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Health and Society: Two Essays

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1.1. HAVING FUN

The holiday is a social arena which provides "a playground for risky behaviour and excessive consumption" (Briggs 2013 p129). Young British tourists in the Spanish Balearic Islands have a reputation for risk-taking behaviour in the form of high levels of alcohol consumption and drug use along with sexual behaviour [1]. Briggs (2013) saw this behaviour in this part of Spain as different to young British holidaymakers elsewhere. He stated: "I would like to direct attention to young British holidaymakers and their consumerist attitudes but also frame their behaviours within an aggressively commodified social context that endorses and amplifies the group's deviance and risk-taking, cashes in on their desire for indulgent hedonism, and leaves them almost penniless by the time they return home" (p128).

Briggs (2013) undertook an ethnographic study of British youth (17-35 years old) in San Antonio, Ibiza, Spain, in the summers of 2009 to 2011. The high level of alcohol and drug consumption, and sex was explained by a number of factors:

i) The behaviours were perceived to be exciting. For example, "Aaron's" reply to the question, "what is a 'good' night out?" was: "How fucked I get and who I end up with at the end of the night" (p127). While "Gerald" was proud of his "fourteen pints during the day" (ie: before the evening had began).

ii) The desire to escape the constraints of work, routine, and family at home. Briggs (2012) pointed out that "the everyday home life of these young people is subjected to the demands of necessity: some get up early in the morning on weekdays in order to study, work or look for a job while others have, what they say are

[1] This is an example of "offshoring" (appendix 1A).

stressful family commitments and other associated obligations that form part of their normative non-holiday identity".

iii) The role of these behaviours in the construction of identities. Many of the tourists are working-class, and "they don't have the resources to 'party' like the elite regularly, but while on holiday they focus on the consumption and destruction of resources - most notably money, time and health – in ways that copy the expressive waste of the leisure class... and suggest a desire to recreate the self in the image of the boundless celebrity consumer that is so central to popular culture..." (Briggs 2012) [2].

iv) Group dynamics of an "anything goes" attitude. For example, two members of the "Southside Crew" (four male friends) had a competition for as "many shags as possible" during the holiday.

v) The design of San Antonio's "drinking strip" ("night-time economy") that encourages consumer spending. Briggs (2013) pointed out: "In general, there is no regulation of this space; the police only seem to appear to arrest or move on prostitutes. There are private security outside a few clubs and bars, and while they quickly resort to violence to resolve disorder, they often let the same troublemakers in the next night... As the night progresses, this social space swells with young British tourists; in particular, male groups lose their friends, get into fights and/or wander off and are at the mercy of other socio-commercial pressures which occupy the same landscape..." (p132).

1.2. MODERATE DRINKING

As an antidote to high alcohol consumption, and the public concerns about that, "moderate" drinking has been championed. But what is moderate drinking, asked Yeomans (2013)?

Moderation is presented as a mid-point between extremes - abstinence and "excessive" drinking [3]. But

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[2] Charles Kettering of General Motors described the role of advertising and marketing as "the organised creation of dissatisfaction" (Schor 1991).

[3] This can be seen in the context of "harm reduction" (to both the individual and society), which is a key concept in public health, and it is constructed differently for different substances across time - for example, illicit drugs (as opposed to a focus on cessation for tobacco) (Berridge 1999).

Berridge (1999) argued that the different approaches to illicit drugs and tobacco are not so much due to the degree of dangerousness or the perceptions of risk, but rather to the different roles for professionals, for instance. Drugs have been "a psychiatric preserve" in the UK since the 1960s, while smoking is dealt with by the medical profession generally. Policy decisions are also important - eg:

there is a problem in defining the latter. There is no agreed definition and measurement of it, say in the form of "binge drinking", or the number of units classed as "unsafe" change. For example, in the UK, in 1979, officially it was recommended that eight units per day should not be exceeded, while more recently, the figure has dropped to 2-3 units for women and 3-4 for men [4]. In Finland, limits of fifteen units per week for men and ten for women are recommended, but in the Basque area of Spain nearly three times greater than in the UK (Yeomans 2013). Moderate drinking also varies historically. For example, the promotion of teetotalism by temperance societies in Victorian Britain. "The ambiguity involved in understandings of excess mean that there is no simple, uncomplicated extreme to which moderate drinking can be counterposed. Moderation, therefore, cannot be defined solely in reference to what it is not" (Yeomans 2013 p60).

