



..... Part 1

..... Social Patterning

..... of Health





Social Class

Social classes are strata of society defined in terms of (1) the relationship between capital and labour, extending to (2) aspects of labour market position and work characteristics.

With the possible exception of the earliest or pre-Neolithic societies, human sociability has consistently shown evidence of enduring hierarchy or strata. This division of social formations by hierarchy or strata is usually referred to as 'social stratification'. Even in post-Neolithic but still traditional or pre-modern societies, stratification was more complex than simple oppositions between 'master and slave' and 'lord and serf' suggest. In highly differentiated modern societies, stratification is invariably multi-dimensional. While social class is the dimension of stratification that has been most often highlighted and debated, it is far from being the only one. Moreover, as the historian Braudel (1984) has so painstakingly shown in his study of Europe from 1400 to 1800, transitions from pre-modern to modern were invariably slow and uneven: no modern or capitalist society is without its pre-modern or feudal residue.

Neither the concept of social class nor the phenomena it denotes originated with Marx, but his contribution remains influential. While recognizing the dynamic, complex and multi-dimensional nature of stratification in modern societies, he insisted: (1) that class is fundamental, and (2) that there would develop an antagonistic polarization between two 'basic' classes – the *bourgeoisie* (the owners of capital) and the *proletariat* (the wage-labourers) – that would ultimately lead to revolutionary or transformatory change. Opinion remains divided on whether Marx simply got it wrong – the polarization he anticipated in the industrialized West, leading to a revolutionary shift in favour of the proletariat, has yet to occur – or whether his analysis was convincing but his timing was out. Weber took a lot of what Marx argued about class on board but disassociated himself from any sense of historical inevitability, emphasizing the salience of class-based life chances or opportunities and contending that other dimensions of stratification than class, notably 'honour' (or status) and 'party' (or political organization around agendas for change), remained important in their own right and could and do vary independent of class.

The classical Marx–Weber debate lives on but has been joined by a plethora of rival theories of class in modern society, and more recently by theories about the demise of class in post-modern societies. There is space here only to comment on ideas regarding the 'death of class'. Some have argued that the 'discourse of class' that came to prevail in modern society was never truly warranted; others have held that while class was a, or even *the*, fundamental form of stratification in modern society, this is no longer true of post-modern society (Pakulski and Waters, 1996). For the latter, class has been complemented, and even displaced, both by the likes



of gender, ethnicity, sexuality and so on, and by a novel cultural shift towards the increasingly individualistic, open, and hybrid business of identity-formation. In other words, class is not what it was – either objectively or subjectively. An alternative position is that class remains significant *objectively* but has become less significant *subjectively*: namely, class continues to mould individuals' experiences, although they are less likely than even a generation ago either to recognize this or to construct their identities in terms of class (Scambler, 2002).

A gap is also apparent between the concepts of class found in theories and those encountered in the research domain. Socio-economic classifications (SECs), often presented as proxies for class, have routinely shown a strong inverse association between occupational standing and health status and longevity. Mention might be made here of a relatively subtle SEC, the broadly neo-Weberian National Statistics Socio-economic Classification (NS-SEC) scheme introduced in England and Wales (see Rose and O'Reilly, 1997). In this scheme, occupations are differentiated in terms of reward mechanisms, promotion prospects, autonomy and job security. It comprises the following: senior professionals/senior managers; associate professionals/junior managers; other administrative and clerical workers; own account non-professionals; supervisors, technicians and related workers; intermediate workers; other workers; and never worked/other inactive. The most advantaged NS-SEC 'classes' typically exhibit personalized reward structures, have good opportunities for advancement and relatively high levels of autonomy within the job, and are relatively secure (these attributes tending to be reversed for the most disadvantaged or routine 'classes') (Langford and Johnson, 2010).

As far as England and Wales are concerned, the changes captured through studies of a succession of SECs on the one hand, and, say, life expectancy on the other, are unambiguous. They show an upward trend in life expectancy for men and women across the SEC spectrum. However, the improvement in life expectancy has been more rapid among those at the top than among those at the bottom of the 'socio-economic hierarchy' (Graham, 2009). The same pattern is found in other developed or high-income countries (Mackenbach, 2005).

Data in this vein also testify to the existence of a 'social gradient' – that is to say, the relationships between SECs and measures of health and longevity are finely graded. Not only are there considerable differences between the best- and worst-off in England and Wales, but the higher one's social position is (or level of education, occupational status or housing conditions) the better one's health is likely to be. The authors of the Marmot Review (2010: 16) write:

These serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad', unhealthy behaviour, or difficulties in access to health care, important as these factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society.

