

Marxist Perspectives on the Structural and Psychosocial
Determinants of Health Inequality

by

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PART I INTRODUCTION

Economic progress has allowed “developed nations” to transcend absolute deprivation and associated illnesses in the epidemiological transition, whereby “the older infectious causes of death...gave way to degenerative diseases” such that “while [they] still remain the diseases of poverty in the third world today, the degenerative diseases of old age have become the main causes of death in the developed countries” (Wilkinson 2005, 10). That is, instead of dying from traditional infectious diseases in childhood (e.g., acute respiratory infections and gastroenteritis), people are dying from degenerative diseases associated with later adulthood, most notably cardiovascular diseases and certain cancers (Centers for Disease Control and Prevention 2005). Moreover, there are marked disparities in life expectancy between and within countries. While the former is datum, the degree and prevalence of the latter is not. For instance, the Commission on Social Determinants of Health reports that “With regard to mortality, mean difference in life expectancy both between those at the top and at the bottom of a society’s social structure are anywhere from four to ten years” (Siegrist and Marmot, Introduction 2006, 1). In view of modern scientific and technological advances in medicine and the persistent increase in health care spending—particularly in developed nations—such findings are difficult to comprehend.

These disparities follow a ‘social gradient’ in health across the whole of society. That is, ‘social status’, position in the socioeconomic hierarchy, is inversely related to both ‘mortality’, frequency of death, and ‘morbidity’, frequency of disease outcomes, such that higher socioeconomic status implies a longer life-span, on average (Fig. 1).

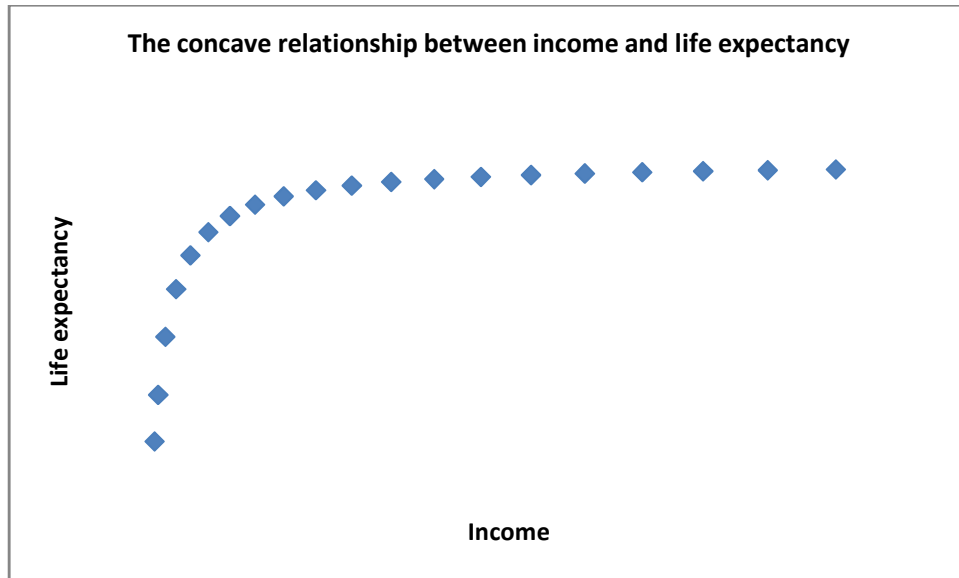


Figure 1 Life expectancy increases significantly with increase in income for those of low to upper-middle socioeconomic status. Adapted from Kawachi and Kennedy 2002.

The concept of a social gradient originated from the British Whitehall studies of civil servants, which began in 1967. What is unique about the Whitehall I and Whitehall II studies is the breadth of socioeconomic positions surveyed, from lower-level clerks to ministers, both male and female.¹ In short, these two studies have provided a wealth of information concerning how socioeconomic status relates to health with respect to personal biography and lifestyle choices. British civil servants are an ideal cohort with which to examine the social gradient because “White-collar organizations, and the civil service is best at this without question, are brilliant at stratification, better than the national social-class system” (Marmot 2004, 40-1). A major finding is the observation that administrators—those at the top of the socioeconomic hierarchy—comprise about half the average mortality in early old age, while workers classified as “other”—those at the bottom of the socioeconomic hierarchy—comprise about twice the average (Fig. 2).

¹ Whitehall I only surveyed males, but Whitehall II surveyed both males and females.

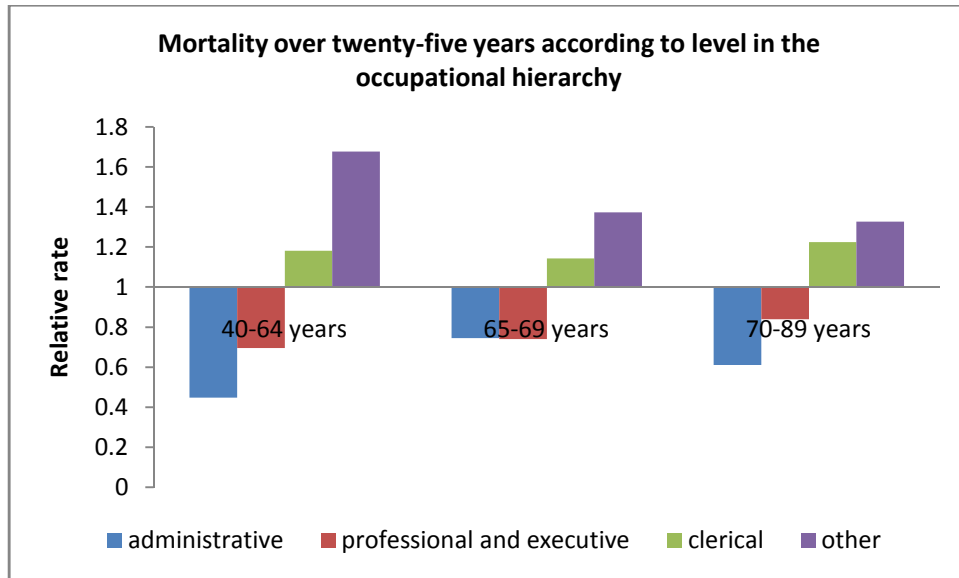


Figure 2 Those at the top of the social gradient enjoy a fourfold difference in average mortality at age 40-64 compared to those at the bottom. Reproduced from Marmot 2004. Data from Marmot and Shipley 1996.

Moreover, these data exclude workers at either extreme of the social gradient, such as corporate CEOs or the unemployed/unemployable. So while it seems tempting to group civil servants together because they all work for the government, “This superficial homogeneity belies the exquisitely stratified nature of such an organization” (Marmot 2004, 40). Whitehall has been and remains one of the most comprehensive studies relating socioeconomic status and health inequality.

However, it is important to note that socioeconomic status, while the defining characteristic of the gradient, is not the only variable. Others include stage of life course, gender, type of country, indicator of health, and indicator of social inequality under study. Moreover, there are primarily four semantic variations used to describe the effects of the social gradient: as ‘social variations in health’, ‘social disparities in health’, ‘social inequalities in health’, and ‘social inequities in health’. ‘Social inequalities’ in health is preferable because ‘social variations’ and ‘social disparities’ describe variations in health without reference to

vertical social stratification; and, 'inequities in health' suggests that certain causes of mortality and morbidity are "considered unfair and unjust to the extent that they are avoidable," but scientific progress has not yet advanced to a level where such conclusions are possible (Siegrist and Marmot 2006, 4-5). In short, premature illness still haunts our "advanced" societies; economic progress (and the concurrent development of science and technology) has conferred differential returns for those lower in the socioeconomic hierarchy with respect to increased well-being. Thus there appears a direct relationship between socioeconomic status and health inequality. The causal connection between these two modalities is the subject of much scholarly debate.

