CHAPTER FOUR

METHODOLOGICAL INDIVIDUALISM AND HEALTH INEQUALITIES: A CRITIQUE

The dominant bio-medical model of public health has strong and tenacious philosophical roots in the research tradition of Methodological Individualism (MI). It is not intended to suggest that disease in a population can be understood without reference to biology. The question, however, is what approach one should take: the individual as the unit of study with his or her biology abstracted from social conditions, or disease in populations with biology understood in relation to its social context. The former approach derives from the ideology of MI, which has at its heart, atomistic individuals of the idealized market. The ideology of MI in turn is located within positivist tradition, which provided the breeding ground for the neo-liberal conception of the social world where individuals are relatively free agents with needs, desires, rights and so on. They can choose any profession or occupation, what to buy and sell, where to live etc. The neo-liberals view social institutions as having emerged through the decisions and agreements of individuals or groups of individuals. Even knowledge is explained in terms of individual perceivers or thinkers. Thus, existing social institutions as well as institutional changes are explained in terms of relatively free individuals exercising their choice. The social or economic hegemony exercised by one group of individuals on the other and the consequent class conflict has no place in this theory. The issues of unfreedom, exploitation or inequality are bypassed by
drawing upon a naturalistic explanation of social hierarchy. The neo-liberal conception of social hierarchy or inequality can be understood from J. D. Bernal's description of the analogy between social hierarchy and natural order:

The hierarchy of society was reproduced in the hierarchy of the universe itself; just as there was the pope, bishops, and archbishops, the emperor, kings, and nobles, so there was a celestial hierarchy of the nine choirs of angels, seraphim, cherubim thrones; dominations, virtues and powers; principalities, archangels, and angels (all fruits of the imagination of the pseudo Dionysius). Each of these had a definite function to perform in the running of the universe, and they were attached in due rank to the planetary spheres to keep them in appropriate motion. The lowest order of mere angels that belonged to the sphere of the moon had naturally most to do with the order of human beings just below them. In general there was a cosmic order, a social order, an order inside the human body, all representing states to which Nature tended to return when it was disturbed. There was a place for everything and everything in its place. The elements were in order—earth underneath, water above it, air above that, and fire, the noblest element, at the top. The noble organs of the body—the heart and lungs—were carefully separated by the diaphragm from the inferior organs of the belly. The animals and the plants had their appropriate parts to play in this general order, not only in providing man with necessities, but even more by furnishing him with moral examples—the industriousness of the ant, the courage of the lion, the self-sacrifice of the pelican. ¹

The neo-liberal ideology became the mantra for the newly emerging bourgeois class at the time of the Industrial Revolution. This economically empowered bourgeoisie broke free from the fetters of feudalism and a new capitalist order evolved. The new social order was equally capable of extending both freedom and unfreedom and of simultaneously reducing one set of risks to human welfare and survival while increasing others. Thus, what brought emancipation and welfare to one set of people, resulted, at the same time, in a degradation of the quality of life experienced by another set of people. The primacy of the individual over society meant that the causes of inequality and deprivation were located within the individual and his capability or incapability to

reap the fruits of the capitalist system. Issues of equity and the responsibility of the state to ensure equity were seen as irrelevant and antithetical to the ideology of capitalism.

The social production of health inequality as shaped by neo-liberalism has to be understood in this historical context of the emergence of a new capitalist order. In this neo-liberal era, shaped by the philosophy of MI, the Marxian class-based explanations, which expose the social mechanisms of exploitation, have been completely marginalised. Although, it has been generally accepted that income inequality leads to health inequality, the causes of income inequality have hardly been researched. The focus has simply been on establishing an empirical relationship between income inequality and health or on countering the effects of the former on the latter rather than countering the cause of income inequality. The first part of the chapter looks at precisely this proposition. The Black Report brought to the surface the issue of health inequalities and tried to provide an explanatory framework, but the research that ensued in its wake confined itself largely to the descriptive level. In the next section, Wilkinson’s model of social cohesion (capital too), which is currently in debate as an alternative to the prevalent paradigm of research in health inequality, is discussed in detail, exposing its inherent affinity to the philosophy of individualism. In the next part of the chapter, the influence of MI in public health policy, in the form of “victim blaming” is illustrated taking the case of AIDS. The contention in this chapter is that income inequalities with their genesis in class structures have led to health
inequalities. Prevalent public health policy, which is rooted in the neo-liberal philosophy of MI, only serves to perpetuate these inequalities.

BLACK REPORT: A RESURGENCE OF THE DEBATE ON HEALTH INEQUALITIES

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

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


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

In Britain, Stevenson, the Registrar General produced mortality statistics by social class which consistently showed an inverse relation between social position and mortality. Social class has been a less popular topic in the United States at least since George III, but mortality statistics show a similar inverse

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relation between measures of socio-economic status and mortality. Both in the United States and Britain, despite overall decline in death rates, socio-economic disparities in mortality rates have been increasing in the last decades of the twentieth century. Huge international evidence continues to accumulate documenting the inverse relationship between socio-economic status and health. The Black Report, which is considered a milestone, provided an impetus to the resurgence of a new interest in class inequalities in health. This was of course primarily due to the fact that over this period of neo-liberal economic reforms globally, income inequalities between and within countries increased sharply.

Prior to the Black Report, it was a widely prevalent notion that contemporary British society was more egalitarian than in the past. The preconceived notion was that class divisions and socio-economic inequalities were becoming less important. This assumption was based on the nature of welfare state and the increasing volume of protective and regulatory legislation. It was also based on the understanding that having undergone an epidemiological transition, diseases in the developed world were in a sense less dependent on environmental factors, unlike pre-transition communicable diseases. Thus, the so-

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called life style diseases were more related, it was believed, to individual 
behavioural and genetic factors. As a result, social epidemiology was considered 
less relevant as an explanatory model.

In 1980, the Black Report questioned the prevalent notion of so-called 
equality. It not only drew attention to very large differences in death rates 
between occupational classes but it also suggested that these differences were not 
declining.12

Table 4.1
Mortality by Social Class 1931–1981 (Men, 15–64 Years, England Wales)

<table>
<thead>
<tr>
<th>Class</th>
<th>1931</th>
<th>1951</th>
<th>1961</th>
<th>1971</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>90</td>
<td>86</td>
<td>76(75)</td>
<td>77(75)</td>
<td>66</td>
</tr>
<tr>
<td>Managerial</td>
<td>94</td>
<td>92</td>
<td>81</td>
<td>81</td>
<td>76</td>
</tr>
<tr>
<td>Skilled Manual &amp; Non Manual</td>
<td>97</td>
<td>101</td>
<td>100</td>
<td>104</td>
<td>103</td>
</tr>
<tr>
<td>Semi Skilled</td>
<td>102</td>
<td>104</td>
<td>103</td>
<td>114</td>
<td>116</td>
</tr>
<tr>
<td>Unskilled</td>
<td>111</td>
<td>118</td>
<td>143 (127)</td>
<td>137 (121)</td>
<td>166</td>
</tr>
</tbody>
</table>


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

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

From the above table, it can be seen that the mortality differentials, as measured by age-standardized death rates for occupational classes, have increased

12 The Black Report, op. cit.
since the sixties. Of these, absolute mortality rate increase is observed to be highest for unskilled labourers.

