



PERGAMON

Social Science & Medicine 51 (2000) 135–146

SOCIAL
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Income inequality, social cohesion and the health status of populations: the role of neo-liberalism

David Coburn*

Department of Public Health Sciences, University of Toronto, Toronto, Canada M5S 1A8

Abstract

There has been a recent upsurge of interest in the relationship between income inequality and health within nations and between nations. On the latter topic Wilkinson and others believe that, in the advanced capitalist countries, higher income inequality leads to lowered social cohesion which in turn produces poorer health status. I argue that, despite a by-now voluminous literature, not enough attention has been paid to the social context of income inequality — health relationships or to the causes of income inequality itself. In this paper I contend that there is a particular affinity between neo-liberal (market-oriented) political doctrines, income inequality and lowered social cohesion. Neo-liberalism, it is argued, produces both higher income inequality and lowered social cohesion. Part of the negative effect of neo-liberalism on health status is due to its undermining of the welfare state. The welfare state may have direct effects on health as well as being one of the underlying structural causes of social cohesion. The rise of neo-liberalism and the decline of the welfare state are themselves tied to globalization and the changing class structures of the advanced capitalist societies. More attention should be paid to understanding the causes of income inequalities and not just to its effects because income inequalities are neither necessary nor inevitable. Moreover, understanding the contextual causes of inequality may also influence our notion of the causal pathways involved in inequality-health status relationships (and vice versa). © 2000 Elsevier Science Ltd. All rights reserved.

Keywords: Income inequality; Health inequalities; Political economy of health; Class and health

Introduction

There has been a recent upsurge of interest in the relationships between socio-economic status (SES) and health. Numerous papers in *Social Science & Medicine*, the *International Journal of Health Services*, recent special editions of such journals as the *Sociology of Health and Illness* (1998) and *The Milbank Quarterly*

(1998) and a variety of books (Evans et al., 1994; Amick et al., 1995; Blane et al., 1996) have focused directly or indirectly on the social determinants of health generally and on the SES and health status relationship specifically.

It has long been known that there are historically persistent inverse relationships between SES and health status within nations. In most developed countries health inequalities have not decreased despite rising national wealth (as measured by increasing GNP per capita) and improvements in longevity. Recently attention has turned to analysis of the relationships between

* Tel.: +1-416-978-7513; fax: +1-416-978-2087.

E-mail address: david.coburn@utoronto.ca (D. Coburn).

levels of inequality and longevity amongst the economically advanced nations rather than only within them. In his interesting and provocative book, *Unhealthy Societies: The Afflictions of Inequality* (1996), a central writer in the area, Richard Wilkinson, proposes that, after certain absolute levels of GNP per capita are attained (about US\$5000), the major determinant of differing levels of health status amongst nations lies in their degree of income inequality. In the developed nations, controlling for such factors as GNP/cap, the greater a nation's income inequality — the poorer the average national health status. That is, it is inequality rather than wealth that is important for health.

Wilkinson also cites support for his findings about international differences by research on differences in health status among states in the United States (Kaplan et al., 1996; Kennedy et al., 1996, more recently see Daly et al., 1998; Lynch et al., 1998). The US analyses supports 'the Wilkinson hypothesis' in indicating that inter-state and inter-city differences in health status are more closely related to the income inequality of these areas than to their average level of income.

A focus on absolute levels of income as determinants of health does not explain why some 'rich' countries show lower levels of health than do some poorer, but more egalitarian, countries. It has also been frequently pointed out that within countries, there are differences in health status across the SES gradient. That is, it is not simply those at the low end of the SES continuum that are the issue. Even SES groups quite high in income and SES show poorer health than those immediately above them. Attention has thus turned to the more indirect influence of psycho-social factors on health status rather than simply the direct and immediate effects of material life circumstances. If indeed relative status is related to health up and down the SES hierarchy, then it is likely that psycho-social factors, and not only absolute material conditions are a major influence on health (Wilkinson, 1997a).

Though the psycho-social channels relating inequality to health status within countries are numerous and rather general, many observers argue that those lower in SES show lowered self-esteem, lack of control, more harmful emotional reactions to life events, higher stress or the like. Attempting to explain between country differences Wilkinson, Kawachi and others (Kawachi and Kennedy, 1997; Kawachi et al., 1997; Wilkinson, 1996) have drawn on the work of Putnam (1993) to argue that social cohesion/trust is one of the main mechanisms linking the national degree of income inequality with health. Putnam had contended that northern Italy was more socially and economically successful than southern Italy because the north had developed greater 'social capital' that is, more exten-

sive social networks and greater social 'trust' than had the south. Drawing on these findings, the 'inequality' theorists argue, with some supporting evidence, that higher income inequality produces lowered social cohesion/lower trust which in turn produces lowered health status. It is also implied that between country differences are explained by the fact that elongated status hierarchies exacerbate the status effects noted within countries. Thus, there is a, more or less linear, income inequality-social cohesion/trust/esteem, etc., health status linkage.