There is a paucity of material for developing societies, certainly as far as social gradients are concerned. However, there is ample evidence for ubiquitous inter- and intra-national health inequalities, the most dramatic of which appear across the developed/developing and North/South divides (WHO, 2008).





There is no doubting the sociological utility of SECs like NS-SEC, but do they catch enough of the ongoing contradictions between capital and labour that are so pivotal not only for Marx but also for many mainstream sociologists? Indicators of or proxies for class, like the NS-SEC, have raised important issues around the (nature of the) causal relationship between class and health. To some extent the disciplinary boundary between social epidemiology and medical sociology has been obscured here. Positively, this might be interpreted as a victory for ‘inter-disciplinarity’; negatively, it might be seen as social epidemiology’s co-option of medical sociology. Most probably the answer lies somewhere in the middle. Much depends, however, on whether class theory has any purchase in the here-and-now. If it does, then it falls on sociologists to do it justice.

The statistical linkages between occupational standing (or other SECs developed across the globe) and health have led to a number of sociological models, many of them focusing on the causal role of material, behavioural and psychosocial factors for health, and many also using the notion of the lifecourse as a vehicle (see Graham, 2009). These could be defined as ‘middle range’ sociological models since they focus on measurable aspects of social phenomena and observed empirical regularities. However, measures like that of the NS-SEC neither purport to be nor are substitutes for Marxian models of class. This gives rise to two questions. First, is it premature to write neo-Marxist concepts of class out of the medical-sociological script? And second, does class, thus understood, have some causal bearing on the enduring statistical associations between SECs and health/longevity?

Navarro (2002) has long argued against neglecting Marx’s theories, holding class relations accountable not just for inter- and intra-national health inequalities but also for the near-ubiquitous failure of governments to tackle them effectively and for the flaws found in many health care systems. A related thesis is that class relations understood in this way are largely responsible for the consistent and long-standing associations between SECs and health. It is class relations, in short, that ‘lock’ people into their SEC (and the parsimony of post-war social or inter-SEC mobility is indeed remarkable). In an extension of this thesis, it has been suggested that the attention of researchers should switch from its past and present focus on the poor health behaviours and prospects of the poor and powerless to concentrate on the behaviours of the rich and powerful. The polemically-named ‘greedy bastards hypothesis’ (or GBH) claims that it is the behaviours of a small, hardcore group of thoroughly global capitalists who are active in the UK (the chief executive officers of major and multi-national corporations, financiers, rentiers and so on) – increasingly and significantly *favoured* since the mid-1970s by the globalizing power elite of the state – that provide the principal causal motor for (1) the enduring nature, and even deepening, of health inequalities in the UK, and (2) the persistent failure to properly address these (Scambler, 2002). Implicit in the GBH is a critique of the abandonment of sociology’s classic focus on social structures or relations. It sees the maldistribution of wealth and income as – directly and indirectly – pivotal for health inequalities, and defines both this maldistribution *and its near-systematic neglect* as a function of class relations. The rich, it suggests, engage in forms of ‘illness behaviour’ with profound implications for the poor, while it is the illness





behaviour of the poor that is the more-or-less exclusive object of current (funded) research programmes. The bulk of research funding comes directly or indirectly from the state.

Arguably it is not simply a matter of choosing *either* middle-range theories consonant with known statistical linkages between SECs and health *or* a more traditional or modern sociological emphasis on social structure. Both can contribute to our understanding of how people's social positions and behaviours will have ramifications for their health status and life expectancy. Graham (1995) seminaly showed, Durkheim-like, how seemingly individual decisions to engage in 'risk behaviours' like smoking can be rational by-products of the structured circumstances in which women happen, unwittingly, to find themselves. The challenge of the next decade may be to discover more effective ways of (1) integrating macro-, meso- and micro-sociological theories of health inequalities, (2) facilitating genuinely interdisciplinary – sociological, psychological and biological – approaches to health inequalities, and (3) propagating policies to tackle health inequalities. Arguably, none of these projects can be comprehensively pursued in the absence of a classic modern theory of relations of class.

See also: *Material and Cultural Factors; Neoliberal Globalization and Health Inequalities*

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Gender

Gender concerns the social relations within and between groups of men and women, boys and girls; it is an interactive process that also has health implications.