OVERVIEW OF THE STRUCTURAL AND PSYCHOSOCIAL DETERMINANTS OF HEALTH

There are two dominant camps of scholarship that address determinants of health: those who concentrate on the structural features of society and those who concentrate on the psychosocial. Prominent among the former is sociologist and medical doctor Howard Waitzkin, who is exemplary of the structuralist camp most active before the collapse of the Soviet Union. Prominent among the latter are the more contemporary scholars, including social epidemiologist Ichiro Kawachi and psychologist Bruce Kennedy, epidemiologist and public health specialist Michael Marmot, and social epidemiologist Richard Wilkinson, who together have helped create the current narrative founded on the idea of a social gradient in health.

Waitzkin's influential work culminated in *The Second Sickness: Contradictions of Capitalist Health Care* (Rowman & Littlefield 2000 [1983]). He develops a theoretical framework informed by Marxist dialectic and historical materialism that focuses on connections between the health system—which broadly encompasses anything health-care related, from

professionals to the institutions that train them—and the broader political and socioeconomic systems of society. Waitzkin argues that without such a perspective, “the health system falsely takes on the appearance of an autonomous, free-floating entity, whose defects purportedly can be corrected by limited terms in the medical sphere” (Waitzkin 2000, 4). His analysis builds on a series of contradictions related to the dynamic between medicine, social structure, and social pathology, all of which are mediated by institutions. The contradictions include those between profit and safety, plentiful resources and medical maldistribution, rising costs and diminishing returns, and technological progress and humanistic decline. For instance, the contradiction between profit and safety discourages technical improvements in both occupational and environmental safety in the interest of profit. This has resulted in such well-documented cases as plastic workers’ liver cancer in the United States and “Minamata Disease” from mercury poisoning in Japan. In short, Waitzkin locates the source of health inequalities in the dynamics of the capitalist accumulation process. These contradictions and their implications receive attention below in part II.

Waitzkin’s approach to health inequality concentrates on the “medicosocial complex,” which encompasses multiple systems within a greater social context. In this way Marxist dialectic and historical materialist theory—with its emphasis on the workings of institutions—can overshadow the nuances of social intercourse within the systems of broader society. In contrast, contemporary scholars focus on the more direct, unmediated relationship between the unequal structure of society and the health outcome of the individual—the very experience of inequality. Thus while both camps are technically structural insofar as they locate the determinants of health inequality in socioeconomic structures of inequality, the term itself is

reserved for Waitzkin's analysis because of his emphasis on discrete outcomes of the capitalist accumulation process as mediated by institutions.

Kawachi and Kennedy's *The Health of Nations: Why Inequality is Harmful to Your Health* (The New Press 2002) assesses the nature of economic "development" and its implications for the well-being of economic actors across the socioeconomic spectrum. They posit that:

Far from being a benign by-product of capitalism's success...growing inequalities threaten the various freedoms that economic development is supposed to bring about: freedom from want, freedom from ill health, freedom to exercise democratic choice, as well as freedom to pursue leisure and the activities that we have reason to value. (Kawachi and Kennedy 2002, 6-7)

That is, the ability an individual has to exercise these freedoms appears decisive to his/her health status. Since these freedoms ultimately require the capacity to consume, contemporary patterns of consumption are, in this view, largely to blame for the inability of economic growth to liberate people from want.

Kawachi and Kennedy introduce 'the relative income hypothesis' to explain how the inability to consume influences health outcomes. It posits that well-being is contingent on relative income. This implies, for instance, that a yearly income of \$50,000 when others earn \$25,000 is preferable to a yearly income of \$100,000 when others earn \$250,000.² Therefore, in contrast to the "trickle-down" model of economic development, the relative income hypothesis predicts that a doubling of incomes for every citizen would not result in increased well-being because the role of inequality would remain unchanged. This has important implications for understanding the relationship between socioeconomic status and health inequality.

² Note that this model applies to developed nations where absolute deprivation as a major barrier to well-being is generally negligible.

In assessing traditional explanations for socioeconomic differences in health—for instance, lack of access to health care, reverse causation³, and the adoption of unhealthy “lifestyles” by those of lower socioeconomic status—Kawachi and Kennedy find that they fail to withstand scrutiny. For instance, in Britain, access to health care is not a limiting factor because it is free.⁴ Nevertheless, socioeconomic differences in health remain. Moreover, life course studies have discounted reverse causation. By tracking individuals early in their careers (i.e. free of illness), researchers have demonstrated that lower socioeconomic status ultimately results in premature mortality and increased morbidity. Finally, “lifestyle” is a historically contingent concept and is thus an inappropriate benchmark. For instance, sedentary lifestyles and obesity as displays of “conspicuous leisure and consumption” were once symbolic of wealth. Now the opposite is true.

To illustrate the explanatory power of the relative income hypothesis, Kawachi and Kennedy consider the manner in which car ownership in Britain influences well-being. While car ownership has no inherent value, it assumes great importance when everyone appears to drive a car. In fact, not owning a car is the leading indicator of mortality risk. It is crucial for a person’s access to employment, healthy and affordable food, leisure facilities, social engagements, and health services. Nevertheless, these issues of access are largely determined by socioeconomic status. In this way Kawachi and Kennedy argue that “Lack of access to a car is thus not so much a marker of life-threatening hardship, but a rather sensitive indicator of *relative* deprivation.”

³ That is, health determines socioeconomic position.

⁴ In fact, Wilkinson finds that “In Britain, where medical care is free, poorer people tend to use [the] medical services more than richer people.” (Wilkinson 2005, 59)

Therefore, “Lacking income is harmful to health because low income is an exquisite indicator of one’s *relative* position in society” (original emphasis; Kawachi and Kennedy 2002, 64).

A concept related to the relative income hypothesis is ‘positional competition’, the pursuit of relative status. In our society people spend a considerable portion of their income on ‘positional goods’ (i.e. goods whose primary value is that others lack them) that are intended to reflect their lifestyles. Kawachi and Kennedy define ‘lifestyle’ as the consumer choices that partially define social status: “Lifestyle consumption is visible and therefore inevitably functions as a sign of social distinction” (Kawachi and Kennedy 2002, 139). In this way consumer society requires that people spend in order to acquire social status. Such is a heavy burden for most except those of high socioeconomic status. For this reason Kawachi and Kennedy describe consumerism as a “hedonic treadmill,” with positional competition creating an environment in which the “pursuit of happiness is the proverbial carrot dangling on the end of a stick” (Kawachi and Kennedy 2002, 109). The authors describe the consequences thus:

More time at work has meant less time for leisure and less time spent with families and friends, reduced parental investment in children, and generally less of the types of consumption that really make a difference. Striving harder has also led to frustration, especially for those who have little hope of achieving their dreams. (Kawachi and Kennedy 2002, 109-10)

It follows that working longer hours not only exhausts the body, but can undermine people’s sense of control over their lives and perceived self-efficacy. The result is that people work harder but feel worse.⁵

While Kawachi and Kennedy develop a general explanatory model for the social gradient in health, they only locate the major variables that link socioeconomic status and health

⁵ Kawachi and Kennedy note that “Americans now work more hours than the fabled workaholics of Japan, who logged in at 1,898 hours” at work per anum. (Kawachi and Kennedy 2002, 113; data from Mishel et al. 1999.)

inequality. Marmot, however, provides a causal mechanism to explain the manner in which relative income and positional competition function to determine health outcome. In *The Status Syndrome: How Social Standing Affects Our Health and Longevity* (Owl Books 2004), Marmot argues that “Degrees of control and participation underlie the status syndrome,” a term he uses to describe the pathology of the social gradient in health (Marmot 2004, 2). In this way the gradient is reflected by an individual’s ‘ontological security’, his/her sense of agency and competency (e.g., the ability to engage in meaningful relationships).