The Black Report, has been summarised by Macintyre into three main components: a description of differences between occupational classes in mortality, morbidity and use of health services, trends in these over time, and comparisons with other industrial countries; an analysis of likely explanations for these inequalities; recommendations for further research and for a broadly based strategy to reduce health inequalities or to reduce their consequences.\(^\text{13}\)

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

**EXPLANATIONS FOR SOCIAL CLASS DIFFERENCES IN MORTALITY**

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

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

\(^{13}\) S. Macintyre (1997) *op. cit.*
This approach suggests that both health and class are artificial variables thrown up by attempts to measure social phenomena and that the relationship between them may, itself be an artefact of little causal significance.¹⁴

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

Accordingly, the failure of health inequalities to diminish in recent decades is believed to be explained to a greater or lesser extent by the reduction in the proportion of the population in the poorest social classes.¹⁵

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

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

Occupational class is here relegated to the status of a dependent variable and health acquires the greater degree of causal significance. The occupational class structure is seen as a filter or sorter of human beings and one of the major bases of selection is health, that is, physical strength, vigour or ability.16

This view implies that contrary to the “hard” version of the artefact explanation, there is a real relationship between class and health, but health determines class position and not vice versa. In other words, this implies that those who are unhealthy remain poor and not that those who are remain unhealthy, turning the causal explanation upside down. “Natural” here has two interesting connotations: “natural” meaning biologically based (as in “the natural world”), and “natural” meaning morally neutral, something about which there is no inequality or unfairness (male/female differences in life expectancy are often seen as being “natural” in both these senses).17 This “hard” version of selection thus “explains away” observed inequalities in health by occupational class as being nothing meriting social concern or collective intervention.

Materialist/Structural Explanation: This explanation emphasises “the role of economic and associated socio–structural factors in the distribution of

16 Ibid., p. 105.

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health and well being”. As the Working Group noted, this position is frequently misunderstood partly owing to confusion between “materialist” and “material” factors. The “hard” version is that physical, material conditions of life, which are determined by occupational class position, produce class gradients in health and death, and that relative deprivation in income and wealth produces relative deprivation in health and longevity. This treats the main correlate of the occupational classification, and the one that directly influences health, as being income and wealth, as implied in Titmuss’s 1943 description on the basis of the occupational class classification.

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

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

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material inequality are also closely associated with another determinant of health, namely education.\(^\text{20}\)

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

**Cultural/Behavioural Explanation**: The “hard” version of this explanation is as follows:

A fourth approach is that of cultural or behavioural explanations of the distribution of health in modern industrial society. These are recognisable by the independent and autonomous causal role which they assign to ideas and behaviour in the onset of disease and event of death. Such explanations, when applied to modern industrial societies, often focus on the individual as a unit of analysis emphasizing unthinking, reckless or irresponsible behaviour or incautious life style as the moving determinant of poor health status. Explanation takes an individual form.\(^\text{21}\)

This recalls both views about irresponsibility commonly expressed in debates about infant mortality around the turn of the century, and about personal responsibility for health prevalent in the mid 1970s.\(^\text{22,23}\) However, the Working Group then discussed a more socially (rather than individually) based model of health related behaviours:


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

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

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

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

RECOMMENDATIONS FOR POLICY

The Working Group gave third priority for “preventive and educational action to encourage good health”, involving both collective action (e.g. banning tobacco

25 Ibid., p. 113.
advertising, and creating safer conditions of work) and individually directed health education ("we recommend that a greatly enlarged programme of health education, with a particular emphasis on schools, should be sponsored by the government"). They have emphasised "the health effects of such aspects of what can be regarded as individual behaviour as smoking, diet, alcohol consumption and exercise", which suggests that they were not completely rejecting the role, such behaviours might play in the genesis or maintenance of inequalities.

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

However, despite the provisional or general nature of the evidence then available, the Black Report drew unequivocal conclusions about the direction of that evidence. They found that material deprivation played the major role in

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27 Ibid., p. 129.
explaining the very unfavourable health record of the poorer sections of the population (especially of the partly skilled and unskilled manual groups making up more than a quarter of the entire population), with biological, cultural, and personal life-styles factors playing a contributory role. This conclusion carried a powerful implication for the construction of policy. The elimination or reduction of material deprivation, and not just the organisation of more efficient health care services, had to become a national objective for action in England. Low wages and minimum social security and child benefits had to be raised as part of a strategy to lift low incomes. Poor housing and environmental conditions had to be tackled.

EMPIRICAL FINDINGS ON HEALTH INEQUALITIES

Since the publication of the Black Report, a wealth of literature has been published on the income and health inequality linkage. Lynch and Kaplan\(^ {28} \) have noted a steep increase during the last ten years in the number of research articles per month that show social class, socio-economic factors, income, or poverty as descriptors of health inequality. Although the relevance of class analysis (e.g. pragmatic, functionalist, neo-Weberian, or neo-Marxist) is still debated in epidemiology (along with other forms of research on social inequalities such as those due to gender, race or ethnicity, age, migration, or sexual orientation), the growing evidence of an increasing polarization of the United States’ social

structure in terms of gradational measures of class (i.e. income, wealth),\textsuperscript{29,30} has become difficult to ignore.

In recent years, Townsend and Davidson\textsuperscript{31}, Acheson\textsuperscript{32}, Whitehead\textsuperscript{33}, using survey data, have focussed on relative differences particularly in terms of income inequality and health experience. These studies reveal that relative income distribution in developed societies is positively correlated with negative health outcomes - the "egalitarian wealth thesis" (Wilkinson\textsuperscript{34}, Blane, Brunner, and Wilkinson\textsuperscript{35}). The use of survey data has, however, been critiqued as revealing everything about health inequalities without revealing very much at all.\textsuperscript{36} While these can identify that in less egalitarian societies, those at the bottom of the social order are more likely to experience ill health or even behave in certain


\textsuperscript{36} S. Macintyre (1997) op. cit.
ways, they explain little about why or how this happens nor do they expose any underpinning dynamics, which may determine health inequalities.\textsuperscript{37}

Many other researchers have come up with a number of empirical studies supporting the negative correlation between income and mortality. Rogers\textsuperscript{38} used data for fifty-six countries to find an association between income inequality and infant mortality, life expectancy at birth and at the age of five, after considering Gross National Product. Flegg\textsuperscript{39} investigated fifty-nine countries mainly developing ones and found that income distribution was related to infant mortality after controlling a variety of factors. Pampel and Pillai\textsuperscript{40} questioned the relative importance of income inequality. They found some association with infant mortality among eighteen developed countries and showed that it was not a statistically significant determinant, when they adjusted for a number of other factors. Le Grand\textsuperscript{41} reported that the share of national income going to the bottom 20 per cent of the population was related to average age at death, in a group of seventeen developed countries after controlling for Gross Domestic Product (GDP) and public and private expenditure on health care.