Wilkinson's contention that the health differences amongst countries is explained by their differing degrees of income inequality has been critiqued on methodological grounds by Judge (1995 — see also Wilkinson's response, and Judge, 1996) and by Gravelle (1998 — also see responses). In this paper I do not question the income inequality-health status relationship nor will I analyze in any depth the rather vague use of the concept of social cohesion, something which requires separate analysis. Rather, I initially assume that income inequalities amongst nations are related to national levels of health status partly through the vehicle of social cohesion/social disorganization. I discuss 'the Wilkinson Hypothesis' on between country differences to provide a focus for discussion, the analysis that follows has obvious relevance also for within country SES-health status relationship.

Background

As a number of analysts note almost all the attention within the SES-health status tradition has been devoted to attempts to explain why and how SES is related to health (Bartley et al., 1998; Daly et al., 1998; Popay et al., 1998). There has been an overwhelming tendency to focus on the possible social/psycho-biological mechanisms through which social factors might be tied to health rather than on examination of the basic social causes of inequality and health. With only a few exceptions (Muntaner and Lynch, 1999; Navarro, 1999a,b; Scambler and Higgs, 1999) there has been a startling lack of attention to the social/political/economic context of SES or income inequality — health status relationships. It is striking that in various summaries of the literature relating SES to various negative outcomes, and in those proposing or studying various measures to 'prevent' these negative outcomes, the possible causes of inequalities are seldom, if ever, mentioned. For example, a good deal of attention is now centered on low income children in the belief that enriching their environments will help prevent health or others difficulties later in life. Seldom, however, is

there any discussion of the causes of SES differences themselves.

The neglect of putative ‘causes’ is justified on the basis that we should focus our research attention on something we can actually do something about (Syme, 1998). SES or income inequalities are, apparently, viewed as beyond the reach of reform activities. A focus on ‘meso’ or ‘micro’ levels of amelioration of health inequalities is valuable. It might also be argued that bringing about relatively small changes in the consequences of inequality might lead, in time through feedback mechanisms, to changes in inequality itself as Symes implies (Syme, 1998). Nevertheless it is somewhat troublesome that assumptions of what is feasible or unfeasible are used as a justification for the failure to contextualize the Income inequality — health status relationship. Such assessments may not, in fact, be correct. If the ‘contextualizing causes’ of income inequality and social disorganization are not even examined the notion of the feasibility of reform is premature. Moreover, if we assume, with Bhaskar and the ‘realists’ (Bhaskar, 1975, 1989; Sayer, 1992), that social systems are ‘open’ systems then contextual factors may modify our notions of the causal model involved in the SES-health linkage itself. That is, it is misleading to simply draw out the relationships amongst particular social ‘variables’ without consideration of the context within which such relationships exist (cf. Robertson, 1998). Finally, analysis of the income inequality — health relationship might be as useful for what it tells us about social structures as it is for the immediate concerns of public health. Health matters have for too long been viewed as somehow separate from the societies in which they are, in fact, embedded.

The general lack of attention to the possible determinants of SES and to income inequalities is doubly interesting given obvious international and national political and economic trends which one would assume have implications for our understanding of income inequality and, presumably, the health of populations. These trends include the ‘globalization’ of the world economy as well as the rise of New Right political regimes and the concomitant ‘decline of the welfare state’ (Stubbs and Underhill, 1994).

In this paper I use the income inequality-lowered social cohesion-lowered health status sequence put forward by Wilkinson and others as a starting point for broadening discussion of the topic. In doing so I hope only to make more explicit, potential causal pathways and models which are implicit in Wilkinson’s writings on the topic and to build on Wilkinson’s work and explicit proposals which have appeared in recent studies in the area (Lynch et al., 1998; Muntaner and Lynch, 1999; Scambler and Higgs, 1999).

In analyzing the issues raised by the II — SC — health status relationships I relate inequalities to their

broader context, including their relationship to the welfare state and the class bases of different types of welfare state regime. The result of such a consideration does bring back in processes involved in the relationships amongst markets, states and civil society and leads to a somewhat different causal picture about national and international differences in income inequality and in longevity than that usually implied by Wilkinson and others.

In broadening the discussion about the determinants of health Wilkinson contends that Income Inequality produces social disorganization (or lowered social cohesion) which leads to lower average national health status. He is, however, somewhat equivocal about the nature of the causal pathways involving income inequality and social cohesion. In places he suggests that it is possible that social cohesion produces lowered income inequality or that there is some form of reciprocal relationship between the two. That is, a highly cohesive community might ‘not permit’ high levels of income inequality. Wilkinson also suggests that income inequality may directly produce both lowered social cohesion and lowered longevity, i.e., social cohesion might not be the mediator between income inequality and health status. In a number of places Wilkinson and particularly Kawachi and colleagues also imply that markets are at the source of the income inequality problem even though there are obviously differences amongst ‘market societies’. Other writers point to the importance of welfare state measures or a version of social capital (referring to the social infrastructure) as possibly underlying either social cohesion or as a major link between income inequality and longevity (Daly et al., 1998; Davey Smith, 1996; Kawachi and Kennedy, 1997; Kawachi et al., 1997).