Marmot uses the concept of ‘autonomy’ to explain the manner in which the social gradient in health operates: “Autonomy—how much control you have over your life—and the opportunities you have for full social engagement and participation are crucial for health, well-being, and longevity.” He continues, “It is inequality in these that plays a big part in producing the social gradient in health” (Marmot 2004, 2). In particular, autonomy (or a lack thereof) affects the body physiologically through stress-mediated pathways and is fundamental to social integration.⁶

Autonomy is determined by two features of society: hierarchies and cooperation. Since the two vary both between and within societies over time, levels of autonomy are historically contingent. That is, the degree of control one might have over his/her life and the level of access to opportunities for social participation differ from one historical moment to another. For instance, the atomistic society that “hyper-capitalism” promotes is largely concerned with the individual. While it emphasizes the importance of personal agency to living a successful life, it

⁶ Moreover, these same social forces that affect adults are often transmitted to the next generation. Marmot writes, “the seeds of the status syndrome may, to some extent, be sewn in early childhood, and the ‘rewards’ reaped in adult life.” (Marmot 2004, 11)

neglects the importance of social support to, for instance, helping people overcome life's travails. Consequently, someone who has failed to succeed has little recourse to "rise above" and will suffer from a lack of autonomy. Marmot's 'status syndrome' predicts that this predisposition will result in premature death and increased morbidity. Moreover, these types of occurrences tend to increase in frequency with lower socioeconomic status.

Wilkinson elaborates on Marmot's causal mechanism with a more robust analysis of the psychological contributions to health status. In *The Impact of Inequality: How to Make Sick Societies Healthier* (The New Press 2005), Wilkinson argues that "to understand the benefits of greater equality we need to understand our responses to inequality and dominance hierarchies" (Wilkinson 2005, 21). In particular, he explains lower health status by concentrating on "forms of social and psychological stress, including depression and anxiety, that dominate people's whole experience of life" (Wilkinson 2005, 18).

Conflict is endemic to society. We, like all animals, have yet to resolve competition over scarce resources, and thus the different ways in which we organize our societies should reflect this. In fact, our society embraces goods whose value depends on their scarcity (or positional quality à la Kawachi and Kennedy). Wilkinson distinguishes between two organizational extremes: vertical (i.e. dominance-oriented) hierarchies based on power and coercion in which social relations are ordered according to differential power; and, horizontal (i.e. egalitarian) arrangements based on notions of fairness and need in which social relations reflect notions of social obligation, equality, and cooperation. All societies fall somewhere in between these two forms of social organization, where the degree of inequality is reflected by proximity to the former extreme based on power and coercion. As figure 3 attempts to convey, the social

dynamics provoked by inequality promote “strategies that are more self-interested, less affiliative, often highly antisocial, more stressful, and likely to give rise to higher levels of violence, poorer community relations, and worse health” (Wilkinson 2005, 23).

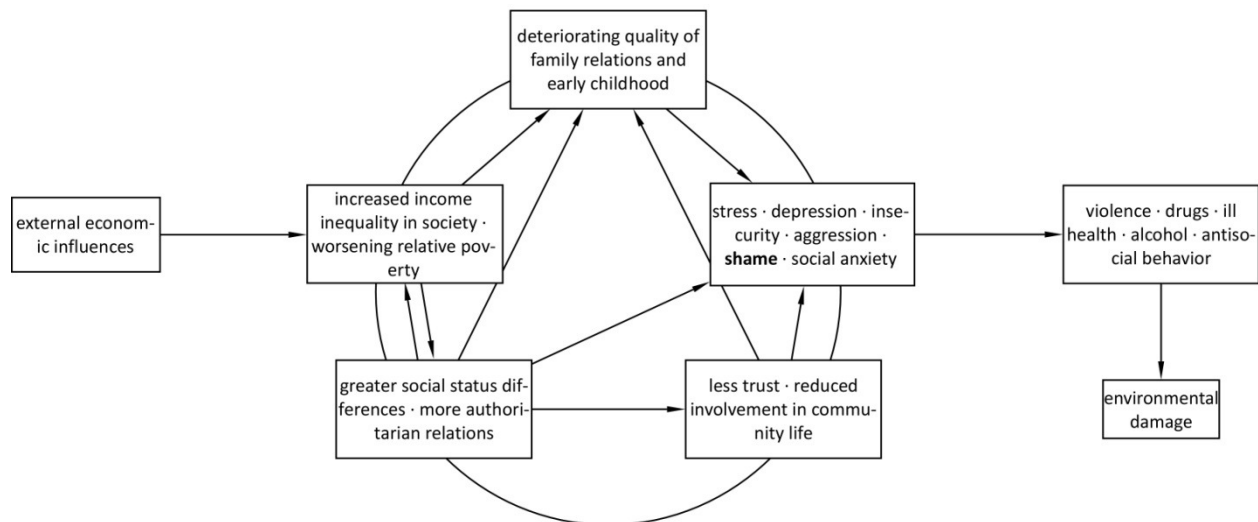


Figure 3 The effects of income inequality on social and psychological well-being. Adapted from Wilkinson 2005.

In short, greater material inequality is linked to various adverse psychological, behavioral, and health outcomes.

Wilkinson operationalizes ‘shame’ as the primary psychosocial mediator between the effects of socioeconomic status and health inequality. Consumer culture requires that people maintain a basal level of consumption for social membership. However, the normative level is largely established by the consumption patterns of the wealthy (and disseminated through mainstream media outlets). He argues that shame results from the inability to conform to this requirement and is thus a direct consequence of relative income. Wilkinson finds that these social status differentials as reflected by income differentials “have a huge impact on whether people feel valued, appreciated, and needed or, on the other hand, looked down on, ignored, treated as significant, disrespected, stigmatized, and humiliated” (Wilkinson 2005, 26). The

pervasiveness of such *psychosocial* traumas produces the chronic stress that *physiologically* contributes to increased morbidity and premature mortality.

PART II STRUCTURALIST

Despite the apparent advantages of the psychosocial explanations of social inequalities in health vis-à-vis the structural, the arguments advanced are not explicitly supported by social theory. That is, these causal mechanisms lack a basic motivation. (This should come as no surprise, as most of the contemporary scholars discussed are epidemiologists.) However, Waitzkin explicitly uses a Marxist framework to argue that the source of health inequality is in the dynamics of the capitalist accumulation process as mediated by various institutions.

HEALTHCARE, SOCIAL CONTRADICTIONS, AND DILEMMAS OF REFORM

The primary structural derivatives of the social inequalities in health responsible for the three contradictions identified by Waitzkin are medical oppression in class structure, monopoly capital, the state, and medical ideology. As discussed below, the Marxist discourse on class structure is predicated upon the existence of two classes: the capitalist class and the working class. The former owns the means of production, which leaves the latter only their labor-power to sell for the necessary means of subsistence. Profit derives from the difference between the wages paid for the worker's necessary means of subsistence and the value that is created by the worker's labor-power (in the form of commodities). The capitalist's goal is to maximize this differential and thereby create surplus value. Within this framework the minimum limit of the working-day is bound by the time required for the production and reproduction of the worker. On the other hand, the maximum limit of the working-day is bound by physical and social

conditions, namely the physical limits of labor-power and the moral standards established by the “general state of social advancement” (Marx, Capital Volume One 1976, 341).