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

WILKINSON'S MODEL OF SOCIAL COHESION: AN EVALUATION

The main thrust of the programme's empirical studies involves correlations between national mortality and morbidity rates and national measures of income inequality (e.g. Gini coefficient or the per cent share of total household income received by the least well-off 50 per cent of the population), which are typically strong (Correlations range between 0.6 and 0.8). A second aspect of this research programme is the attribution of the effects of income inequality on population health, to the breakdown of social cohesion (e.g. cooperation, reciprocity, trust, civic participation), in the Durkheimian tradition of social

anomie. Wilkinson contends that income inequality produces social disorganisation (or lowered social cohesion) which leads to lower average national health status. Although the relationship between income inequality and health is backed up by many empirical studies, the role of social cohesion as mediator of this relationship is mostly an untested hypothesis. Wilkinson arrives at this explanation after reviewing a large body of research on social relations and health across several disciplines (including epidemiology, sociology, political science, anthropology, and behavioural neuroscience). Recent work by Kawachi and colleagues\textsuperscript{47,48} provides some empirical support for the idea that social cohesion (i.e., organization membership) mediates the effects of income inequality on health.

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


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

By “social capital”, I mean features of social life – networks, norms, and trusts – that enable participants to act together more effectively to pursue shared objectives.... To the extent that the norms, networks, and trust link substantial sectors of the community and span underlying social cleavages – to the extent that the social capital is of a bridging sort – then the enhanced cooperation is likely to serve broader interests and to be widely welcomed.49

An important contribution of Wilkinson’s model of “Income Inequality and Social Cohesion” is that it provides a sociological alternative to former models, which emphasize poverty, health behaviour (such as smoking, overweight, drinking alcohol, using drugs, and being sedentary,50,51 in particular among the poor52) and cultural aspects of social relations as determinants of population health. Most research on income and health in United States, prior to Wilkinson’s model of social cohesion, primarily focussed on effects of poverty on personal attributes such as culture of poverty, genetic or racial inferiority, low self-esteem, lack of “values”, inability to delay gratification53,54 etc. However


Wilkinson's study on income inequality confirms that behavioural risk factors (e.g. smoking) are minor determinants of the social gradient in mortality.\textsuperscript{55} Further, Wilkinson's analysis of developed capitalist countries that have gone through the epidemiologic transition (e.g. Europe, Japan, The United States, Canada, Australia) show that population health is strongly associated with the distribution of income, even after taking into account average disposable personal income, absolute levels of poverty, smoking, racial differences and provision of health services.

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

The model ignores class relations, an approach that might help explain how income inequalities are generated and account for both relative and absolute deprivation. Furthermore, Wilkinson's model implies that social cohesion rather than political change is the major determinant of population health. Historical evidence suggests that class formation could determine both reductions in income inequality and increases in social cohesion. Drawing on recent examples, the authors argue that an emphasis on social cohesion can be used to render communities responsible for their mortality and morbidity rates: a community level version of "blaming the victim."\textsuperscript{56}

Since income inequality, an indicator of social stratification, is a strong predictor of mortality and morbidity rates, a model of social inequalities in health should address the social mechanisms that generate income inequality in the first

\textsuperscript{55} R. G. Wilkinson (1996) \textit{op. cit.}

In Wilkinson’s analysis, it is the receipt of income that is important, not the way income is generated. In this way, the model linking income inequality, social cohesion, and health is based on how income is used to consume various social goods rather than on how income results from particular production relations. David Coburn, in his critique of Wilkinson’s model notes:

There is a particular affinity between neo-liberal (market-oriented) political doctrines, income inequality and lowered social cohesion. Neo-liberalism produces both higher income inequality and lowered social cohesion. Part of the negative effect of neo-liberalism on health status is due to its undermining of the welfare state. The welfare state may have direct effects on health as well as being one of the underlying causes of social cohesion. The rise of neo-liberalism and the decline of the welfare state are themselves tied to globalisation and changing class structures of the advanced capitalist societies. More attention should be paid to understanding the causes of income inequalities and not just to its effects because income inequalities are neither necessary nor inevitable.

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

Increasingly we live in what might be called a “cash and keys” society. Whenever we leave the confines of our own homes we face the world with the two perfect symbols of the nature of social relations on the street. Cash equips us to take part in the transaction mediated by the market, while keys protect our private gains from each other’s envy and greed... Although we are wholly dependent on one another for our livelihoods, this interdependence is turned from being a social process into a process by which we fend for ourselves in an attempt to wrest a living from an asocial environment. Instead of being people with whom we have bonds and share common interests, others become rivals, competitors for jobs, for houses, for space, seats on the bus, parking places...
The absence of any concept of "the social" in neo-liberalism is related to the neo-liberal practice of universalising market characteristics to all areas of human existence. Even "the self" comes to be viewed in terms of "its" usefulness in the market as an instrument of "economic" advancement. Social development or even "social capital" becomes individual "human capital". The neo-liberal vision is individualistic rather than collectivist or communitarian. There is a stark divide between collectivist views of society (including the notion that goods can be held "in common") and market ideology. Thus, the first act of many contemporary neo-liberal regimes has been to "privatize" state organisations or functions and those that might be said to have been included in "the commons". Privatization in fact means the individual ownership of what were once possessions or functions of the state as representative of society, or of those things that were previously viewed as the possession of everyone (including natural products, land etc.). The implication of targeted programmes in the neo-liberal regime is that the problem lies with individuals and families and not with the structure of opportunities within society. In fact, Wilkinson remarks: "Indeed, integration in the economic life of society, reduced unemployment, material security and narrower income differences provide the material base for a more cohesive society". But, unfortunately these issues are not raised in the Wilkinson's model. The "starting fact" for Wilkinson's model is that by some process (which he does not discuss) income is distributed unevenly and that this

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has consequences for health. Where Wilkinson differs from the aggressive individualistic agenda of the neo-liberal ideology is that he shifts the onus of welfare and good health from the individual to the community. This only facilitates the capitalist state’s marginalisation from the sphere of ensuring welfare to its citizens. In the world of Wilkinson, in fact, the state absolves itself of all responsibility without even the sense of guilt that an aggressive individualistic policy might have bred. Thus, the main contribution of the social cohesion approach (read also social capital) to the psychosocial perspective is that it takes components of individual-centred approaches and develops them at the macro level.  

The omission of class analysis seriously limits Wilkinson’s model. Class analysis provides a more encompassing framework than the “income inequality and social cohesion model”. The task of class analysis is precisely to understand not only how macro structure (e.g. class relations at the national level) constrains micro processes (e.g. interpersonal behaviour) but also how micro processes can affect macro structures (e.g. via collective action). The theories of social stratification and class analysis seek to explain how relational positions in a social system (social formation in neo-Marxian terminology) generate income inequalities.  