Thom (1999) noted "how the very development of a units based system of measuring alcohol was connected to broader public health agendas. In the mid-twentieth century, definitions of problematic drinking were dominated by issues of addiction or dependence and so shaped by the related concern for whether individuals had 'lost control' over their drinking. The units system, however, meant that all drinkers could be more easily 'located along a continuum from non-harmful to harmful drinking and the size and degree of problem in the population more precisely calculated' (Thom 1999 p130). The issuing of units guidance therefore allowed professional medical groups to define the 'drink problem' in epidemiological or public health terms. Unfettered by the boundaries of scientific knowledge, the regulatory gaze of expert groups was thus extended far beyond the addicted or dependent" (Yeomans 2013 p67).

The process of developing official recommendations for alcohol limits today makes use of medical evidence. There are a lot of health risks associated with heavy drinking, and logically, thus, abstinence appears the

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drugs defined by a legal system of regulation, yet tobacco not categorised as a drug. Berridge (1999) added the cultural positioning of the different substances in the UK in recent years: "Media and middle-class opinion has moved against smoking, while it has become more tolerant of illicit drugs. But certainly smoking seems to be descending the social scale; and it has always been easier to attack habits which are associated with women and the poor" (p45).

[4] In the UK, an alcohol unit is eight grams of pure alcohol, but it is eleven in Finland (Yeomans 2013).

safest option. But health risks are also associated with that. Yeomans (2013) pointed out that mortality data showed that individuals who consumed one or two drinks per day were better off than both heavy drinkers and abstainers. "Current understandings of alcohol are, therefore, dominated by a rather blurry perception of omnipresent risk. Many harmful effects can be described in clinical detail and some knowledge is evident of how certain risk factors help produce an uneven distribution of these harmful consequences among populations. However, it is not possible to confidently explain why, given that no type of drinking or abstinence is entirely risk-free, only some people are harmed by alcohol consumption" (Yeomans 2013).

It could be said that there is a situation of "scientific uncertainty", but expert groups felt the need to give definitive advice. Yeomans (2013) stated critically "that medical doctors have actively embraced their role in advising people on how they should and should not behave. Secondly, and most importantly, many of them implicitly regard the normative function of their profession as more important than commitment to scientific certainty. Doctors are, in this sense, professionally defined by the exercise of a 'quasi-religious form of moral authority' (Rowbotham 2009 p16)" (p68).

Weingart (1998) referred to a "medicalisation of science", where the communication and impact of science is more important than accuracy. "It could be argued that in an era of what Booker and North call 'competitive risk' [5] (cited in Burgess 2009 p529) scientists are prone to hyping their findings in order to gain political attention and maximise impact. While this jostling for position can bring scientists perilously close to what Nerlich calls the 'hype-dishonesty threshold'..., it is feared that acknowledging the uncertainties about drinking and harm would weaken impact of the science on public policy debates about alcohol consumption" (Yeomans 2013 p71). Put another way, consistency and clarity of message are attractive to policy-makers, particularly if all experts are united in saying what is good for people (Yeomans 2013).