It follows that there is an impetus for the capitalist to decrease the lower bound and increase the upper in the service of profit. Marx describes the situation thus: “capital has one single life impulse, the tendency to create value and surplus-value, to make its constant factor, the means of production, absorb the greatest possible amount of surplus labour.” Marx goes on to say that in this way, capital is “vampire-like, only lives by sucking living labour, and lives the more, the more labour it sucks” (Capital Volume One 1976, 341). And capital does this without regard to the worker’s well-being, save maintaining the worker as one might a machine to maximize efficient production—if such is profitable at the given historical moment. Moreover, increased division of labor increases competition among workers as technological advancement allows one worker to perform the labor of many:

The more productive capital grows, the more the division of labour and the application of machinery expands. The more the division of labour and the application of machinery expands, the more competition among the workers expands and the more their wages contract. (original emphasis; Marx, Wage Labour and Capital 1978, 216)

In this way, as time progresses, workers are forced to accept increasingly unsatisfying, repulsive and often hazardous work.

The social contradiction between profit and safety proposed by Waitzkin follows from these conditions and is manifested in two forms: occupational safety and environmental safety. In both cases, considerations of profit tend to overshadow safety concerns. In general, increased safety typically implies increased production costs and, as a result, decreased profits. Occupational safety requires technical improvements to protect workers from toxic fumes, chemical exposure, accidents, repetitive stress injuries, etc.; moreover, it often entails a slower

pace of work. Environmental safety requires the proper disposal of industrial byproducts and wastes instead of their release into the surrounding community. Either way, workers must choose between the safety of themselves and their community on one hand and continued employment on the other. In this way, the “constraint of private profit is a structural basis for resistance to changes in production that would ensure occupational health and safety” (Waitzkin 2000, 8). To illustrate his point, Waitzkin considers two scenarios: plastic workers’ liver cancer and brain disease from mercury poisoning.⁷

Plastic workers’ liver cancer is an example that concerns occupational safety. In 1974 three workers in a plastic factory developed angiosarcoma in the liver, a cancer that was previously thought rare. However, further investigation led to the discovery of twenty-six additional cases. Studies immediately found an unambiguous link between vinyl chloride, a chemical used in the production of plastics, and liver cancer. Although the connection was already known in the medical community, evidence dating back to 1938 that linked vinyl-chloride exposure to animals with carcinogenesis had been suppressed by the plastics industry. Nevertheless, the industry continued to resist attempts at reducing occupational exposure. Finally, a compromise was reached between the U.S. Occupational Safety and Health Administration and the plastics industry, but exposure limits were still above what was deemed safe by outside investigators. Aware of the potential threat to health, workers were forced to choose between occupational safety and continued employment. This example lends credence to Marx’s observation that in addition to the “deterioration of human labour-power by robbing it of its normal, moral and physical, conditions of development and function,” these conditions

⁷ Additionally, Waitzkin reports on asbestos workers’ lung disease and cancer and “farmworkers’ back.”

also produce the “premature exhaustion and death of this labour-power itself.” In effect, “It extends the labourer’s time of production during a given period by shortening his actual lifetime” (Wage Labour and Capital 1978, 374). Nevertheless, private enterprise invariably favors profit over safety.

Brain disease from mercury poisoning is an example that concerns environmental safety. In 1907 a chemical plant was built in the coastal community of Minamata, Japan, whose major industry was fishing. Since the factory dumped its unprocessed waste products in Minamata Bay, fish began to die. In response to protest, petrochemical conglomerate Chisso Corporation, which had purchased the plant, began providing local fishermen monetary compensation. A few years later in 1932 the company began the production of acetaldehyde, which required mercury as a catalyst in production, and the heavy metal started to appear in the factory’s discharge. Beginning in 1952, cats began to show bizarre behavior followed by death; soon, children and adults began to exhibit similar neurological disorders which were symptomatic of heavy-metal poisoning. Between 1956 and 1957, 52 people were affected and 21 died from ingesting contaminated fish. Soon thereafter, a scientist under the employ of Chisso Corporation reported similar results when he fed waste from acetaldehyde production to a cat. The corporation silenced him and suppressed the evidence until trials began in the late 1960s. However, the company continued to deny accusations concerning the environmental outcome of its waste disposal procedures. Eventually the plant began to use a less hazardous method of acetylaldehyde production. Nevertheless, Japanese researchers estimated that upwards of 10,000 people fell ill with “Minamata Disease” as a result of consuming fish caught in the waters surrounding the bay. Again, private enterprise chose profit over safety.

MONOPOLY CAPITAL

Monopoly capital refers to the concentration of economic capital in a small number of companies—monopolies. Under capitalism, monopolization is attractive because it reinforces corporate profit. Waitzkin argues that health-care systems tend to follow this trend, especially in countries like the United States where the health industry is largely privatized. He writes, “Contributing to the problems of medical maldistribution and rising costs of care, monopoly capital manifests itself in several ways,” namely in medical centers, finance capital, and the “medical-industrial complex” (Waitzkin 2000, 42).

Since ca. 1910, the number of medical centers, typically associated with universities, has steadily increased. Waitzkin observes that “Capital is highly concentrated in these medical centers, which are heavily oriented to advanced technology” (Waitzkin 2000, 42). Consequently, medical practitioners often specialize and are trained to use advanced technologies like critical care units (CCUs, see below). It follows that there is a degree of reluctance on the part of health professionals to leave urban centers where they can utilize their narrow expertise and practice cutting-edge medicine, which is facilitated by the use of advanced technologies. Otherwise, their education might seem superfluous in its application to more traditional, “basic” medicine (i.e. that which does not depend on advanced technologies).⁸ Taken together, Waitzkin argues that the “nearly unrestricted growth of medical centers has heightened the maldistribution of health workers and facilities throughout the United States and within regions” (2000, 42).

⁸ Waitzkin writes: “as expensive technology proliferates, cheap and mundane medical practices receive little attention, even though they may be more appropriate.” (Waitzkin 2000, 6)

The influence of finance capital in medicine is evident in the ability of large profit-making corporations—in particular, pharmaceutical, medical equipment and insurance companies—to impact public policy by virtue of the capital they command. For instance, Waitzkin observes that among publically traded (private) insurance companies in the late 1990s, five companies accounted for 54% of total revenues acquired by the top twenty six companies.⁹ It is thus evident how companies like Metropolitan Life and Prudential, both of which control more assets than General Motors, can influence health reform proposals. As the author notes, it is no coincidence that most national health insurance proposals in the United States include a continuing role for the insurance industry.

The “medical-industrial complex” is a model that emphasizes the exploitation of illness for profit as a central feature of the health-care system under capitalism. In particular, the pharmaceutical and medical equipment industries are key players because of their “advertising and marketing practices, price and patent collusion, and promotion of drugs before their safety is tested” (Waitzkin 2000, 43). Waitzkin emphasizes their role in the development and promotion of advanced technology:

These industries have played a prominent role in developing and promoting expensive therapeutic innovations in cardiovascular disease (coronary care units [CCUs] and coronary artery bypass surgery), radiologic studies in hypertension and head trauma, fetal monitoring, computerized tomographic scanning, and so forth.

The result, he continues, is that the “medical profession has tended to adopt technologically advanced diagnostic and treatment modalities without controlled trial demonstrating their effectiveness” (Waitzkin 2000, 43). This follows from the need under capitalism for these

⁹ The companies are Metropolitan Life, CIGNA, Aetna, Nationwide, and Principal Financial, all of which are traded on the New York Stock Exchange. (Waitzkin 2000, 43)

corporations to diversify and expand in an effort to create new markets within the health industry (i.e. the creation of new medical needs like CCUs).¹⁰

A corollary of this preoccupation with technological progress is a humanistic decline in the practice of medicine—a shift from “caring” to “curing.” That is, contemporary medicine promotes an etiological interpretation of health care (i.e. treating pathology as a purely physical phenomenon) vis-à-vis a more holistic, medicosocial treatment. This approach is insufficient when concerned with a person’s overall well-being and not just the physical manifestations of their illness. In this way Waitzkin argues that medicine requires a pastoral function. He writes, “Even if their effectiveness is difficult to prove for large populations, medical professionals can offer nurturance, counseling, and emotional support for clients when they are ill or troubled” (2000, 33). Waitzkin notes that prior medical traditions have embraced the emotional relationship between medical practitioners and clients. Examples include homeopathy and folk healing, both of which are sensitive to an individual’s social context.