Different positions in production relation (e.g. moneylender, 

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property owner, manager, and worker) generate various sources of income (e.g. much greater income can be generated from the position of manager than that of worker). Although any class location can receive low income (e.g. there are many poor business owners\(^{66}\)), high income and wealth are overwhelmingly associated with capital ownership in capitalist economic systems.\(^{67}\)

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


thus, occurs when the class process involves appropriation of the surplus labour of labourers by non-labourers.\(^\text{70}\)

Marxian class based explanations are preferable because they expose the social mechanisms of exploitation in a way that income distribution models cannot. In this way, Marxian class analysis of the labour process goes even deeper than the Weberian class analysis as the former links exchanges in the labour market and production through the concept of exploitation, while the Weberian class analysis keeps labour market exchanges and production separate.\(^\text{71}\) Such a Weberian approach is evident in dominant social epidemiology, where research into the health effects of work stress and work organisation have been conceptualised as independent of social class.\(^\text{72}\) Thus Wilkinson’s model:

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\ldots\text{presents itself as an alternative to materialist structural inequalities (class, gender, and race) and invokes a romanticised view of communities without social conflict that favours an idealist psychology over a psychology connected with material resources and social structure. The evidence on social capital as a determinant of better health is scant and ambiguous. Even if confirmed, such hypotheses call for attention to social determinants beyond the proximal realm of individualized socio-psychological infrastructure. Social capital is used in public health as an alternative to state-centred economic redistribution and party politics, and represents a potential privatisation of both economics and politics.}\(^\text{73}\)
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The problem of disregarding class structures in society and the consequent undermining of the role of the state and political change have already been discussed. What needs to be emphasised along with it is that firstly, as Muntaner

\(^{70}\) Ibid.

\(^{71}\) E. O. Wright (1997) op. cit., p. 34.


and Lynch observed, the concept of social cohesion itself has serious problems, both conceptually and empirically. Nazi Germany was a very cohesive society with a strong sense of togetherness and even a denial of class divisions. So, social cohesion, *per se* cannot be chosen as an ideal goal. Moreover, the enormous decline in health indicators in the former Soviet Union cannot be attributed to only a collapse of its social cohesion. Furthermore, societies and communities can be highly cohesive, while reproducing exploitative relations.

Secondly, current indicators of social cohesion use middle-class standards of collective action, which working class communities might not be able to meet. An erroneous characterisation of working class communities as non-cohesive could be used as a justification of paternalistic or punitive social policies.

Thirdly, the social capital/social cohesion formulations of Richard Wilkinson and colleagues, is very much similar to the "the culture of poverty" hypothesis popularised by Oscar Lewis. The culture of poverty turns upon the poor themselves holding their dearth of community ties and community heritage (i.e., social capital) as the main causes of their poor health status. Perceptions and subjectivity become all important, because it is not objective inequalities that ultimately determine the well-being of populations, rather, the subjective response to those inequalities, which affected individuals and groups can control. Consequently, one implication of the social capital/social cohesion hypothesis for public health is that, communities may be seen as responsible for their crime

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rates\textsuperscript{75} or aggregated health rates, an idea that justified the privatisation of health services, such as managed care.\textsuperscript{76} Another possible direction may be to take a step back from the structural sources of health inequalities.\textsuperscript{77} After all, if they are not an integral part of theories of health inequalities and are so difficult to change, then perhaps an achievable alternative is to retreat to mass psychotherapy for the poor to change their perceptions of place in the social hierarchy.\textsuperscript{78} Functionalist sociologist Warner revealed this idea in his book \textit{Social Class in America}:

The lives of many are destroyed because they do not understand the workings of social class. It is the hope of the author that this book will provide a connective instrument, which will permit men and women better to evaluate their social situation and thereby better adapt themselves to social reality and fit their dreams and aspiration to what is possible.\textsuperscript{79}

The problem with subjectivity as an explanation for health inequality is not only that it has little empirical evidence but also that it may not yield egalitarian public health policies.\textsuperscript{80,81} Policy outcomes that arise may not be the ones desired by any proponent of the social capital/psychological environment approach to health inequalities or for that matter, by any one in the broader public health community.

\textsuperscript{77} R. G. Wilkinson (1999) \textit{op. cit.}
\textsuperscript{81} C. Muntaner and J. Lynch (1999) \textit{op. cit.}
Fourthly, in spite of its severe limitations, Wilkinson's model should be appreciated for having addressed the lack of research on the psychological effects of inequalities. There is a substantial scholarship on the psychology of racism and sexism, but little research has been done on the effects of class ideology (i.e., classism). This asymmetry could reflect that in most wealthy democratic capitalist countries, income inequalities are perceived as legitimate, while gender and race inequalities are not. While Wilkinson uses Sennett and Cobb's classic *The Hidden Injuries of Class* for his argument about his psychology of inequality, he fails to mention Sennett's new volume, which stresses the erosion of control over labour process even among persons of relatively high income (e.g. the rise of non-standard work arrangements, lack of control due to mechanisation). Attitudes about the causes of social inequalities, cast in terms of reductionist biological hypothesis (e.g. the inheritance of intelligence) or idealist lay psychology (e.g. self, effort, morality, responsibility, will power) pushes back the task of explaining health inequalities.

Fifthly, Wilkinson is correct in stressing the need to explain the social psychology of health inequalities. Nevertheless, Wilkinson's social psychology neglects precisely the impact of social (economic, political, and cultural) relations on individual behaviour. A similarity can be noticed in his approach and

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interpersonal social psychology that was criticised by British Psychology more than twenty years ago.\textsuperscript{86,87} That approach to social psychology was abandoned because it focussed on interpersonal behaviour without analysing the social relations that determine it. Populations are not just unrelated heaps of individuals, whose patterns of connections can be ignored. However, over simplified models of the pattern of connections among people may mask, not reveal, determinants of population health. For instance, strong links among individuals can both increase and decrease the risk of certain health outcomes. Tight connections among infants in a day-care centre may increase their risk of otitis media. In one context, strong friendships and networks of peers can increase the risk of smoking, drinking, or use of illicit drugs, while in others, they may decrease the risk of suicide. The way in which individuals and groups get connected to form friendship networks, neighbourhoods, communities and populations are very important in the public health perspective. The concept of social capital, in its present form, cannot provide an adequate basis to understand how these connections may be linked to population health. It appears that social capital has been under-theorized in its public health usage and that it is time to engage in serious debate about its definition, measurement, and application in public health research and practice. Discussion so far has rarely moved beyond the level of “bonding” social ties—the informal and more intimate connection between family members, friends, and neighbours. These are surely important, but it is also important to consider the

bridging connections (to broader social networks) and linking social connections (to social institutions) that help to determine which individuals and groups have access to and control over resources and their health. This calls for a broad framework of appreciating the formal and informal connections among population subgroups, and how these individuals and groups are linked to social institutions (e.g. class based parties) and the state.