Here, I extend the discussions linking income inequality and health by arguing that, rather than income inequality producing lowered social cohesion/trust leading to lowered health status, neo-liberalism (market dominance) produces *both* higher income inequality and lower social cohesion (a proposition suggested by Muntaner and Lynch, 1999) and, presumably, either lowered health status or a health status which is not as high as it might otherwise have been. Neo-liberalism has this effect partly through its undermining of (particular types of) welfare state. Discussion of this thesis, while focused on the income inequality-health status international literature, also has implications for the more widespread and substantial evidence of within country SES — health status relationships. It also draws in analyses of the ‘rise and fall’ of the welfare state as well as the presumed class causes and consequences of such a sequence and thus broadens and contextualizes the topic.

I cannot here examine the history and consequences for health of the revival of neo-liberalism. Simply as a

first step, I show that the fundamental postulates or assumptions of neo-liberalism are congruent with a 'neo-liberalism produces both inequality and lowered social cohesion' conclusion. That is, there is an affinity between neo-liberal doctrines, inequality, and social fragmentation. While I cite evidence supporting this proposition, this paper does not constitute a 'test' of the neo-liberalism — inequality/lower social cohesion — health status linkages, but is simply a first step in opening up neglected areas for exploration. I hope to help 'bring the social back in' by pointing to possible linkages between national and international studies of SES-health status differences and broader social processes. Such a consideration involves a theoretical and empirical literature often viewed as at some distance from the health field, such as those on welfare state theory, globalization and class dynamics.

In asserting a particular affinity between neo-liberalism, inequality and lowered social cohesiveness I point out:

1. that 'ideal-typical' neo-liberal tenets are congruent with the production of, or at least acceptance of, greater socio-economic inequalities (and that selective examples support that contention); and,
2. that there are striking parallels between 'ideal' or pure neo-liberal ideology or tenets and factors related to, or constituent of, social disorganization/lowered trust;
3. that neo-liberalism and economic globalization are associated with the decline of the welfare state. This decline is one of the causes both of increased inequality and lowered social cohesion.

In making these arguments, for the sake of clarity and simplicity I omit the numerous caveats that might modify or make more complex the linkages I suggest. Obviously, societal inequalities and changes in health status have complex, multifaceted causes. I am not trying to posit a 'single cause' explanation. Rather, I point to neo-liberalism as a major, if complex, set of causes, amongst others. Although I equate neo-liberalism with the dominance of markets, the comparisons made are not between 'market' versus 'nonmarket' societies but amongst capitalist societies with varying degrees of market domination.

In the Conclusions I note and briefly respond to some of the more obvious objections to the thesis proposed and outline a possible causal pathway between such macro forces as globalization, changes in the balance of class forces, neo-liberalism and health status.

General tenets of neo-liberalism

I assume that neo-liberalism refers to the dominance

of markets and the market model. Though composed of a complex combination of characteristics the basic assumptions of neo-liberalism, the 'philosophy' of the new right are:

1. that markets are the best and most efficient allocators of resources in production and distribution;
2. that societies are composed of autonomous individuals (producers and consumers) motivated chiefly or entirely by material or economic considerations;
3. that competition is the major market vehicle for innovations.

Neo-liberalism is distinguished from neo-conservatism by the fact that the latter contains a particular social component supportive of traditional family values, particular religious traditions etc and not only a 'free-enterprise' economic doctrine.

The essence of neo-liberalism, its pure form, is a more or less thoroughgoing adherence, in rhetoric if not in practice, to the virtues of a market economy, and, by extension, a market-oriented society. While some neo-liberals appear to assume that one can construct any kind of 'society' on any kind of economy, the position taken here is that the economy, the state and civil society are, in fact, inextricably interrelated.

The relationship between neo-liberal doctrines and inequality

Neo-liberals, I contend, are not particularly concerned about inequality or regard it either as a positive virtue or as inevitable or necessary. That is, if 'the market' is the best or most efficient allocator of goods and resources neo-liberals are inclined to accept whatever markets bring. Certainly, political parties which espouse neo-liberal principles have been the mainspring behind attacks on the Keynesian Welfare State (KWS), whose functions included, not only the correction of market fluctuations but also the amelioration of market-produced inequalities. The welfare state, in the neo-liberal view, interferes with the 'normal' functioning of the market. Neo-liberals oppose any form of 'intervention' in markets because they feel that such intervention damages the operation of 'the invisible hand' which most efficiently aligns production, consumption and distribution (while they at the same time deny that markets themselves are 'structured' by state action).

Neo-liberals contend not only that market inequalities are the necessary by-product of a well-functioning economy but that these inequalities are 'just' because what one puts into the market one gets out. That is, the invisible hand doctrine implies some reasonable relationship between one's activities and subsequent

‘rewards’. Moreover, as noted, there is a resistance to ‘correcting’ market produced inequalities through various welfare state measures, since these are assumed to lead to ‘market distortions’. State actions then are not only inefficient but may also be unethical (while some feel markets are ‘ethical’ e.g., Hendrickson, 1996, others radically disagree see McMurtry, 1998).