The situation of uncertainty has also lead to "risk being understood as danger" (Yeomans 2013), as seen in the recent recommendation (made in 2006 in the UK) that pregnant women should abstain entirely from alcohol. Such precautionary decisions are made in the context of worst-case scenarios (Haggerty 2003). Yeomans (2013) stated: "The point is not that uncertainty about alcohol and its

[5] Or an "expert marketplace" (Yeomans 2013).

effects means that alcohol does not cause harm, but that it is frequently difficult to ascertain why and in what situations harm occurs. Naturally, it can be concluded from this that more research is needed. But, given that some sociologists regard uncertainty as a fundamental component of contemporary social forms (Bauman 2007), putting faith in the eventual accumulation of solid, complete scientific knowledge may not be either a wise or sufficient course of action" (pp73-74).

So where does that leave us? Yeomans (2013) drew two conclusions from his discussion of moderate drinking: "First, the scientific 'hype' and political posturing that construct a façade of certainty must be discouraged as they undermine the credibility of both experts and governments alike. Secondly, the importance of alcohol as a source of pleasure and sociability must be recognised... Both of these aims could be accomplished by the creation of a more open, inclusive public dialogue about alcohol consumption which recognises the social value of drink as well as its problematic potential" (p74).

1.3. "MIDDLE-CLASS DRINKING"

Alcohol consumption in the UK is higher than in other European countries (eg: more consumption of ten or more drinks in a day). But within the UK, there are differences between socio-economic groups with greater consumption among adults in professional than manual occupations (Brierley-Jones et al 2014). Yet this pattern is different to the media's presentation of "alcohol as a problem" for the lower classes.

The class differences manifest in the type of alcohol consumed. The "binge drinking" of the lower classes (highlighted by the media) involves beer and lager (and spirits), while "middle-class drinking" is wine-based. Put in everyday language, a consumer of large amounts of wine is a "connoisseur", but the same amount of beer is a "drunk".

Brierley et al (2014) explored "middle-class drinking" in five focus groups with white-collar public sector employees in north-east England. The discussions revolved around alcohol consumption and reduction, and were linked to the "Better Health at Work" scheme. The researchers drew out a number of themes from analysis of the transcripts:

i) Home drinking versus "traditional drinking" - Home drinking involved regular, moderate amounts of wine (often with meals) and was perceived as "respectable and sophisticated". While "traditional drinking" was mostly beer at weekends in large quantities at a pub, say.

ii) Respectability versus having fun - Moderate home drinking was seen as unproblematic as the "perceived respectability of wine arose in part from its association with the fulfilment of domestic and family responsibilities such as childcare and cooking at home" (Brierley-Jones et al 2014 p1060). "Traditional drinking", on the other hand, was to socialise and have fun. "While the typical traditional drinker often consumed alcohol purposefully to get drunk, the typical home drinker did not. The latter reported a dislike of the sensation of intoxication, though some liked 'feeling tipsy'. One home drinker claimed: 'I enjoy one glass of wine... but that's it, I don't particularly like to feel drunk or feel sick or anything like that'... This contrasts with the traditional drinker who claimed she drank when out with friends 'until I am sick'..." (Brierley-Jones et al 2014 p1060).

iii) Sophistication versus vulgarity - "As a symbol of good taste, wine transformed a banal, routine activity into something special. Wine was described as turning a 'basic' meal into a 'nice' one, particularly by those who reported they did not go out socially. Similarly, wine transformed the same evening meal from 'tea', something every day or perhaps a meal associated with young children, into 'dinner', something special and adult" (Brierley-Jones et al 2014 p1061). But the "traditional drinker" was viewed as loud, offensive, and anti-social.

iv) Form versus substance - Wine was reported to be drunk for pleasure, as one woman said: "I drink a glass of wine for the taste, I like how it tastes... I am not going to just drink it, if I didn't like it I wouldn't drink it" (p1062). Beer was taken in larger quantities to "quench your thirst", and still had the association with men and heavy industry. One man described a village pub near a foundry that used to be open in the early morning as the workers needed a drink "to put the sweat back into them" after a long nightshift.

v) The future versus the past - Wine drinkers talked about the future (eg: concerns for health) while beer drinkers remembered "good nights".

vi) Drunk home wine drinkers versus moderate "traditional drinkers" - In practice, the distinction between moderate home drinkers and heavy "traditional drinkers" was not so strong. The researchers also noted an "omnivorous" group who did both types of drinking.