Sixthly, the idea of social cohesion championed by so many communitarians in the USA often falls into the trap of narrow associationism. Alexis de Tocqueville in *Democracy in America* displayed a sharp and critical view, for example, when reflecting on the individualism and self-sufficiency that is so dear to communitarians. “Individualism”, he wrote, “is a calm and considered feeling, which disposes each citizen to isolate himself from the mass of his fellows and withdraw into the circle of family and friends, with this little society formed to his taste and leaves the greater society to look after itself.”

This sentence highlights the perils of narrow associationism, or a negative effect of social capital that is largely absent from current public health and social policy debates. Thus, social capital may become only an extended (in the sense of a narrow association of few individuals like family and friends) version of individualism.

Concluding the discussion on Wilkinson’s model, it should be emphasised that the idea of social cohesion, which appears to challenge the dominant neo-liberal praxis in public health, is in reality, an extension of Durkheim’s concept of

“moral individualism”. In effect, there is danger of its becoming a ploy in the hands of the bourgeoisie to perpetuate the status quo while creating an illusion of an alternative system. The stress on community participation serves only to shift the focus away from the state and thereby curb any demand for structural change that could reorganise society and address the issue of income inequality that lies at the root of health inequality. Thus, methodological individualism, which has so far dominated the public health sphere, still continues to hold sway in the new garb of social capital. Under the new model, the real shift has been only that of ‘community blaming’ in place of individual ‘victim blaming’. The attainment of better health status becomes the responsibility of the community as a whole through such measures as better social cohesion and solidarity. In the case of the prevalent paradigm, better health is the responsibility of the individual through measures such as behaviour modification, self-help and self-control. In both the cases, the state has no role to play and there is no space for macro structural change.

Individualism in public health paradigm revolves around the cult of victim blaming. Even the social cohesion model is an extension of victim blaming. Therefore, it is very important to examine the philosophical origin of victim blaming and expose its inherent fallacies. The next section deals with this and furthermore takes the case of the policy on AIDS to illustrate the impact of the individualised ethic on public health policy.
Individualism has remained the cornerstone of public health discourse over time. Tesh notes the bias of the individualistic ethic:

...the ideology of individualism...in science takes for granted a reductionist unit of analysis. Hence, it reinforces the political assumptions that impugn structural analysis of causality...Research that takes the social structure as the unit of analysis gets pushed to the periphery of science. At most it is a lesser kind of science, social science. At worst it is not science at all but a pseudo-science contaminated with politics.⁸⁹

Is heart disease caused by atherosclerosis in those choosing to eat too much butter, or is it caused by the stress of them living isolated lives in a social structure that fails to value their input compared to the input of a select few with command of the resources? How one does explain the fact that residents of Roseto were so much less likely than residents of Banger to die of heart disease, despite comparability on all the traditional causative (risk) factors.

Hence, the political meets the methodological. It is no coincidence that the disciplines that currently dominate the health policy world, economics, psychology and biomedical science, have deep within them a core assumption that the individual is the unit of measurement, analysis and modification. Many other social sciences, especially sociology, anthropology and community psychology, assume that the social structure, not the individual, is the unit of investigation and modification. These are not politically popular disciplines. They are, however, the disciplines in which the influences of community setting and social structure are

integral to theories of individual behaviour. The dominant mode of public health
is analysed in illness behaviour. David Mechanic notes:

By this term we refer to the ways in which given symptoms differentially
perceived, evaluated and acted (or not acted) upon by different kinds of
persons... in short, the realm of illness behaviour falls logically and
chronologically between two major traditional concerns of medical science:
etiology and therapy. Variables affecting illness behaviour come into play prior
to medical scrutiny and treatment, but after etiological processes have been
initiated. In this sense, illness-behaviour even determines whether diagnosis and
treatment will begin at all.\footnote{D. Mechanic (1962) "The Concept of Illness Behaviour", \textit{Journal of Chronic Diseases}, Vol. 15, pp. 189-194.}

Illness behaviour, then, comprises the different actions, which individuals
take in response to symptoms. The various backgrounds and need experiences of
individual patient shape the illness behaviour in predictable ways. In such
analysis, the focus is on the individual as the genesis of individual ills and well-
being. In addition, this has the profound effect of reinforcing the ideological
construct of the bourgeoisie, i.e., individualism. However, to focus on individual
life-style is to assume an independence and freedom of the individual that is just
an illusion. To quote Coburn's study:

The finding of links between the psychosocial aspects of work and workers'
general well-being also contain implications for the research and policy making
regarding 'life-styles'. Health attitudes and behaviours are influenced by events
apparently far removed from the attitudes and behaviours studied. Such
relationships, emphasizing the social bases of individual behaviour, call into
question classificatory schemes, which lead to the study of the individual and his
environment separately. Such a scheme might lead to the same fragmented
approach to man and society as earlier mind-body dichotomies did to the
individual.

Finally, intentionally or not, the current emphasis on life style and health
promotion has an individualistic bias. As Beauchamp has noted:

Victim blaming misdefines structural and collective problems of an entire
society as individual problems.... These behavioural explanations for public
problems tend to protect the larger society and powerful interest from the
burdens of collective action, and instead encourage attempts to change the
‘faulty’ behaviour of the victim. If we are really interested in preventing death and disability and in increasing over all levels of well-being, we will have to become more radical - radical in the sense of getting to the root of the problem. Since many of our current health problems are embedded in the social structural and value characteristics of our society, to change these will require first, a painful re-examination of the values and interest implicit in current (public) health policies and approaches and second, a willingness to change.\textsuperscript{91}

Life-style is indeed determined by the work, economic, and political environment in which one lives. The dominant prevailing ideology in public health emphasises individual etiology—habits, diets and the like—as the subject of research, rather than living and working conditions, environmental factors—pollutants, carcinogens, etc. Greenberg and Randal’s\textsuperscript{92} study shows that the dominance of corporate interest in the top decision-making bodies of the National Cancer Institute and the American Cancer Society has given rise to a great deal of cancer research on biological and individual behaviour, such as smoking and personal habits, but has paid very little attention to the study of environmental factors, which are increasingly recognised as the agents most responsible for cancer. As these authors indicate, the American Cancer Society:

[...has shown scant interest in the carcinogenic effects of air and water pollution, drugs and food additives. It looks the other way... attitude closely resembles that of the drug and chemical industries, which many of its directors—all unpaid volunteers—are directly or indirectly associated.\textsuperscript{93}]

Greenberg and Randal show that most of the educational campaigns carried out by these agencies emphasise individual responsibility and behaviour, and do not include information about carcinogens that exist in peoples’ work

\textsuperscript{92} D. S. Greenberg and J. E. Randal cited in V. Navarro (1977) Ibid.
\textsuperscript{93} Ibid.
places, nor in other areas, which might antagonise or threaten industry. Even today, when there is increased evidence that most cancers are caused by environmental carcinogens, much of the research focus on cures and the study of individual preventive behaviour. Individual behaviour has become the trademark in explaining inequalities. The whole ideological apparatus (positivist) is mobilised to make citizens believe that the greatest improvements in health will come from what individuals do for themselves. As a Report by the Department of Health and Social Security in Great Britain indicates:

The primary responsibility for his own health falls on the individual. The role of the health profession and of government is limited to ensuring that the public have access to such knowledge as is available about the importance of personal habit on health and at the very least no obstacles are placed in the way of those who decide to act on that knowledge.  