Moreover, the use of advanced technology further contributes to this humanistic decline by the deskilling of many health professions. Waitzkin finds that “For nurses and ‘allied’ health workers...formal professionalization has coincided with increasing specialization, fragmentation, and preprogramming of the work process” (Waitzkin 2000, 34). For instance, as new advanced technologies are introduced into the medical profession, new specialized workers are required for their operation (e.g., X-ray technicians). That is, division of labor in the health professions increases with the introduction of these technologies. Marx argues that with

¹⁰ This also provides the impetus for corporations to expand into “underdeveloped” regions of the world. As Marx writes, the “need of a constantly expanding market for its products chases the bourgeoisie over the whole surface of the globe.” (Manifesto of the Communist Party 1978, 476)

the division of labor, some crippling of body (i.e. for manual laborers) and mind occurs. He quotes David Urquhart's assertion that "To subdivide a man is to execute him, if he deserves the sentence, to assassinate him if he does not ... The subdivision of labour is the assassination of the people" (Marx, Capital Volume One 1976, 484-5). In this way the introduction of new advanced technologies contributes to the humanistic decline in the health professions. However, the effects are not limited to health-care workers. The alienation health professionals often feel in the daily performance of rote tasks is also felt by the patients with whom they must interact. That is, the fragmented tasks these workers perform result in impersonal, fragmented relationships with their patients.¹¹ All things considered, the "technical components of modern medicine have tended to overwhelm its humanistic goal" (Waitzkin 2000, 33).

Waitzkin addresses issues of access primarily through his discussion of the private-public contradiction, which in many ways is at the intersection of the other three. Largely a consequence of the corporate invasion of medicine, the private-public contradiction "encourages the public subsidization of private practice and health-care facilities" (Waitzkin 2000, 31). The result is less funding for public institutions "to the benefit of private profit and to the detriment of patients using the public sector" (Waitzkin 2000, 44). As public hospitals are converted to private hospitals or become affiliated with medical schools, medical maldistribution is exacerbated by the same forces discussed above, namely class structure, monopoly capital, the state and medical ideology. Many patients of lower socioeconomic status are denied access to private medical facilities despite having Medicare or Medicaid, and the

¹¹ Waitzkin writes: "The diversity of these tasks and the variety of health-care workers who carry them out lead to a frequently untegrated and dissatisfying situation for patients and workers alike." (Waitzkin 2000, 34)

situation is more severe for the working poor who cannot afford private insurance yet do not qualify for public insurance; alternatively, Waitzkin argues, “Poverty and language barriers interfere with [people’s] ability to use transportation, education facilities, and welfare benefits for which they are eligible” (2000, 114). The aura of medicine’s power, promoted by the use of advanced technology, maintains this status quo by obfuscating the illness-generating social conditions responsible for many diseases, which is more acute lower in the socioeconomic hierarchy. In short, a brief analysis of access shows that the problems of the health system are linked to the broader political, economic, and social systems of capitalist society.

PART III PSYCHOSOCIAL

While the arguments of the psychosocial camp lack cogency for want of an explicit explanatory framework rooted in social theory, this is not to suggest that their logic is resistant to traditional theorists, particularly Marx. In fact, the opposite is true. The status syndrome and autonomy argument advanced by Marmot is located in the sphere of production, whereas the positional competition and consumer culture argument advanced by Kawachi and Kennedy and Wilkinson is located in the sphere of consumption. Thus, the dominant discourse within the psychosocial camp already suggests two distinct theoretical trajectories. Operating within a Marxist framework makes it possible to identify and explain the different motivations behind the causal mechanisms proposed by the psychosocial camp.

PHYSIOLOGICAL CONSEQUENCES OF PSYCHOLOGICAL STRESS

Understanding the psychosocial derivatives of social inequalities in health requires an appreciation for the physiological consequences of psychological stress—stress can make us sick. An ironic benefit of epidemiological transition is that people in developed nations “are now living well enough and long enough to slowly fall apart.” That is, “The diseases that plague us now are ones of slow accumulation of damage” (Sapolsky 2004, 3). Renowned biologist Robert Sapolsky argues that our pathology concerns such “intangibles” as “emotional turmoil, psychological characteristics, our position in society, and how our society treats people of that position” (3). Note that these are psychological and social disruptions that may produce acute physical crises and chronic physical challenges. Nevertheless, regardless of the stressor, the body activates the same stress-response, which Walter Cannon called the “fight-or-flight” syndrome. In nature, this is generally a desired ability. Our ancestors utilized the fight-or-flight response to both evade predators and capture prey. However, prolonged activation of the stress-response can cause more damage than the stressor itself.

To understand this paradox requires a rudimentary understanding of vertebrate physiology. The principle way the brain controls bodily function is through nerve impulses. The autonomic nervous system comprises the sympathetic and the parasympathetic pathways. The former mediates vigilance, arousal, activation, and mobilization: it dilates pupils, inhibits salivation, accelerates heartbeat, inhibits digestion, stimulates secretion of epinephrine, and stimulates orgasm. On the other hand, the latter mediates calm, vegetative activities: it constricts pupils, stimulates salivation, slows heartbeat, stimulates digestion, and stimulates sexual arousal. In short, “the autonomic system works in opposition: sympathetic and parasympathetic projections from the brain course their way out to a particular organ where,

when activated, they bring about opposite results” (Sapolsky 2004, 22-3). The other way the brain controls bodily function is through hormone secretion. However, it is typical that the two act in concert.¹²

In general the stress-response is concerned with optimizing muscle function. Therefore, the first action is to mobilize energy (primarily in the form of glucose) from storage sites and to inhibit processes involved in further storage. To get it to the target muscles as rapidly as possible, heart rate, blood pressure, and breathing rate all increase to rapidly transport both energy-rich molecules and oxygen. Moreover, given the immediate nature of the stress-response, long-term processes are suspended: digestion, growth, and reproduction¹³. Also, the immune system is suppressed, our perception of pain becomes blunted, certain aspects of memory improve, and senses become sharper. Sapolsky summarizes the consequences of the stress-response with the following metaphor: “the body spends so much on the defense budget that it neglects education and health care and social services” (13). The consequences are self-evident: the body slowly degrades. For in a state of chronic stress, to follow the metaphor, “education and health care and social services” are curtailed almost indefinitely.

¹² The brain responds to stress through the release of hormones by the autonomic nervous system. While hormones like epinephrine and norepinephrine act within seconds, another class of hormones, glucocorticoids, reinforce this response over the course of minutes or hours. When the brain senses or anticipates stress, it triggers the release of corticotrophin releasing hormone (CRH) into the hypothalamic-pituitary circulatory system. The next step in the signal cascade is the release of corticotrophin (ACTH) by the pituitary. ACTH enters the bloodstream and upon reaching the adrenal gland, triggers the secretion of glucocorticoid. Together, epinephrine, norepinephrine, and glucocorticoid dominate the stress-response.