In concluding, Brierley-Jones et al (2014) linked their findings to alcohol harm reduction strategies - "Firstly, current public health messages are aimed at those with more traditional drinking habits which

resemble most closely the typical 'problem drinker'... Secondly, home drinking, particularly of wine, as an embedded social practice, a means of distinction and a source of cultural capital, may make it resistant to change... Thirdly, minimum pricing may prove ineffective for higher socio-economic groups, as increasing the economic capital required to obtain alcohol may increase further wine's symbolic value" (p1073).

Brierley-Jones et al (2014) referred in their analysis to the work of Pierre Bourdieu, who wrote about consumption and status. So, for instance, food and drink consumed varies between individuals within a social hierarchy. After the basic needs are met, the choice of food and drink are a "distance from necessity". "Practices such as eating and drinking come to symbolise a propensity or inability to share in or aspire to the tastes and habits of the dominating class, of being 'cultured'. Differential practices thus function to symbolise distinction from some social groups and affinity with others, so conferring status" (Brierley-Jones et al 2014 p1055).

Bourdieu (1977) coined the term "habitus" to mean "the sum of social structuring influences on individual biographies that direct aesthetic choices below the level of consciousness" (Brierley-Jones et al 2014). The key aspect of "habitus" for Brierley-Jones et al (2014) was its ability to explain the "reproduction of dispositions and practices (and inequalities) between generations". Family, in particular, transmit the early values. For example, "luxury and presentation stand opposed to necessity and utility leading to the selection of light and delicate foods by some social groups and filling and energy-rich ones by others. Such choices become symbolically marked as more or less tasteful according to their affinity to bourgeois taste and their distance from necessity" (Brierley-Jones et al 2014 p1056).

To sum up, " By means of habitus, taste becomes embedded into mental structures and 'bodily hexis' (the shape and demeanour of the physical body) and organises the 'system of matching properties' in such a way that 'each taste [6] feels itself to be natural – and so it is almost, being a habitus' (Bourdieu 1984). Thus, choices, behaviours and even people 'naturally' go together" (Bourdieu et al 2014 p1056).

Socially mobile individuals (both up and down) will be most sensitive to the taste demarcators.

[6] "As the propensity and capacity to appropriate a given class of classified, classifying objects or practices, [taste] is the generative formula of life-style, a unitary set of distinctive preferences which express the same expressive intention in the specific logic of each of the symbolic subspaces, furniture, clothing, language or bodily hexis. [Taste ensures that] each dimension of life-style 'symbolises with' the others" (Bourdieu 1984 quoted in Brierley-Jones et al 2014 p1070).

1.4. HEALTH

Having a good time occurs with and in opposition to being healthy [7].

Petersen and Lupton (1996) described health [8] in modern capitalist societies as a "core moral enterprise". Schooling is important here with "the production of 'good' workers and the socialisation of a 'healthy' moral citizenry attuned to the needs of a fully functioning market economy" (Banfield 1999 p138).

Banfield (1999) picked out the health education teacher as crucial: "The job of socialising young people into the ways of the modern capitalist world is constructed as too important and too complex to be left to the uncertainties and vagaries of the private world of families. Under the watchful gaze of the health education teacher, young people can be cleansed of unhealthy values and inculcated with the requisite amount of self-confidence so that they might lead moral, healthy, and economically productive lives. A health educator is a kind of pastorate working not to save souls for the next world, but to lead individuals to their own salvation in the material world" (p141).