Navarro has argued that this strategy of individual responsibility for self-care assumes the following: first, that the basic cause of an individual’s illness or lack of health is the individual himself, not the systems, therefore, the solution must come primarily from him, not from any structural change of the economic and social system and its health sector. Second that the individual’s behaviour is independent of and undetermined by that socio-economic system. But both assumptions are invalid as Navarro further notes the ideological construction of bourgeois individualism by which one is responsible for one’s wealth or lack of it, and for one’s work or lack of it, and for one’s health and lack of it. Apparently, the emphasis on individual, instead of collective responsibility has an ideological

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94 Department of Health and Social Security cited in V. Navarro (1977) Ibid.
95 V. Navarro (1977) op. cit.
function that is useful to those in power. Allende has critiqued this prevailing notion of individual centric approach:

The individual in society is not an abstract entity; one is born, develops, lives, works, reproduces, falls ill, and dies in strict subjection to the surrounding environment, whose different modalities create diverse modes of reaction, in the face of the etiologic agents of disease. This material environment is determined by wages, nutrition, housing, clothing, culture, and additional concrete and historical factors.  

Allende never discusses health problems as disjunct from the macro-level political and economic issues. In his view, economic advancement of the society, as a whole, is a major precondition for meaningful improvements in medical care and in a population's health.

The individual fallacy is the assumption that data collected at the individual level are appropriate to explain social phenomena. Krieger using a labour process approach to social class provides evidence that a household measure of social class can be better predictor of health outcomes compared to an individual measure of social class. Social class is thus a property of social systems, which can be measured at different levels (e.g. individual, firm, state).

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Johnson has made a similar criticism from a theoretical standpoint:

Survey researchers construct their view of the social world from the responses of individuals to structured questionnaires. Yet if the unit of analysis is the individual per se but not the group to which the individual belongs, the processes occurring at the level of the group remain relatively invisible. We rarely, if ever, sample naturally occurring groups, but rather disparate individuals who make relatively abstract populations.\textsuperscript{100}

Chalmers\textsuperscript{101} proposed that social class should be the unit of analysis in epidemiology. Through this, individual fallacy can be overcome. Muntaner, Lynch and Oates's\textsuperscript{102} study also has implications for the limits of methodological individualism in social epidemiology. Their findings point to the centrality of collective action and view MI as a constraint on social explanation. Thus, the strength of the association between social cohesion (organisation and union membership) and political participation, as opposed to the weaker effects of individual efficacy, suggests that exclusive reliance on properties of individuals might offer an incomplete explanation of the relationship between class and health.

For a further exposition of the predominance of individualism in the field of public health, it might be useful to examine the different aspects of the current AIDS Policy.

\textsuperscript{100} J. V. Johnson cited in C. Muntaner, Patricia, J. O'Campo (1993) \textit{op. cit.}


\textsuperscript{102} C. Muntaner, Patricia and J. O'Campo (1993) \textit{op. cit.}
POLICY ON AIDS

Individualism in the construction of AIDS related policies reflect how biomedical individualism is pervasive in the area of public health. The construction of AIDS incorporates distinct views of etiology, prevention, pathology and treatment of disease; each tacitly promotes different conceptions of proper allocation of individual and social responsibility for AIDS.

Historically, in the first paradigm of AIDS it was considered as a “gay plague” by analogy with the sudden devastating epidemics of the past. In the second paradigm, AIDS was normalised as a chronic disease to be managed medically over the long term.

Both the paradigms have captured important effects of the AIDS epidemic, but neither has proved fully adequate. The sudden appearance of AIDS gave meaning to the word epidemic: a disease that spreads like wildfire consumes life, and then burns out, leaving devastation in its wake. Epidemiologists, the first scientists to lay claim to understanding the mysterious new ailment, were struck by its seemingly exotic preference for young, homosexual men. They therefore searched for causes in the behaviours or “life styles” common to gay men. In the process, they looked for risk factors prevalent in this “risk group” and indicated life in the fast lane, including “promiscuity”, “poppers” (amyl nitrate) and anal sex to be the dominant risk factors.

In popular perception, however, all members of the identified risk groups were seen as potentially contagious; from there it was but a short step to stigmatise and discriminate against those risk groups and hold them “responsible” for AIDS. Soon however, the construction of the ‘other’ (as responsible for AIDS) moved beyond social identities to geographical boundaries. Africa came to be regarded as the birthplace of the disease and from there it was supposed to have spread to Haiti, USA and Europe through immigrants, homosexuals and drug users. “The categories of epidemiology and virology have placed a barely invisible cordon sanitaire around minority communities, deviant individuals and the entire continent of Africa”¹⁰⁵

In 1983, the identification of HIV, the AIDS virus, led to a new phase of the epidemic, in which AIDS was clearly characterised as an infectious disease.¹⁰⁶ Once the virus was identified, scientists lost their interest in the social factors-accompanying transmission. They instead turned to laboratory studies of the virus and its action within the body in the hopes of making new discoveries that would lead to patents, vaccines, and possibly a cure.

The epidemiological perspective that accompanied this kind of biological reductionism concentrated on behaviour modification as the main tool for prevention of the disease. In other words, sexual promiscuity was sought to be controlled. The broader socio-economic context in which immigrant labour, 

prostitutes or homosexuals, (considered as potential carriers of the virus) became susceptible to the infection, was completely left out of the sphere of discussion. Moreover, in spite of the accepted linkage between poverty and disease, no concerted effort was made to analyse the role of poverty in the growth and spread of this disease. Hence, the focus on finding a medical cure for the disease as well as the stress on behaviour modification restricted the scope of social epidemiology in public health and put the onus on the individual to save himself from the disease.

The four fold policy regimes of AIDS, viz., a) those of prevention, b) detention, c) treatment, and d) anti discrimination legislation also carry the same individualistic and mechanistic approach.

For example, the preventive policy of AIDS is very typical of this individualism. This policy addresses the public need to stem the spread of the HIV virus. To identify the conception of the individual implicit in this policy domain, two contrasting approaches to AIDS prevention can be considered, viz. an active and passive approach. Actively preventing the spread of the HIV virus might entail, i) discovering who all carry the virus and monitoring their behaviour accordingly (i.e. quarantining HIV positive individuals); (ii) passing legislation that threatens to punish HIV-positive individuals who knowingly spread the virus; or (iii) enacting laws that punish non-HIV-positive individuals who commit acts that put them at the high risk of contracting the virus.

The first option, a quarantine of all HIV sufferers, has been deemed a practical impossibility given the length of time people are usually sick with the
disease. The second option, threatening to punish those who knowingly spread the virus, seems the most feasible and logical of the three. But there are no laws making behaviour conducive to transmission of the virus illegal. The third option deems as a punishable offence any behaviour that increases the risk of contraction (as opposed to transmission) of the virus. Given the limitations of an active AIDS prevention strategy, public health policy makers have opted for a more passive approach, one that puts the burden of responsibility on the (non-HIV-Positive) individual.

