1998b) also stresses that globalisation has led to a 'new asymmetry' between these highly mobile core members of the capitalist-executive

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and others. In a passage worth quoting at some length, he elaborates in a way which is very pertinent to our argument,

> The mobility acquired by 'people who invest' – those with capital, with money which the investment requires – means the new, indeed unprecedented in its radical unconditionality, disconnection of power from obligations: duties towards employees, but also towards the younger and weaker, towards yet unborn generations and towards the self-reproduction of the living conditions of all; in short, freedom from the duty to contribute to daily life and the perpetuation of the community. There is a new asymmetry emerging between exterritorial nature of power and the continuing territoriality of the 'whole life' – which the now unanchored power, able to move at short notice or without warning, is free to exploit and abandon to the consequences of that exploitation. Shedding the responsibility for the consequences is the most coveted and cherished gain which the new mobility brings to free-floating, locally unbound capital. The costs of coping with the consequences need not be now counted in the calculation of the 'effectiveness of investment'.
>
> (Bauman 1998b:9–10)

Policies to Reduce Health Inequalities

Our judgement of the relative ineffectiveness of British policies designed to tackle health inequalities is implicit in the line we have taken throughout this paper. This does not of course mean that 'nothing can be done'. Whitehead (1995) has distinguished between various levels at which policy interventions can occur: strengthening individuals; strengthening communities; improving access to essential facilities and services; and encouraging macro-economic and cultural change. She points out that, while most work has predictably been done at the first level, there have been some effective engagements at each (see also MacIntyre 1997). She notes successes too for 'strategic approaches', which operate spontaneously across a number of levels.

The policy interventions promising most against health inequalities, *if implemented*, are at Whitehead's fourth level, involving macro-economic and cultural change. She specifically commends: income maintenance policies that give adequate financial support for those who fall into poverty; education and training policies that help prevent poverty in the longer term; and more equitable policies for taxation and income distribution. It seems clear, however, that there is little chance of such policies being implemented. Carroll and Davey Smith (1997:281) note that a more equitable income distribution 'might not only reduce health inequalities, it might do so without adversely affecting overall population health'; but they add: 'unfortunately, the current political climate in countries like the UK is such that we shall almost certainly be denied a chance of finding out the effects of progressive income redistribution and declining socio-economic inequalities on health'. What they do not consider, ironically, is the salience of relations of class in explaining 'the current political climate in countries like the UK'.

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Another way of articulating this point is through the utilisation of a threefold categorisation of types of change relevant to population health: 'operational change', 'political change' and 'structural change' (Goraya and Scambler 1994). Operational change refers to formal health promotion or service initiatives overseen by health workers and allied experts, 'encouraged' or otherwise by government, which neither challenge nor threaten powerful class or other interests (e.g. outreach work). Political change refers to initiatives which bear on health but are beyond the conventional spheres of authority and influence of health workers alone to accomplish; such change, typically requiring governmental sponsorship or action, may increase awareness of powerful class or other interests, and may indeed indirectly pose a challenge or threat to them (e.g. fiscal measures). Structural change refers to initiatives which bear on health but are beyond the capacities of both health workers and (even) governments to deliver, since they presuppose fundamental revisions to class and other structures of power.

Policy initiatives at Whitehead's first three levels have not been uncommon and have typically entailed only operational change, while those at her fourth level, requiring political change, have been far rarer. It is clear from the evidence available, however, that operational change, and such political change as is 'viable', can be only minimally effective against health inequalities in the absence of structural change, for instance, changes in relations of class (Goraya and Scambler 1994; for an analagous argument pertaining to gender relations, see Scambler and Scambler 1995).

It seems axiomatic that the power elite and capitalist-executive, notwithstanding any diminution of their 'duties' (Bauman 1998b), can be expected to set themselves against not only structural change to do with relations of class, but any initiative put up to reduce health inequalities – be it political or, exceptionally, operational – which carries the potential to challenge or threaten their interests. Political change to reduce income inequality is an obvious example here. It is in fact predictable that any government intent on such change would be likely to face one of a variety of 'crises of legitimation' (Habermas 1973). Bauman (1998b) goes further, suggesting that, as a consequence of globalisation, governments of nation-states, including that in Britain, have now lost (most of) their power to intervene politically to regulate 'their' economies. As Offe (1996:ix), elaborating on this same point, puts it, 'instead of asking what is to be done, we might more fruitfully explore whether there is *anybody* capable of doing what needs to be done' (our emphasis).

Just as there is as yet a striking absence of methodologically imaginative and sophisticated post-empiricist research into the social mechanisms linking real class relations with the production and reproduction of health inequalities, so there is an absence too of genuinely sociological research purporting to explain the 'inconsistency' between successive British governments' stated intentions to reduce class-related health inequalities and the conspicuous

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failure of their designated policies to accomplish this. The case here for a triangulation of methods and, in particular, for more painstaking observational and documentary techniques, most notably, we contend, to address the salience of the contributions of the power elite, the capitalist-executive and the new middle class to the enduring ineffectiveness of policy, seems difficult to resist.

Summary Comments: Taking Social Class Seriously

We opened this paper with a critique of the sociological exploration of the link between class and health, alleging a lack of ambition in theory and methodology. We associated this with a disappointing passivity in relation to social epidemiological agendas and leads. Maintaining that the accumulated results of empirical and empiricist works on class and health were pointers to the potential value of an *explicitly sociological* perspective on class, we used Bhaskar's philosophical reflections on natural and social science, together with his transformational model of social activity and relational model of society, to underpin and defend the *reality* of class. We then cited the research of Clement and Myles as representative of the kind of tenable neo-Marxist theory of class relations with sufficient promise to throw light on the as yet under-theorised links between class and health inequalities. We went on to elaborate our theoretical approach through a consideration of the role of class in the production and reproduction of health inequalities and in relation to policies proferred to combat health inequalities, and to give an indication of the direction future research might take and of appropriate methodologies.

It is important to be clear what we have *not* argued here. While much of what we have said represents an unapologetic lament for the absence of a convincing sociology of health inequalities, we remain aware that there has been, and doubtless will continue to be, a sociological return, if an ultimately disappointing one, from research within the prevailing paradigm. We are aware too that the study of health inequalities is properly and necessarily multidisciplinary, and that sociology's contribution, even if recast along the lines we are advocating, can only be partial, complementing research from disciplines such as genetics, biology, epidemiology, economics, political science and social psychology.

It is perhaps appropriate to end on a more directly political note. A strongly relational theory of class would encourage reflection on the emergence and consolidation of the currently dominant empiricist research programme, together with sociologists' involvement in it. We are among those who would contend that such a class analysis of the ubiquitous deployment of nominal class schema like the Registrar General's, yielding data of the kind found in the newly published fifteenth decennial supplement on 'health inequalities' summarised earlier, is long overdue. It is not that medical sociologists are

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unaware of the limitations of the Registrar General's operationalisation of class, far from it; but, as one of us has argued (Scambler 1996), their 'system ties', which have been accentuated of late by the intrusions of markets into academic institutions and scholarship, by a generalised 'McDonaldisation' of academic practice and procedures of appraisal and promotion, and by a characteristic switch to research commissioning by many state and other funding bodies, have served to constrain, channel and 'colonise' their commitments. This seems to us peculiarly true of attempts to expound on links between class and health, which have remained largely uninformed even by mainstream sociological debates on class and social change in high modernity.

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