The whole ideological and political spectrum is now so skewed towards market solutions that even previously ‘social democratic’ governments have moved towards market oriented policies of varying degrees. Neo-liberalism is not confined only to political jurisdictions in which the new right actually forms the government. Some might assert that this is so because there are no alternatives to increasing neo-liberal policies because of the internationalization of markets or ‘globalization’. We return to this argument later.

Given the focus on markets and inequality any discussion of neo-liberalism, inequalities and health in the contemporary era has to be tied to discussion of the welfare state. After all, the rise of the welfare state was viewed as either preventing or ameliorating the unwanted excesses or problems produced by the market system.

Neo-liberalism, the welfare state and inequality

The contemporary rise of neo-liberalism and of inequality following the 1970s is historically tied to the decline of the welfare state. While markets produce inequalities these may be ‘prevented’ (through labor market policies) or ameliorated (through social welfare measures or the ‘decommodification’ of education, health and welfare). Decommodification meant that access to social resources was not completely determined by market criteria (i.e., income or wealth) or by power in the market (the ability of some groups to bargain for ‘private’ welfare benefits — see Esping-Andersen, 1999). Both health, through the effects of the welfare state on the social determinants of health, and health care, through various forms of national health care systems, are tied to the fate of ‘the welfare state’. Any consideration of the social determinants of health would have to take account of welfare state dynamics. Whether or not the effects of welfare state measures are direct and material or indirect and psycho-social is a matter of dispute. Nevertheless, as Popay et al. (1998), Bartley et al. (1998) and Daly et al. (1998) and others note there may be critical periods of the life cycle in which the ‘buffering’ effects of the ‘social wage’ or of social policies generally are crucially important. Daly et al. even contend that: “political units that tolerate a high degree of income inequality are less likely to support the human, physical, cultural, civic, and health resources needed to maximize the

health of their populations”. (Daly et al., 1998, p. 319). Bartley et al., (1997, p. 1195) feel that the welfare state has both material and psychosocial effects “by preventing dramatic falls in living standards and by a wider effect on the degree to which citizens experience a sense of control of their lives”. Redistributive policies are important materially and psycho-socially. George Davey Smith (1996, p. 988) contends that: “Cross nationally, higher levels of both social expenditure and taxation as a proportion of gross domestic product are associated with longer life expectancy, lower maternal mortality, and a smaller proportion of low birthweight deliveries” (see also Kaplan et al., 1996; Kennedy et al., 1996). There are thus many suggestions that ‘the welfare state’ provided the material base for a more cohesive society and/or more or less directly influences health status.

Neo-liberals opposed or only reluctantly accepted the Post-World War II establishment of the major attributes of the KWS as expressed in various pension, social insurance, health care, labor market or welfare measures involving government actions. Nevertheless, the example of the KWS was used to argue that capitalism had ‘solved’ one of its major problems through ameliorating the inequalities produced by market mechanisms. Whereas, in the 19th century, inequality had been viewed as legitimate or perhaps inevitable, within the KWS issues of inequality seemed no longer a major concern, first, because through the notion of ‘social citizenship’ inequalities in the market were ameliorated and, second, because fluctuations of ‘boom and bust’ were reduced by Keynesian counter-cyclical economic policies (demand stimulation in times of downturn; restriction of demand in times of boom).

Most welfare state analysts attribute the formation of welfare state measures, directly or indirectly to some form of working class pressure or, in more complex formulations, to various class coalitions and class strength (Esping-Andersen, 1990; O’Connor and Olsen, 1998; Korpi, 1989; Quandango, 1987). Ross and Trachte (1990) and others have implied a lessened resistance to working class pressures for welfare state measures from dominant classes in an era of monopoly capital because of divisions within capital between the competitive and monopoly sectors. The KWS, however, is not a unitary phenomenon. As Esping-Andersen (1990, 1999) has indicated, there are various ‘types’ of welfare state of which the ones involving the least state action, and the greatest dominance of market-related solutions were the liberal welfare states of the Anglo-American nations (as opposed to social democratic or corporate welfare states developed elsewhere). In fact, it can be argued that the liberal welfare states did do the least to either prevent (particularly because of the absence of labor-market policies) or to rectify (through social welfare and health care) the depreda-

tions of the capitalist marketplace and the inequalities it tended to produce. Within liberal welfare states social policies were most generally designed to supplement market provision, to reflect participation in the market, or generally, to be targetted or 'means-tested' rather than universal in application. That is, these measures are less 'decommodifying' (Korpi and Palme, 1998).

Most recently, given globalization, in which finance, and, to a lesser extent, industrial, capital has escaped from national controls while labor has not, has come a return to neo-liberal doctrines (Ross and Trachte, 1990; Stubbs and Underhill, 1994; Teeple, 1995). Economic globalization was aided by neo-liberals and neo-liberalism benefited from economic globalization. Hence a 'restructuring' of society, including markets and the welfare state. In a global era it is claimed that higher degrees of inequality are inevitable or that inequalities are an inescapable adjunct to economic growth or to the 'realities' of international competition. Inequality is also viewed as a key motivational factor aiding a productive economy i.e., through lowering the costs of (some) labor. Any measures to alter market-produced motivations simply deform the operation of markets and, furthermore, are unjust or at least inefficient. Inequality, then, is more to be welcomed or at least accepted than it is to be prevented or ameliorated by state or other forms of welfare (see Kenworthy (1998) for a summary and rebuttal of many of these arguments).