The conception of the individual implicit in this kind of policy is existentially strong in that individuals are held responsible for themselves. The state escapes from the responsibility of detecting people with AIDS and passing legislation against the deliberate transmission of the virus. The logic of individualism in preventive policy generally presumes that it is an individual's responsibility to protect himself or herself from acts that may unnecessarily expose him or her to the HIV virus. On the other hand, an individual is entitled to sue for grievance if he or she is exposed to the virus by another individual without prior knowledge. In the first scenario, it is everyman (or woman) for himself. In the second, individuals can only be held responsible for things they know they are getting into i.e., if one had no prior knowledge that ones partner was HIV positive, then one is not liable for one's high-risk behaviour, regardless of the risk. AIDS preventive policy rests firmly on an ethos of individual responsibility (an existentially strong conception), owing to the absence of organizational capacity necessary to curtail socially deleterious behaviour.
In the case of Detection Policy, Treatment and Anti Discrimination Law, the same narrow and myopic understanding is reflected. The whole range of AIDS infected patients are clubbed under one fraternity with total disregard to their socio-economic location. Here, individuals are seen as autonomous, sometimes intractable, actors. As argued by several critics, twentieth century biomedical models of public health typically are reductionist; they put primacy on explanations of disease etiology that fall within the purview of medical intervention narrowly constructed, focus on disease mechanisms, and view social features leading to disease as being secondary if not irrelevant. Proponents of such models may even consider emphasis on societal factors such as poverty or discrimination to be unscientific and polemical. Despite lip service to multifactorial etiology, they seek parsimonious biomedical causal explanations highlighting the role of one or a few proximate agents, and they generally assume that biomedical interventions, operating on biological mechanisms, will be sufficient to control disease. The biomedical model of public health is premised on the ideology of MI, adopting the notion of the individual in liberal political and economic theory: it considers individuals “free” to “choose” health behaviours. It treats people as consumers who make free choices in the market place of products and behaviours, and generally ignores the role of industry, agri-business and government in structuring the array of risk factors that individuals are supposed to avoid. There is little place for understanding how behaviours are related to social

conditions and constraints or how communities shape individuals' lives. From this perspective, populations and subgroups within populations - including "risk groups" - consist merely of summed individuals who exist without culture or history. There is no acknowledgement of the fact that when epidemiologists "succeed in identifying populations at risk of disease, it is because these risk groups typically overlap with the real social groups possessing historically conditioned identities". 108

This is nowhere more evident than in case of AIDS in poor countries. Although AIDS is identified as primarily a disease of the poor and though there is an understanding that poverty and developmental schemes lead in myriad ways to exposure of specific groups to occupations like prostitution, interventions simply involve a search for biomedical cure and behaviour modification of individuals or risk groups.

CONCLUSION

In conclusion, the influence of Methodological Individualism in public health continues unabated. The concern for searching the roots and remedies of health inequalities reflected in the major academic debates that culminated with full force towards the turn of the last century, have done little to usher in a radical change in public health paradigm. There has been a hesitation to understand health inequalities in a holistic fashion, which has led to the formulation of

individual centric remedies and prevention. Even Wilkinson's theory of social cohesion, modelled in the Durkheimian tradition of individualism distances itself from a true population perspective. In fact, it creates a smokescreen through its claim as an alternative paradigm, and thereby pushes the task of public health further back. A genuine desire to make people live longer and healthily cannot be dissociated from the larger need to question and reorganise class structures. In the dominant paradigm of public health however, the focus has always been on the individual responsibility for self-care. Relegating to the background, the larger social, cultural and economic context in which lifestyles are adopted, public health policies have continuously harped on behaviour modification. The AIDS policy is one of the best examples of this individualistic and myopic approach.

The public health researcher needs to seriously consider these issues. A fact that emerges through the discussions in this chapter is that the growth individualism and mechanicalism in public health, like in other social sciences cannot be traced without reference to the historical transition of political and social systems. Thus, a meaningful discourse on public health is part of a political exercise and the search for an alternative holistic vision must retain its political and social content.
CONCLUSION

Modern epidemiology is oriented to explaining and quantifying the bobbing of corks on the surface of waters, while largely disregarding the stronger undercurrents that determine where, on average, the cluster of corks ends up along the shoreline of risk. (McMichael, A. J.)

It is a widely accepted fact that the twentieth century has witnessed unprecedented improvements in the aggregate health status of nations. For example, in India, the life expectation at birth increased from 22 years at the start of the century, to 62 years at the turn of the century and infant mortality rates declined from 200 to about 62 (per 1000), in the same period. In the developed world, the “epidemiologic transition” which reduced the infectious and communicable disease load of the population was taking place with a sizable proportion of budgetary resources being allocated to the health sector. Thus, in England, the United States and other developed countries, diseases like malaria, tuberculosis, cholera etc., became virtually extinct. Even developing nations were placing a great deal of emphasis on better health services. For instance, India, after liberating itself from the colonial yoke in 1947, followed a mixed economy model in which state investments were channelled to the social sector in general, and health in particular. Thus, all over the globe, the period spanning from the latter part of the nineteenth century to the middle of the twentieth century marked the golden age of public health.

If one analyses the different aspects of the public health policy during this period, there is a progression from a population-based approach towards a laboratory based biomedical discipline. Indeed, the improvement in health status
achieved by various nations has been primarily attributed to the advances in biomedicine. Although this is questionable, the contrary views have by and large not received the attention they deserve. For instance, some public health practitioners were of the opinion that increases in life expectancy and declines in mortality rates in this period were the result of reduced exposure to infection, improved nutrition and better standards of living together with biomedical advances. The dominant stream of public health, however, did not focus on food security and better housing, working and living conditions, water supply and sanitation as determinants of better health. Instead, it emphasized the role of biomedicine and the impact of modern transitions in epidemiology in the form of risk factor, clinical and molecular epidemiology. This implied that the dominant understanding of public health research and a vision of its future growth remained confined to the reductionist model of medicine, to the exclusion of the population perspective.

The complacence with the state of affairs however received a rude shock with the publication of the Black Report in 1980. Disaggregating national level data the report revealed that in spite of enhancement of aggregate health status, disparity in health between different groups in the same country has risen over time. Moreover, the disparities between countries have also grown sharply. This indicates a widening gap in the standard of health within and between nations. Furthermore, the latter part of the twentieth century also witnessed the emergence of diseases like AIDS and the resurgence of diseases like tuberculosis and malaria, especially among impoverished people and impoverished nations. These
facts certainly shook the unwavering faith in biomedicine and brought to the fore some embarrassing questions for the entire public health community.

There is an increasing recognition today that health inequalities reflect the underlying phenomena of social injustice such as poor access to health care, inadequate food, impure water, unsafe living and working conditions and extreme poverty. In the words of Laurel Garret, "If the passage of time finds ever widening health gaps, disappearing middle classes, international financial lawlessness, and still rising individualism, the essential elements of public health will be imperilled, perhaps nonexistent, all over the world." These issues certainly trouble the conscience of the public health researcher. An enquiry into the causes of such phenomena leads us to assess the nature of public health policy and health services available to the population and examine the philosophical roots of the development of the dominant public health paradigm. This thesis was an effort in this direction.