¹³ Sapolsky writes, “sexual drive decreases, in both sexes; females are less likely to ovulate or to carry pregnancies to term, while males begin to have trouble with erections and secrete less testosterone.” (Sapolsky 2004, 11)

Marmot locates the mechanism that mediates the relationship between socioeconomic status and health inequality in the sphere of production. He states that the status syndrome is “about the fact that control over life circumstances and full social engagement and participation in what society has to offer are distributed unequally, and as a result health is distributed unequally” (Marmot 2004, 6). The issue, as above, concerns equality. And the British Whitehall studies (of which Marmot was a part) clearly illustrate the relationship between relative position in the socioeconomic hierarchy and health.

Lifestyle is related to socioeconomic status. It appears common sense that “the lower the social status, the more likely people are to behave badly—in ways that damage their health” (Marmot 2004, 43). Whitehall corroborates these findings. However, aspects of lifestyle account for the relationship between socioeconomic status and health less than most believe. In one study this amounted to less than a third of the differences (referenced in Marmot 2004, 45). Low socioeconomic status is directly related to control over life circumstances such that “*Relative deprivation in the space of incomes can yield absolute deprivation in the space of capabilities*” (original emphasis; Marmot 2004, 74). Therefore, a lack of control results in stress. To illustrate this Marmot considers the following scenario of a how a potential factory closure differentially affects people according to their socioeconomic status.

Maria is a manual laborer in a clothing factory located in Massachusetts. Her husband is laid off and has consequently turned to alcoholism. As the sole breadwinner in the family, her situation is precarious de facto. With the potential for factory closure, Maria finds herself subject to forces out of her control; not only is she already impoverished, but if the factory does

close, her loss of job implies a loss of livelihood. In short, if her economic situation were not already stressful, her lack of control over her life in view of an impending closure only exacerbates her situation. Here Maria suffers from a lack of autonomy. Rick, on the other hand, is the owner of the clothing factory. While he wishes to keep his family's business viable, competition abroad makes profit impossible unless he opens a sweatshop (which he refuses to do). While the closing of his factory is emotionally difficult, he has sufficient wealth to provide for his family without the income derived from it. Moreover, he has the social capital to facilitate an easy transition into some other endeavor. Here Rick enjoys a high degree of autonomy. In comparison to Maria, his stress is neither acute nor chronic. That is, Maria stands to lose the most, and her awareness of the situation only reinforces the threat to her health. This is an example of how prolonged activation of the stress-response can cause more damage than the stressor itself. It follows that work appears central not only to socioeconomic status as regards capital accumulation, but also psychological and thus physiological well-being. However, Marmot's analysis fails to consider the nuances of this relation; what is the motivation behind his proposed social mechanism? Such an explanation requires the application of a more theoretical foundation, namely Marx's concept of 'estranged labor'.

The young Marx addresses the importance of work to an individual's well-being. As a humanist, he was primarily concerned with mankind's alienation with respect to abstract labor, that work which is done for a wage and not for its own sake.¹⁴ He argues that man is a 'species-being', party to the special unity that follows from mankind's unique ability to be conscious of its species. And since man is thus one among others, he is an individual whose "productive life

¹⁴ Masculine pronouns are used to remain consistent with Marx's original wording.

is the life of the species” (Marx, Economic and Philosophic Manuscripts of 1844 1978, 76). That is, it is in our inherent capacity to produce (make, create, etc.) that humans show themselves to be species-beings.¹⁵ For instance, while animals produce to fulfill immediate needs, humans, when free from the need for the necessary means of subsistence, can produce according to universal standards (e.g., beauty). In short, spontaneous productive activity is the essence of humanity. When labor is not estranged, the product of a worker’s efforts is his to dispose of as he deems appropriate.

However, under conditions of ‘estranged labor’, workers are forced to produce for another, and the product of their labor ceases to belong to them and instead become the property of their employer, the capitalist (hence the object is alienated from its producer). In this way workers under capitalism are alienated from the essence of humanity. If mankind is alienated from its essential humanity, it follows that, as humans are social animals, man is alienated from fellow man. And, “[i]f his own activity is to him an unfree activity, then he is treating it as activity performed in the service, under the dominion, the coercion and the yoke of another man” (Marx, Economic and Philosophic Manuscripts of 1844 1978, 78). Humans thus identify competitively, for capitalism has come to rule every dimension of our lives. Actors no longer relate to one another as fellow actors, but potential instruments of self-interest. Marx’s discussion of work thus provides the theoretical foundation on which Marmot’s argument concerning autonomy rests. In short, work is central to our lives and well-being. When forced to work, both the activity of work and the objects it produces become detached from the laborer. In this way Marmot’s analysis follows Marx’s logic.

¹⁵ Marx writes, “The object of labour is, therefore, the *objectification of man’s species life*.” (Marx, Economic and Philosophic Manuscripts of 1844 1978, 76)

Contemporary theory concerning the impact of work on the “white-collar proletariat” extends Marx’s analysis into the realm of psychology. The thrust of Marmot’s argument comprises four points: (1) work provides income and life chances; (2) we are what we do (to an extent); (3) occupation largely determines social status; and, (4) “we spend so much time in the workplace that it is a major source of pain and pleasure, demands and rewards, frustrations and fulfillment” (Marmot 2004, 121). Two models reviewed by Siegrist and Töres (2006) describe how these variables collude to produce stress for the worker: the ‘demand-control’ model and the ‘effort-reward imbalance’ model.

The ‘demand-control’ model “posits that stressful experience at work results from a distinct job task profile defined by two dimensions, the psychological demands put on the working person and the degree of control available to the person to perform the required tasks” (Siegrist and Töres 2006, 75). This model differentiates between ‘high strain jobs’ and ‘active jobs’. A ‘high strain job’ combines high demands with low control. The result is a perceived loss of autonomy and sense of control compounded by continued pressure. Physiologically, high strain jobs promote a catabolic state of excessive arousal of the autonomic nervous system. However, the anabolic state of relaxation that “follow[s] the experience of control and mastery” does not compensate for the depressed catabolic state. ‘Active jobs’ have the opposite effect. They “are defined by challenging demands that go along with a high degree of decision authority and learning opportunities.” Moreover, active jobs “enable individuals to

experience positive stimulation, success and self efficacy” (Siegrist and Töres 2006, 75).¹⁶ Since the catabolic and anabolic states are together in equilibrium, an imbalance can trigger stress.

The ‘effort-reward imbalance’ model “is concerned with stressful features of the work contract” and “builds on the notion of social reciprocity” (Siegrist and Töres 2006, 76).¹⁷ That is, social reciprocity is the foundation of the employment contract, which stipulates adequate remuneration—money, esteem, opportunity for advancement, and job security—for services rendered. The effort-reward imbalance model posits that:

lack of reciprocity occurs frequently under specific conditions...and that failed reciprocity in terms of high cost and low gain elicits strong negative emotions with a special propensity to sustained autonomic and neuroendocrine activation and their adverse long-term consequences for health. (Siegrist and Töres 2006, 76)

The specific conditions are ‘dependency’, ‘strategic choice’, and ‘overcommitment’. ‘Dependency’ refers to structural constraints of contractual exchanges in which there are incentives for the employer to offer non-equitable remuneration because the risk of losing the worker is minimal. In particular, this applies to unskilled or semiskilled workers like migrant farmers. ‘Strategic choice’ refers to the acceptance of high-cost/low-gain employment conditions that will improve chances of increased remuneration at a later stage. Often these “anticipatory investments” are observed in the early stages of certain professional careers (i.e. when people must “pay their dues,” etc.). However, security is by no means guaranteed, and workers can incur substantial loss on contract violation. ‘Overcommitment’ refers to the motivation for high achievement for want of approval and esteem at work. This pattern of behavior continues in lieu of appropriate remuneration. However, it can serve as an

¹⁶ The effects of ‘high strain jobs’ are compounded in ‘iso-strain jobs’ where high demand and low control are combined with low social support at work or social isolation. (Johnson and Hall 1988)

¹⁷ Note that it is complementary to the first model, demand-control.

investment: “Work-related overcommitment is often experienced as self-rewarding over a period of years in occupational trajectories.” However, it is noted that “in the long run, overcommitted people are susceptible to exhaustion and adaptive breakdown” (Siegrist and Töres 2006, 77). Together, the demand-control and effort-reward imbalance models may account for the increased instance of occupational stress-related disorders throughout the social gradient.