Much contemporary neo-liberal policy, in fact, involves 'recommodifying' aspects of society that were 'decommodified' or taken out of the market, during the rise of the KWS. The rise of neo-liberal political regimes has meant an increased focus on means testing regarding various income support measures, on reducing entitlements, or on undermining the power of labor unions or other organizations opposing the strict application of market mechanisms.

The data produced by Wilkinson, but also more general analyses of international differences in income-inequality do suggest that most 'social democratic' or even 'corporate' welfare state regimes, such as the Scandinavian countries have been much less unequal than more neo-liberal regimes such as the United States, Britain, and the former British colonies (Atkinson, 1995; Gottschalk and Smeeding, 1997, 1999; Korpi and Palme, 1998; Smeeding, 1997). Some analysts have also argued that the more social democratic or corporate welfare state regime types have also been more successful in resisting the trend towards a dismantling or restructuring of the welfare state than have the 'market-oriented' Anglo-democracies (Mishra, 1990). Certainly welfare states have both causes and consequences. Evidence indicates, for example, that less market-based social welfare measures in fact re-

inforce support for the welfare state. Universal plus earnings related welfare measures have the effect of reinforcing working and middle class coalitions in support of the welfare state (Korpi and Palme, 1998).

Redistributive policies in the less neo-liberal states have been important in reducing inequalities (cf. Bartley et al., 1997; Kenworthy, 1998). Welfare states did tend to do what they were supposed to do. Inequalities are thus, more or less directly related to the class structure because class pressure tends to reduce the degree to which markets predominate.

The most recent evidence from the United States, Britain, Australia, Canada, New Zealand and the OECD countries generally, indicates that neo-liberalism in action, while obviously a far from perfect neo-liberalism, is associated with (more or less) rapidly increasing inequality. The US and the UK, but also Canada and Australia, show much higher inequality than do such countries as Switzerland, Germany or the Netherlands who, in turn, show higher inequality than do the Scandinavian countries (Atkinson, 1995; Smeeding, 1997; Korpi and Palme, 1998; Kenworthy, 1998; Gottschalk and Smeeding, 1999). It is not that inequalities did not exist before recent neo-liberal regimes or doctrines, simply that inequality was and is, exacerbated under neo-liberalism. As many of the working papers emanating from the Luxembourg Income Studies (n.d.) indicate, the welfare state did ameliorate market inequalities and inequalities were higher in countries with less 'decommodifying' welfare state systems. With the rise of neo-liberal policies and the decline of the welfare state, inequality is rising in most countries, however, inequality is much more noticeable in countries characterized by neo-liberal political and welfare regimes than in less market-oriented systems (Smeeding, 1997; Korpi and Palme, 1998; Kenworthy, 1998; Gottschalk and Smeeding, 1999).

Arguably then markets produce income inequalities, and neo-liberalism opposes measures to redistribute income resources — therefore the proposition: *the more market-oriented or neo-liberal the regime the greater the income inequality.*

A major possible empirical exception to the 'higher neo-liberalism — higher inequality' scenario amongst the developed nations appears to be Japan. That country seems, on the face of it, to show relative income equality (and very high population longevity) yet to be highly market oriented.

It might, however, be argued that Japan was, and is, less market-oriented than previously thought. Although, at the time when Japan was rapidly growing, economically in the 1960s to 1980s most observers viewed Japan as more 'capitalist' or market-oriented than other developed countries, many now have now begun to retract that earlier judgement. Economic observers of a Japan in the late 1980s and 1990s which

shows signs of prolonged economic turbulence now contend that that country, and other ‘Asian Tigers’ are characterized, not by the dominance of markets, but by close (nonmarket) ties between business and the state and/or by various forms of capitalist ‘cronyism’. Furthermore, Japan, with its earlier emphasis on lifetime employment (for employees of large corporations at least), and by a subordinate and ‘service’ role for women, was far from being a thoroughgoing market-oriented economy. Rather, markets in Japan were considerably modified, constrained or shaped by business-state elite ties and by various cultural or normative practices. In sum, Japan might not be as much of a counter-example as is first assumed, although it is obviously worthy of further study.

Finally, the Japanese example raises the more general issue of the nature of the relationship between economies and national jurisdictions and boundaries (Poland et al., 1998). In an era of global trade metropolitan or core nations, like Japan, have economic footprints which extend far beyond their national boundaries. Perhaps a ‘core economy’ can preserve particular levels of equality at the expense of its periphery? What are the units of analysis where economies and inequality are concerned?