‘Being a man or a woman’, writes Connell (2009: 5), ‘is not a pre-determined state. It is a *becoming*, a condition actively under construction’. The social construction of gender has implications for health. Health is socially patterned while remaining dynamic and sensitive to changes in the social relations of gender within and between societies over time.

The distinction between biological sex and social gender has been indispensable for the study of gender and health. However, sex and gender tend to be treated as competing explanations when – more often than not – they *both* matter and it is their interaction that is important. Male sex makes men vulnerable to prostate disease and female sex makes women vulnerable to cervical cancer and cancer of the womb. Biology also has a role in conditions which *both* men and women experience. Lung function matures more slowly in the male foetus which gives rise to more respiratory distress syndromes and lung-related injuries in newborns. Female sex hormones reduce the risk of coronary heart disease in women in their ‘reproductive years’. But biological factors do not *determine* the health of men and women, boys and girls. Social factors can overrule or even cancel out biological propensities. For example, in HIV infection the biological body puts women at a higher risk of seroconversion during unprotected sex with an infected male partner since, amongst other things, the greater area of mucus membrane exposed during sex provides a fertile ground for the virus to enter the body, and micro-tears in vaginal tissue increase the risk of male-to-female transmission. But, crucially, around the world, it is the *social* relations of gender – especially women’s relative lack of control over sexual activity – that matter most because these are what put women at risk of exposure to the virus in the first place (Gilbert and Selikow, 2010).

In other words, gender relations interact with the biological body to produce particular patterns of morbidity and mortality at different times and in different places. We can see this in international differences in life expectancy. Today women outlive men in virtually all countries of the world. However, the extent of this longevity has fluctuated considerably over time and presently there are large variations across societies, from just one year in the Sudan, to four to five years in the UK and the USA, and twelve years in the Russian Federation (WHO, 2010).

The late 1800s to around the 1970s saw the gradual emergence of the current female longevity advantage in the West. For example, in England and Wales, the number of ‘extra years’, on average, that a female might expect to live at birth compared to a male rose from around two years for those born in 1841 to 6.3 years for those born in 1969/1970. Life expectancy continues to grow for males and



females alike, but the 'gender gap' between them has been decreasing since around the 1970s. This is accounted for by larger 'male gains' at all age points. Between 1980 and 2003, the life expectancy of Western European men as a whole increased by 6.5 per cent and that of women by only 3.5 per cent (White and Cash, 2004), and while these differences seem small, they mark a new historical trend.

Gender distinctions have been breaking down in the West as women's educational and workforce participation has risen and social attitudes about what is gender-appropriate behaviour have loosened for both women and men. Men's health emerged from the shadows of gender and health research in the 1990s as the spotlight turned upon the health-damaging effects of a 'hegemonic' – or dominant, controlling – masculinity. The corollary is that if men cast off their traditional masculinity and/or women take it on, we might expect the differences in life expectancy to decrease. This expectation appears to have been borne out. To take the UK as an example, although the rates of major causes of death remain higher for men, they have experienced swifter declines in heart disease and stroke mortality in recent decades. Lung cancer incidence rates remain higher for men than for women, but they have declined since the mid-1970s while women's have risen. These health conditions are associated with the very lifestyle and health behaviour changes that have accompanied so-called gender convergence. An obvious example is lung cancer where past and current smoking patterns are showing up as men's and women's life-time risks of lung cancer start to narrow, and in some countries even reverse. These changes are not however a simple matter of individual lifestyle choice – rather they are forged within the complex social relations of gender, class, age and ethnicity that influence the lives of men and women (Annandale, 2009).

Many countries in Sub-Saharan Africa have also experienced a decreasing 'gender gap', to the point that in some, such as Mozambique and Zimbabwe, there is now no difference in average life expectancy (WHO, 2010). In Sub-Saharan Africa, the poorest region in the world, any biological advantage women may have in life expectancy is easily diminished as they bear the brunt of the harsh neoliberal economic policies that accompany globalization, alongside gender discrimination. Women in the region are at an exceptionally high risk of premature death from AIDS-related human rights abuses and from sexual violence during armed conflict.