POSITIONAL COMPETITION AND CONSUMER CULTURE

In contrast to Marmot’s emphasis on the sphere of production, Kawachi and Kennedy and Wilkinson locate the mechanism that mediates the relationship between socioeconomic status and health inequality primarily in the sphere of consumption. Their argument focuses on the nature of consumer society under capitalism, in particular the power of ‘needs’ and how they are constructed. Marx articulated the nature of ‘needs’ as it follows from the relationship of capitalist production to distribution, exchange, and consumption. His analysis provides the theoretical framework that makes it possible to connect the concept of ‘need’ advanced by Kawachi and Kennedy and that of ‘shame’ advanced by Wilkinson.

Marx succinctly defined capitalism as ‘generalized commodity production’ where the worker is defined by his/her capacity to labor. As discussed in part II, since the capitalist class owns the means of production, workers are unable to utilize their productive capacity to generate the necessary means of subsistence. Consequently, the worker is forced to sell his/her labor-power as a commodity, which the capitalist purchases for a given period of time in the

form of a wage.¹⁸ It follows that (1) labor-power can create its own use-value because labor as such is itself a source of value, and (2) this value is determined by the labor-time necessary for the production of the labor-power. The exchange-value of a commodity follows from the latter; since labor-power is inherently linked to the worker, its value embodies the sum total of the exchange-values of the commodities necessary to maintain his/er existence.

This 'mass of necessaries' comprises three components. First, 'subsistence costs' describe the necessary means of subsistence to maintain the worker. Second, 'reproduction costs' describe the need to increase the number of workers and replace them as they expire.¹⁹ Third, 'training costs' describe that which is necessary for the worker's subsistence while undergoing vocational education and the cost of the education itself (if applicable).²⁰ In general, the 'mass of necessaries' is the product of a specific "historical and moral" moment. Marx writes:

the number and extent of his so-called necessary requirements, as also the manner in which they are satisfied, are themselves products of history, and depend therefore to a great extent on the level of civilization attained by a country; in particular they depend on the conditions which, and consequently on the habits and expectations with which, the class of free workers has formed. (Capital Volume One 1976, 275)

It follows that there is a fundamental difference between the value of labor-power and value of other commodities, namely that "the determination of the value of labour-power contains a

¹⁸ Marx writes: "The capitalist, it seems, therefore *buys* their labour with money. They *sell* him their labour for money. But this is merely the appearance. In reality what they sell to the capitalist for money is their labour *power*." (Marx, Wage Labour and Capital 1978, 204)

¹⁹ Marx writes: "there must be included the cost of reproduction, whereby the race of workers is enabled to multiply and replace worn-out workers by new ones." (Marx, Wage Labour and Capital 1978, 206)

²⁰ Marx writes: "The less the period of training...that any work requires the smaller is the cost of production of the worker and the lower is the price of his labor, his wages." (Marx, Wage Labour and Capital 1978, 206)

historical and moral element” (Marx, Capital Volume One 1976, 275).²¹ However, the nature of consumption extends beyond the need to fulfill the necessary means of subsistence.

Consumption is a social dynamic, as is evident from the historically and morally contingent nature of how the mass of necessities is defined. Consider the general relation of capitalist production to distribution, exchange, and consumption. Marx describes it thus²²:

Production is determined by general natural laws, distribution by social accident, and the latter may therefore promote production to a greater or lesser extent; exchange stands between the two as formal social movement; and the concluding act, consumption, which is conceived not only as a terminal point but also as an end-in-itself, actually belongs outside economics in so far as it reacts in turn upon the point of departure and initiates the whole process anew. (Marx, The Grundrisse 1978, 227)

Thus consumption provides the means by which the capitalist system functions—“the singularity in which the whole is joined together” (Marx, The Grundrisse 1978, 227). Within this relationship ‘need’ derives from the influence of production on consumption because of the fundamental relation between the two, namely that production and consumption supply each other’s object. Therefore, not only does consumption complete the process initiated by the act of production, but “production produces consumption by creating the specific manner of consumption; and, furthermore, by creating the stimulus of consumption, the ability to consume, as need” (Marx, The Grundrisse 1978, 231). In short, need is socially determined by the influence of production on consumption.

‘Need’ under capitalism is the need for money.²³ In discussing the relative needs of the worker vis-à-vis the capitalist, Marx writes that “The worker’s *crude* need is a far greater source

²¹ Marx writes that the determination of this value is readily apparent: “in a given country at a given period, the average amount of the means of subsistence necessary for the worker is a known *datum*.” (Marx, Capital Volume One 1976, 275)

²² Alternatively, Marx writes: “Production creates the objects which correspond to the given needs; distribution divides them up according to social laws; exchange further parcels out the already divided shares in accord with individual needs; and finally, in consumption, the product steps outside this social movement and becomes a direct object and servant of individual needs, and satisfies it in being consumed.” (Marx, The Grundrisse 1978, 227)

of gain than the *refined* need of the rich” (original emphasis; Marx, Capital Volume One 1976, 98). It follows that ‘greater wealth’ is also ‘greater social wealth’. However, as alluded to in part I, developed nations have overcome ‘crude need’ with respect to the absolute deprivation experienced by the nineteenth-century proletariats à la Marx. Yet, the relationship between wealth and socioeconomic status remains. That is, it is the ability to consume that confers social status. This gives rise to the positional competition described by Kawachi and Kennedy. While ‘crude needs’ and ‘refined needs’ are not entirely analogous to notions of ‘material needs’ and ‘positional needs’, respectively, Marx’s logical framework provides a theoretical explanation for their relevance to the individual. Here, however, the focus of this exposition is on the nature of the goods that satisfy these needs, in particular how they come to decide a person’s ability to participate in society.

Kawachi and Kennedy suggest that needs follow from the ever-changing normative lifestyle established by the consumption patterns of the affluent. In fact, the creation of expanded definitions of need underlies the constant creation of new markets on which capitalism depends (see footnote 10 on p. 18). This requires overt societal distinction between goods that are purported to fulfill our crude, material needs and those that are of a positional nature because others lack them. (Consider again the case of the automobile. Before Henry Ford perfected their production, cars were luxury goods of a purely positional nature. But with the proliferation of cars came a concomitant dependence on them. The automobile became a crude need, a necessity in the daily commute to work. That is, the normative definition of need

²³ Marx writes: “The need for money is therefore the true need produced by the modern economic system [capitalism], and it is the only need which the latter produces.” (Marx, Economic and Philosophic Manuscripts of 1844 1978, 93)

expanded to include, in this instance, the Ford Model T. However, a luxury car is just that, a luxury, and in this way 'positional goods' can fulfill both crude and refined needs, for the corporate CEO still needs transportation to work.) Nevertheless, positional competition is confined to indicators of relative superiority. Since the status conferred by positional goods is generally ephemeral (unless the person is affluent), the pursuit of regard requires constant exertion and ultimately leads nowhere. Thus, Kawachi and Kennedy argue that attempts at "keeping up with the Joneses" are largely in vain: "as the wealth of a society increases, and material needs are met, the demand for former luxuries becomes more extensively diffused throughout the population." They continue, "As the frontier of basic wants closes, demand or the acquisition of positional goods spreads and intensifies [and c]ompetition shifts increasingly from the material sector to the positional sector" (Kawachi and Kennedy 2002, 70). In this way patterns of economic growth that result from greater socioeconomic disparity exacerbate positional competition. This observation led Kawachi and Kennedy to propose the 'relative income hypothesis'.