The relationship between neo-liberalism and social cohesion/trust

A strong argument can be made that neo-liberal doctrines are antithetical to social cohesion or to social ‘trust’. The image of society which neo-liberalism carries with it is that of voluntaristic ‘possessive individualism’ (Macpherson, 1964). The most appropriate relationship is that embodied in contracts reflecting varied material self-interests. In the neo-liberal view, societies are not more than the sum of their parts. As Margaret Thatcher asserted, there is no such thing as ‘society’ only individuals or families. Whereas in previous liberal theory the state is viewed as at least partially representative of the ‘general interests of society’, in the neo-liberal perspective the state should have as small a role as possible. Not much is said by many neo-liberals, however, about how markets themselves are constructed or about corporate monopolies or oligopolies although thoroughgoing neo-liberals i.e., libertarians (utopian capitalists) claim to want to break up such market hindrances.

As noted, the neo-liberal vision is individualistic rather than collectivist or communitarian. There is a stark divide between collectivist views of society, including the notion that goods can be held ‘in common’, and market ideology. Thus, the first act of many contemporary neo-liberal regimes has been to ‘priva-

tize’ state organizations or functions and those which might be said to have been included in ‘the commons’. Privatization in fact means the individual ownership of what were once possessions or functions of the state as representative of society, or of those things which were previously viewed as the possession of everyone (including natural products, land, fish, etc.). As noted earlier even in the era of the welfare state the ‘liberal’ versions of the KWS were characterized by ‘insurance’ or targeted versus universal or citizenship oriented social or other programs. In that sense, then they bracketed or ‘excluded’ low income groups from the rest of society.

The very notion of citizenship as carrying with it particular rights, social as well as political, is an inclusionary concept. The implication of universal citizenship measures is that we are all members of the same society and we should all benefit. The more neo-liberal targetted programs are exclusionary in ‘privatizing’ the negative effects of market mechanisms. The implication of targetted programs is that it is individuals and families which are the problem, not the structure of opportunities within that society. Yet, as noted earlier, during the life-course de commodification makes critical periods less likely to have negative consequences. These crises include periods of inability to earn an income. Wilkinson himself remarks that: “Indeed, integration in the economic life of society, reduced unemployment, material security, and narrower income differences provide the material base for a more cohesive society”. (Wilkinson, 1997a,b, p. 319).

Neo-liberals generally view anything in the ‘public’ sphere as something which would benefit from privatization. Some of the results of these individualist notions may be reflected in attitudes towards private versus public property or goods. That is, what is private is valued and what is public is denigrated. What is mine is valuable, the rest is not mine or not ‘ours’ either hence is of little concern.

Given the absence of a broader sense of community, neo-liberals advocate individualistic market based ‘solutions’ to problems. Thus, ‘gated’ communities and private security guards as a response to crime, private health insurance as a response to the increased health needs of an aging population. There is an emphasis on private versus public transportation, private versus public schooling, private versus public health care (see Reich, 1991). Reducing the size of government means reducing government expenditures. Neo-liberals strongly favor lower taxes (see Raphael, 1999). Given the use of government revenues to redistribute income then lower taxes imply increased inequality but also connote a privatizing or individualizing of societal risks and opportunities. Even given obvious societal ‘inefficiencies’ as, for example, in the US health care system, neo-liberals prefer private to public expendi-

tures (Drache and Sullivan, 1999). Wilkinson neatly captures the essence of neo-liberalism in the notion of a ‘cash and keys’ economy (Wilkinson, 1996, p. 266 cited in Nettleton and Burrows, 1998):

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

In light of this quote it is interesting that income inequality, and ‘social trust’ have been found to be highly related to homicide and violent crimes (Wilkinson et al., 1998) as well as to a whole range of other social indicators ranging from library books/per cap to high school graduation rates (Lynch et al., 1998).

The absence of any concept of ‘the social’ in neo-liberalism is related to neo-liberal views which imply the universalizing of market characteristics to all areas of human existence. Even ‘the self’ comes to be viewed in terms of its market use. In an ‘enterprise culture’ the self is seen in terms of ‘its’ usefulness on the market as an instrument for ‘economic’ advancement. Social development or even ‘social capital’ becomes individual ‘human capital’. The importance of those aspects of ‘social capital’, aspects of the social environment which benefit everyone, are downplayed or ignored (Coleman, 1988; Evans, 1996; Heller, 1996). Society is thus reduced to a collection of individuals in which the whole is viewed simply as the sum of the individual voluntary actions — social structure disappears.

Privatization and the lack of (noncontractual) connections amongst citizens, implies a generalized increase in scepticism or distrust towards one’s fellows. If everyone is legitimately seeking their own economic self-interest, as neo-liberalism implies, then there is reason for widespread suspicion of the motives and intentions of others rather than ‘trust’. There might be an increasing emphasis on self-aggrandizement at the expense of collective goals, an increasing contempt for public institutions and a lack of support for those organizations through which collective notions are expressed, maintained or reproduced.

Furthermore, since markets are efficient (and just)

allocators of rewards, then economic or ‘social’ problems are attributed to individual failings. If markets give people what they deserve there is likely to be an increase in individual blame and an inclination to punish rather than help others. Thus, recipients of social welfare measures are ‘welfare bums’. As Sennett and Cobb indicate there are many, relatively nonvisible ‘injuries of class’ (Sennett and Cobb, 1973).