The thesis analysed how the conception of public health and its basic science i.e., epidemiology, has been influenced in the path of its historical progression, by the philosophy of MI which is rooted in positivism and which emerged hand in hand with the capitalist order. The positivist view of society is one in which the individual is a free rational agent exercising his profit maximising or utility maximising choice in the free market. Thus, MI uproots the individual from his socio economic context, renders discussions about the issues of unfreedom and constraints against choice meaningless, and makes him responsible for the quality of life he enjoys. In economics, this led to the
predominance of the neoclassical school and in psychology, to the predominance of behaviourism. In the sphere of public health, this resulted in a progression along the lines of risk factor epidemiology, clinical epidemiology, and finally, molecular epidemiology. The thesis does not belittle the developments in biomedicine that have undoubtedly led to the discovery of several life saving drugs and vaccines. The argument is that these developments have excluded the most vital aspect of public health analysis i.e., the population perspective. It has given rise to a myopic vision that the source of disease and ill-health lies primarily within the individual, in his genes and molecules, or in the form of bacteria that resides within his body. It has also impressed upon the individual's mind that the solution is locked within the drugs and pills available in the market at a certain price or in some form of behaviour modification. Such a prescription serves two purposes. First, it takes away from the collective the power of effective intervention, and, second, it gives rise to a booming industry of drugs and medicines. It helps to breed and sustain the attitude that problems are to be solved by some sort of "technological fix" or by alterations in individual behaviour rather than by broader and more complicated changes that might challenge the position of those now dominant in society. The focus on scientific "expertise" and individual genius is overemphasized, and historical and social contexts downplayed. Scientific ideas are used directly to justify the status quo or to demonstrate its inevitability.

In fact, this attitude of inevitability is all pervasive in not only the field of health, but also other social sciences, for example, economics. Neo-classical
economics with its market fetishism has advanced a theory of liberalization and privatization that is deemed inevitable for development. Although the developed nations, in the past and indeed the present, continues to spend a significant proportion of their resources on social overhead capital, the structural reforms package advocated for the developing world by the World Bank and International Monetary Fund, emphasizes cuts in state expenditure which impinge upon the meagre funds for the social sectors. Thus, soaring food prices, lack of infrastructural facilities, sanitation, water works and widespread unemployment, along with fund cuts in the health sector have led to increasing ill health among the poor and the disintegration of the already fragmented health systems in the third world. While phenomenal success is being achieved in the field of biomolecular medicine, the broader issues of public health like food security, water supply, sanitation, living and working conditions, are gradually receding into oblivion. The retrogression of the state from the sphere of public welfare in the era of aggressive liberalization and privatization is lowering the chances of healthy survival of the deprived sections of the society.

The philosophy of MI, as has been discussed in the previous Chapters, has facilitated the growth of a narrow biological and individualist model of medicine that promotes "victim blaming". It is the prerogative of the individual, irrespective of his socio-economic location, to secure his health through the purchase of drugs and vaccines or changes in his behaviour. Some simple everyday examples illustrate the above case. The sprouting of health clubs, the emphasis on meditation and spiritual enhancement to deal with stress, the
identification of personal habits like smoking and alcoholism as the major
hindrances to personal health, are all a part of the attempt to place the
responsibility of health solely on the individual. The case of AIDS, elaborated in
chapter four, is an instance of the same obsession with biomedicine and behaviour
modification. Instead of considering AIDS as problem of development, and
addressing the historical and socio-economic causes of the formation of high risk
groups (like prostitutes and immigrant labour), and high risk regions (like sub-
Saharan Africa), the prevalent public health practice is to suggest behaviour
modification together with accelerated research in curative medicines and
preventive vaccines. Indeed, the striking fact that in sub-Saharan Africa, HIV
infection is most rampant in places like mines, plantations and urban squatter
camps where the wealth of the globalised economy meets extreme poverty seems
to go unnoticed by the dominant public health paradigm. It has been estimated
that infant and child deaths due to the “debt war” in sub-Saharan Africa far
exceeds that caused by AIDS. Yet AIDS and not hunger is considered the major
public health issue. This certainly indicates a large lacuna in public health
research.

After the publication of the Black Report, there was a proliferation of
literature on the association between economic categories and mortality.
However, most of these restricted themselves to the descriptive level and did not
have any major implications at the policy level. At the same time, there was an
increasing recognition that health inequalities are unacceptable and that some
steps should be taken to redress the problem. The most recent development in this
direction is the theory of social capital. In fact, the model of Wilkinson is very much in the limelight and is being hailed in influential public health circles as a resurgence of holism. The most significant contribution of this model is that it provides a sociological explanation for health inequalities. But, its lack of an explanatory framework for the development of income inequalities and the emphasis on better social cohesion as the whole and sole solution for the attainment of better health status for a community leaves a lot to be desired.

Social cohesion as a form of empowering a community to take care of its economic, social and physical needs excludes from its purview the historical location of that community and the need for structural reforms in the economic and social base of that community. Thus, Wilkinson’s theory of social cohesion, which is strongly reminiscent of Durkheim’s “moral individualism”, takes the health debate through a full cycle and comes back to the individual. The difference with the earlier versions of individualism, as has been explicated in chapter four, is that the focus is not on the individual alone but the community. This certainly should not be mistaken as a resurgence of the population perspective because, unlike in the case of population based epidemiology, in this case, firstly, lack of social cohesion and not of supportive environmental or socio economic structures, is identified as the cause of disease, and secondly, the onus for change lies on the community and not the state. Therefore, the model identifying degradation of fellow feeling and social cohesiveness as the main causes of deteriorating health, can be regarded as a neo-Durkheimian version of individualism.
In conclusion, the impact of MI in social sciences effectively replaced the holistic vision of the individual as a part of the collective by the individualist vision of the collective as a simple aggregation of individuals. In the sphere of public health, it led to the undermining of the population perspective and the domination of bio molecular medicine together with the retrogression of the state from the health sector. Empirical evidence suggests that this has given rise to extreme health inequalities and the resurgence of infectious diseases. An alternative vision of public health, which by its definition, is committed to the betterment of the health of populations, must incorporate the effects of economic and social inequalities into its frame of analysis. In modern times, when the third world is reeling under the influence of structural reforms, the issues of food security and active state participation in the provision of the basic conditions of health, become particularly important. It has to be borne in mind that unlike the first world, the third world is yet to experience an epidemiological transition. Thus, the issue of a major overhauling in the health status of large multitudes cannot be considered in isolation from the issue of restructuring and reform of the existing socio-economic order. Public health cannot be considered as a technological fix, a package of benefits with a price tag attached, or a variable dependent upon individual or community behaviour. It involves a political question whose resolution would imply an endogenous restructuring of political, social and economic forces from below.