The 'relative income hypothesis' is the "conjecture that a person's level of well-being depends not just on their own level of income, but on everybody else's" (Kawachi and Kennedy 2002, 54). From a Marxist-humanist perspective, this functions because the inability to achieve the desired level of consumption is essentially a social failure that deprives the worker of his/her humanity:

just as society itself produces man as man, so is society produced by him. Activity and consumption, both in their content and in their mode of existence, are social: social activity and social consumption; the human essence of nature first exists only for social man; for only here does nature exist for him as a bond with man—as his existence for the other and the other's existence for him—as the life-element of the human world;

only here does nature exist as the *foundation* of his own *human* existence. (original emphasis; Marx, Economic and Philosophic Manuscripts of 1844 1978, 85)

This paints a grim picture of the relationship between the worker and his/her need to consume. However, although the purpose of life under capitalism is to consume, a complete understanding of this dynamic is not possible without a psychological mechanism to mediate the relationship between consumption and failure. Here Marx has provided the theoretical foundation on which to make the logical transition from Kawachi and Kennedy's discussion of need to Wilkinson's discussion of shame.

Wilkinson finds that low social status, few friendships, and poor emotional development early in life are the major contributors to the psychological risk factors for ill health (Wilkinson 2005, 86-7). Moreover, "they are all focused centrally on different aspects of the way we are affected by the quality of social relations" (Wilkinson 2005, 88-9). Thus these factors are all profoundly social in nature. It follows that the risk factors manifest themselves in social insecurity and anxiety. He writes:

What these three psychosocial variables...[are] surely pointing to is the way we, as reflexive beings, come to know and experience ourselves through each other's eyes. At the core of what it means to say that, as humans, we are social beings is that we monitor ourselves through each other's eyes. (Wilkinson 2005, 90)

That is, monitoring ourselves through each other's eyes is necessary to direct our social behavior and interaction. Moreover, it is a cultural phenomenon in that socialization occurs reflexively, for members of society realize themselves through each other's eyes. Wilkinson writes, "So essential is this intimate monitoring of others' reactions to us for our security, safety, socialization, and learning that instead of experiencing it as their reaction to us, we often experience it as if it were our experience of ourselves" (Wilkinson 2005, 91). In this way

pride results from the perception of positive evaluations of the self, which is the reflexive response to someone else's appreciation of a particular characteristic or action. On the other hand, shame results from the failure to achieve positive evaluations of the self by eliciting the appreciation of others, a dynamic which thus functions to promote conformity.

In his analysis of shame and conformity, Thomas Scheff posits shame as the key social emotion (Scheff 1988). He notes Charles Darwin's observations concerning the relationship between blushing and self-attention, namely that (1) blushing is caused by shame and (2) shame is caused by the perception of negative evaluations of the self. Scheff writes of the latter that "shame is *the* social emotion, arising as it does out of the monitoring of one's own actions by viewing one's self from the standpoint of others" (original emphasis; Scheff 1988, 398). It follows that "Mutual conformity and respect lead to pride and fellow feeling, which lead to further conformity, which leads to further positive feeling, in a system that seems virtually automatic" (Scheff 1988, 397). That is, it is shame—more appropriately the avoidance of shame—that directs our social behavior and interaction towards conformity. Wilkinson argues that since the purpose of life under capitalism is to consume, this conformity manifests itself in patterns of consumption. As such, shame is the psychological mechanism that drives us towards the normative lifestyle established by the consumption patterns of the affluent.

Taken together, the argument advanced by Kawachi and Kennedy and that advanced by Wilkinson imply that shame is the force behind 'positional competition', the social imperative to "keep up with the Joneses." Segal provides a segue between shame and positional competition:

A consumer society makes the development of new consumer goods and the desire for them into a central dynamic of its socioeconomic life. An individual's self-respect and

social esteem are strongly tied to his level of consumption relative to others in society.
(cited in Kawachi and Kennedy 2002, 71-2)

Failing to consume in accordance with the social imperative undermines social status, which “has a direct effect on how others see us, whether boosting pride and esteem or making us feel we are devalued and seen as inferior” (Wilkinson 2005, 98). Here Wilkinson is tacitly referring to how shame creates the impetus for insatiable consumption. In short, chronic stress results from the influence of positional competition on shame because failure to consume at a “normal” level (yet out of reach for most) is a moral failure to obey society’s dictates and thus is unable to elicit the appreciation of others. Without other’s appreciation, reflexive appraisal will only engender feelings of shame, the opposite of “pride and fellow feeling.”

Consider the ‘Roseto effect’, which, though describing an isolated event, illustrates how these findings are manifested in “the real world.” Medical researcher Stewart Wolf studied the town of Roseto, Pennsylvania, where there was a medical mystery: while the citizens of Roseto were subject to the same risk factors as other Americans—cigarette smoking, obesity, etc.—their rate of heart attack was nearly half that of the surrounding communities. Wolf and his researchers examined the typical epidemiological variables, but none could explain this phenomenon. However, what appeared to separate the citizens of Roseto from those of surrounding communities was their high degree of solidarity with the community—a more horizontal (i.e. egalitarian) ordering of social relations—as observed by the lead investigators. Kawachi and Kennedy explain that in Roseto, “The social emphasis of the community was on interdependence, which could be traced all the way back to the time when the town had been settled by immigrants who originated from the same village in rural Italy” (Kawachi and Kennedy 2002, 155-6).

Since solidarity discourages conspicuous consumption, the residents of Reseto were relatively “immune” to many of the stresses wrought by consumer society. While there was income disparity, such did not manifest itself in a way that was readily apparent. Wolf et al. reports that “During the first five years of our study it was difficult to distinguish, on the basis of dress or behavior, the wealthy from the impecunious in Roseto. [...] Despite the affluence of many, there was no atmosphere of ‘keeping up with the Joneses’” (cited in Kawachi and Kennedy 2002, 156). However, as time progressed the younger, more assimilated generations began to behave in accordance with mainstream consumer culture and the taboos against conspicuous consumption weakened. Expensive cars appeared on Roseto’s streets, and ostentatious houses were built in a recently annexed section of town. As the community’s solidarity diminished—social relations shifted toward a vertical ordering—the rate of heart attack eventually increased to a level commensurate with surrounding communities. This lends credence to the observation that there is a direct relationship between (apparent) socioeconomic disparity and health inequalities.

PART IV CONCLUSION

The two camps of scholarship that dominate the discourse on the determinants of health inequality include those who focus on the structural aspects and those who focus on the psychosocial. Of the two traditions, neither is superior. Nor do they necessarily offer conflicting reports. Rather, they represent different logical frameworks for the analysis of the determinants of health. Interestingly, the sheer breadth of Waitzkin’s structuralist analysis desensitized it to the nuances integral to the psychosocial analyses of Kawachi and Kennedy, Marmot, and Wilkinson. Yet, the structuralist analysis is rooted in social theory, namely

dialectic and historical materialism, which provides a solid foundation from which to develop a coherent argument. However, while the psychosocial analyses were not informed by a logical framework rooted in social theory, they still proved amenable to Marxist analysis. In particular, Marx's dissection of consumer society with respect to the coercive power of 'needs' and how they are socially constructed facilitated the development of 'shame' as the force behind 'positional competition'. And the connection has significant explanatory power. Thus this exposition has not only analyzed the structural and psychosocial determinants of health, but illustrates the enduring relevance of classical social theory to contemporary sociological formulations.

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