While it has been asserted that neo-liberalism produces a lowered sense of community it might also be argued that the rise of neo-liberalism is itself a signifier of the decline of more widespread feelings of social solidarity. The political rise of neo-liberalism is freighted with a more individualistic view of society and, perhaps, itself reflects a decline in the notion of ‘we are all in the same boat’. Not only do neo-liberal policies undermine the social infrastructure underlying social cohesion but neo-liberal movements themselves are partial causes of the decline of a sense of social cohesion.

Thus the proposition: *The more market-oriented the society, the higher the social fragmentation and the lower the social cohesion and trust.*

Neo-liberalism, income inequality and social cohesion/trust

Bringing the two major areas noted above together leads to our general hypothesis that neo-liberalism produces *both* higher levels of inequality *and* lower levels of social cohesion (cf. Muntaner and Lynch, 1999). Rather than an inequality — social cohesion–health status sequence neo-liberalism produces both inequality and social fragmentation which may, if Wilkinson and others are right, have negative consequences in lowered health status.

I have argued that a focus on the relationship between neo-liberalism, income inequality and health leads to a somewhat different understanding of income inequality and health relationships than previously discussed. The emphasis on neo-liberalism as a political movement, and as a signal of attacks on the power of the working class to negotiate within the market or on the welfare state generally is supported by recent examinations of globalization, neo-liberalism inequality and the welfare state by Navarro (1998, 1999a,b), and by analyses of trends in income inequality and the redistributive effects of the welfare state (Kenworthy, 1998). Moreover, it might be argued that social cohesion and the related concept of social capital, themselves have dual meanings. On the one hand some view social capital as ‘social infrastructure’ and others see it more in terms of social networks or trust, its area of greatest overlap with the concept of social cohesion. Even so

much of the discussion about social cohesion seems to measure its effects rather than the actual existence of social networks. That is, ‘trust’ is an assumed consequence of social networks rather than a measure of the extensiveness of social networks. The question arises whether at least some attention should be paid to the social infrastructural arrangements as embedded in the welfare state, which might underlie income inequality — life expectancy relationships. In this light the explosion of interest in social cohesion seems to again signal attention to the ‘mechanisms’ of income inequality rather than to its causes. There does seem a contradiction between an increasing emphasis on social capital and social cohesion under regimes which are actually undermining these processes.

Discussion

After putting forward the proposition that neo-liberalism is a major ‘contextual’ factor regarding income inequality/SES — health status relationships I briefly note some objections to, or modifications of, these arguments before discussing possible underlying causal mechanisms.

First, there might be an efficiency–equity trade-off — that in fact it is ‘prosperity’ rather than lowered inequality that is the most highly related to improved health status and that market societies are associated with higher levels of wealth production than are others. Prosperity trumps equality. Certainly, there is evidence that increased wealth production is associated with improved health cf. the evidence analyzed by Wilkinson. That is, as noted above, below a particular level of GNP/cap (around US\$5000), GNP rather than income inequalities seems to be the major determinant of health status amongst nations. However, contra the prosperity argument, over this level there is little or no relationship between GNP/cap and health status amongst nations. Again, as noted, some ‘less developed’ countries have much better health statistics than do others — many of these seem to have a more equal social infrastructure than the others. Moreover, there are as many suggestions that income equality facilitates economic growth as there are that it harms it.

In the popular literature generally there has been an unwarranted tendency to equate economic ‘development’ with human well-being. In fact, in the advanced capitalist countries, national wealth seems to have relatively little to do with national well-being. Broad indicators of social well-being show considerable divergence from purely economic indicators. Interestingly, there is some data that indicates that, during the welfare state era indices of well-being more or less tracked indices of GNP/cap. With the decline of the

welfare state these indices of social well-being began to markedly decline as compared to purely economic indices (Brink and Zeesman, 1997). The ‘economy’, after all, is presumably only the means to an end and not an end in itself.

There is, however, still some debate about the relationship between ‘wealth, inequality and health’ even in Wilkinson’s account. That is, Wilkinson notes that there has been a general increase in levels of health status over the past decades in the developed countries despite variations in the degree of inequality over that time. Wilkinson thus is describing fluctuations about a baseline rather than the baseline increases themselves. Higher inequality is thus associated with relative decreases in the trend towards greater longevity. He attributes the secular increase itself to improvements in the ‘quality’ of life which are somehow related to higher income levels. The secular rise of e.g., longevity, in Wilkinson’s account, however, does deserve further consideration even though it might be argued that long-term inequality might eventually produce decreases in health status.