Yet some countries, as distinct from the West and Sub-Saharan Africa, have experienced an *increasing* 'gender gap' in life expectancy. For example, as with their counterparts elsewhere in the world, Russian women have longer average life expectancies than men. However, the life expectancies of both men and women worsened between 1980 and 2002 with men's worsening more than women's. And by 2008 the average life expectancy of 74 years for women, and 62 years for men, represented the largest 'gender gap' in the world (WHO, 2010). Heart disease mortality has been increasing, especially for men, and there has also been a dramatic rise in all forms of violent deaths (including alcohol-related). Pietilä and Rytkönen (2008: 1082) found that even though their Russian respondents attributed this gap more to changing structural conditions in their country than to individual behaviours, they drew heavily on the notion of gender roles as natural: 'a kind of haven, standing for something permanent and stable in the context of rapid social change'.





Situating global variations in life expectancy within their societal and global contexts helps to explain the social patterning of mortality. Yet it tells us little about a person's health during their lifetime. As Arber (2004) explained in the first edition of *Key Concepts in Medical Sociology*, research has been concerned with the apparent paradox that 'women are sicker but men die quicker' (or why, on average, in most countries of the world, women still live longer than men, but they are also – or appear to be – sicker during their lives). However, the first aspect of the 'gender paradox' has been questioned.

From the mid-1990s, research has shown that self-reported gender differences in general health status and longstanding illness appear to be relatively small amongst adults in the West. Nevertheless, women generally suffer more from chronic conditions such as arthritis and rheumatism. Although rates of mental illness do not differ much overall, depression and anxiety tend to be higher amongst women and personality disorder and suicide higher amongst men. In light of these findings, the 'gender paradox' is often resolved by the deduction that although any 'excess' morbidity experienced by women is debilitating, it typically does not result in an early death. However, it needs to be appreciated that since doing health is also part of doing gender (Saltonstall, 1993), self-assessments of health and gender are intricately connected and cause and effect are not easily disentangled.

The 'men die quicker' side of the equation has been linked to their more dangerous employment conditions, life chances, risk-taking, and seeming reluctance to seek help when ill. The latter in particular is interpreted as part of 'doing masculinity': for example, Courtenay highlights that 'when a man brags "I haven't been to a doctor in years", he is simultaneously describing a health practice and situating himself in a masculine arena' (2009: 15). However, masculinity is plural: men in more marginalized and subordinated positions bear the brunt of those who are in hegemonic positions, as do many women (Connell, 2009). Moreover, for many people, seeking care in the first place hinges on an ability to pay for this. In low income countries, and in economically deprived communities in high income countries, girls and women often cannot afford to seek formal health care and families invest less in their care even though their needs may be greater than those of males.

So while the lives of some groups of men and women may be converging, important differences remain which subject them to different social and material exposures. In spite of Western women's increased labour force participation, horizontal and vertical segregation remains. This means that on average women are paid less than men and they are still mainly responsible for childcare and the home. Meanwhile, large numbers of women and girls from the global South migrate to find work as lowly paid domestic and care workers which enables the careers of wealthier women of the North (Sen et al., 2007).

Research generally finds that the magnitude of socioeconomic gradients in health in the West is sharper amongst men than amongst women. Since it is hard to imagine that socioeconomic inequality matters less for the health of women than for men, it is possible that the shallower gradient is an artefact of how socioeconomic





status is measured. Occupationally-based measures are problematic because they are usually based on a male occupational structure and consequently fail to differentiate between the jobs that women do. To fully capture the relationship between gender, socioeconomic status and health we need to move beyond individual characteristics and take the gendered context of the places people live in – such as municipalities, states and countries – into account. Such research has been limited to date, although there is some evidence from a study by Chen and colleagues (2005) that in a very unequal nation such as the USA, living in a more equal (as compared to unequal) state benefits the mental health of women. The authors report that this could be because those states where women's status is higher may provide better material and social resources, such as higher wages and family-friendly policies. Living in a more equal state may also have psychosocial effects, reducing the stress associated with overt and covert discrimination. Other research has found that high levels of patriarchy are associated with higher male mortality in many societies (Stanistreet et al., 2005).

In conclusion, on average, women still live longer than men in most countries. However, the social patterning of gender and health is exceedingly complex and highly responsive to social contexts and to social change. This is evident in the decreasing and increasing 'gender gaps' in life expectancy in different parts of the world. The conventional assumption that women are sicker during their lives is questionable and in need of further research. Finally, gender does not stand alone as an influence upon health; rather, it intersects in complex and in as yet relatively unexplored ways with other factors such as socioeconomic status.

See also: *Social Class; Neoliberal Globalization and Health Inequalities*

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