A second objection to the neo-liberalism — health status/social cohesion proposition, might be that there is ‘no alternative’ to neo-liberal policies. That, in fact, these are simply outcomes of increased global competition over which no single nation or political regime has much control. The change from nationally based monopoly to global capitalism ensures that, whether we like it or not, neo-liberal policies are our only choice i.e., TINA. That this is not the case, however, is indicated by the differences in economic policy and in income inequality and health that exist amongst the developed nations, and, even amongst particular areas within nations. There are local, national and international examples of, more or less successful, resistance to neo-liberal policies, one of the most recent and most prominent being opposition to the Multilateral Agreement on Investment. There are, in fact, choices to be made. Even so one might agree that the spread of neo-liberalism on a world-wide basis has somewhat constrained national differences, and, that alternatives to neo-liberal perspectives, other than simply a defense of the remnants of the KWS, are not widely debated.

The issue of the inevitability of market oriented policies, does bring up the distinction between neo-liberal tenets, political rhetoric and reality. The principles or general philosophy of neo-liberalism are not always, or perhaps never, actually put into practice. We still have, some might claim, ‘insufficient’ markets rather than an excess of these. Furthermore, some would contend that neo-liberal political regimes have not, for example, actually reduced the power of the state. The state may have retained a role, as exemplified by increased general state expenditures within countries having neo-liberal governments. Certainly, a number of neo-liberal

regimes have, despite their emphasis on individual ‘liberty’ shown a good deal of evidence of centralizing or authoritarian tendencies. ‘Strong’ (authoritarian) state policies are viewed as necessary to ‘break’ opposition to the restructuring of society, but, as noted, these are not state collective policies but policies, often punitive, which are aimed at supporting, or enforcing, markets.

It might be argued that, under neo-liberalism, the welfare state has not disappeared but has simply changed its form. Some authors contend that we now have, not a directly involved state but, ‘the regulative state’ (Ruggie, 1996). In the new globalizing era states do not carry out actions themselves but simply regulate private agencies in civil society to do so. Whatever the ultimate merits of such an argument it is clear that, under neo-liberal regimes, entitlements have been reduced or undermined, and not simply structured in a different way.

An important question is how to begin to understand the mechanisms underlying the rise of neo-liberalism and how this might influence our understanding of rising SES inequalities? While there is not the space here to fully describe a possible sequence, Ross and Trachte (1990) have pointed to one explanatory pathway through their analysis of the change from monopoly to global capitalism. Extending their argument to the welfare state and to neo-liberalism permits a provisional explanation of increasing SES inequalities in class terms (for a more extended discussion see Coburn, 1999 and cf. Muntaner and Lynch, 1999).

Ross and Trachte claim that the globalization of capital has created a new balance of power in which the ‘relative autonomy of the state’ prevalent under nationally based monopoly capitalism, has declined. Under monopoly capital the working class had gained in power in confrontation with a business class divided between its monopoly and competitive fractions. The increasing globalization of financial and industrial capital gave business great political power in its interactions with national, regional and local authorities. The state, which, within monopoly capitalism had attained a ‘relative autonomy’ because of the more equal balance of class power between capital and labor and because of the divisions within capital, in the new global phase is more directly shaped and constrained by business interests (see Navarro, 1998, 1999a,b).

Global competition and the mobility of capital are real forces but are also employed rhetorically by the new right to capture the ideological and political agenda (Navarro, 1999a,b). Ross and Trachte’s argument is that economic globalization brings a new phase of capitalism which produced dramatic changes in the balance of class power. The ‘legitimation’ as opposed to the ‘accumulation’ functions of the state became largely irrelevant in the face of the escape of corporations from national control. Business power

increased and state autonomy decreased. The consequence is the overpowering dominance of market doctrines and policies and, as I assert, increased inequality.

The model which emerges based on this argument is thus that economic globalization is accompanied by and produces changes in the balance of class power. The decline of working class power in the face of a resurgent business class is marked by the domination of neo-liberal ideology and policies, by attacks on the welfare state, and by a dominance of employer interests in the market. The decline of the power of workers to bargain for benefits within markets (Esping-Andersen, 1999), or to politically force decommodification through state welfare measures, produces higher income inequality and lowered social cohesion and, directly and indirectly, lowered health status. International differences in health status can thus be traced to different national class structures, national institutions and different national degrees of ‘marketization’ within common international pressures (Esping-Andersen, 1999; Gough, 1978, 1979).

The argument presented here emphasizes a unique relationship amongst neo-liberalism, income inequality, social fragmentation, and lower health status. It also raises issues about the generally unanalyzed contextual conditions of various hypotheses relating income inequality to health status between and within countries. Hopefully, it will help to draw back into discussion broader social, political and economic factors which to date have been largely ignored in the income inequality/SES — health status literature. Inequality is not a necessary condition produced by extra-human forces. Degrees of inequality are clearly influenced by international, national and local political policies which are amenable to change. We can either ignore these processes or seek to understand and begin to change them.

Acknowledgements

This paper arose from ideas stimulated by discussion in the Critical Social Science and Health Group at the University of Toronto (Joan Eakin, Richard Edwards, Rhonda Love, Pat McKeever, Blake Poland, Ann Robertson and others). I owe much to discussions in that group and with participants in a reading course on Social Cohesion and Health (Blake Poland, Rhonda Love, Ann Robertson, Sylvia-Ann Brooker, Robert Rose, Lyn Talbot). The reviewers comments were helpful.

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