This has produced a focus on the individual in relation to health that Crawford (1980) called "healthism". "Ill health, then, is seen not as a social product: the outcome of poverty, alienation, unhealthy workplaces, or environmental degradation... [It] is understood as the failure of individuals, and groups of individuals, to make wise choices or to work hard enough to achieve their own goals" (Banfield 1999 p142). The emphasis on the individual reduces "health" (and "success") to the application of rules and techniques (eg: goal-setting and project managing behaviours).

While health is "a sign of self-control, moderation and discipline", consumer capitalism encourages self-indulgence. Banfield (1999) noted: "Although self-control and self-indulgence are contradictory, both are simultaneously promoted as desirable within contemporary consumer culture. Along with psychological and somatic signs of wellbeing, consumer goods are also seen as symbols of health" (p141).

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[7] Duncan (2004) asked: "What is health? What causes ill-health? What should be done to promote better health? How should that work be undertaken? These questions — at least in the context of the developed world — have in recent times been subject to profound dispute. It is hardly a caricature to suggest that this dispute is between those who regard health as a matter of individual responsibility and its improvement highly amenable to individual lifestyle actions and behaviour changes, and those who view health as profoundly shaped by social circumstances and thus requiring structural change (socioeconomic and environmental) in order for it to be improved" (p178).

[8] Defining health is not without its problems (appendix 1B).

1.5. HAVING FUN AT WORK

Besen-Cassino (2013) interviewed forty current and former students in the USA who worked at a national coffee chain (given the pseudonym "Coffee Bean"). She stated: "What I found is that young people see low-paid chain stores as places to socialise with friends away from watchful parental eyes. They can try on adult roles and be associated with their favourite brands. Corporations like Starbucks and Old Navy, in turn, target such kids, marketing their jobs as cool, fashionable, and desirable. Soon, their workers match their desired consumers" (p43).

Many retail and service companies seek workers that "embody the look of their brands" - eg: bookshop employees appear to be avid readers - as the "perfectly tailored workforce helps build authenticity and brand loyalty" (Besen-Cassino 2013) (appendix 1C).

What is a low-paid job with limited prospects and options is perceived by the employees as highly desirable. One employee of "Coffee Bean", "Jamie" saw the job not as work but as "where I hang out", while "Jules" (who worked at a high-end clothing shop) described every shift as a "party".

"Just as consuming certain brands distinguishes young people from others, so, too, does choosing a workplace. In addition to the benefits, well-known chains can offer social distinction and function as identity markers" (Besen-Cassino 2013 pp44-45). One employee of a well-known chain admitted, "If I shop there, I'll work there" [9].

The companies are aware of these views and advertise their jobs with this in mind. For example, "What is it like to work at Starbucks?... It is a lot like working with friends..." (2012 advertisement in Besen-Cassino 2013). Besen-Cassino (2013) pointed out: "Interviewing affluent young people, employers rarely ask about qualifications or talents, nor do they speak of the power or control these youth will enjoy on the job. Rather, they're asked about their favourite music and movies. It's all about the fun environment and the cool brand" (p46) [10].

Williams and Connell (2010) noted how the employers are seeking affluent workers (ie: potential customers) by offering, for example, part-time jobs that pay too little to live on. In other words, too little for less affluent

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[9] "During the past few decades, as a result of unfettered markets, more and more aspects of life have become commodified... In late capitalism, young people search for identities through the brands of the products they buy—and sell" (Besen-Cassino 2013 p45).

[10] Duncan (2007) pointed out: "One of the features of happiness in the modern era, especially in affluent nations, however, is the ideal that happiness is and should be attainable by everyone — and a certain alarm or sense of injustice if it appears that not everyone reports improved happiness" (p86).

workers (who also may not be potential customers). Such individuals end up in fast food jobs (Besen-Cassino 2013).

Besen-Cassino (2013) concluded: "Affluent young workers, who think of their jobs as an extension of their social lives, are less likely to speak up when their jobs are problematic, when they experience sexual harassment, or when they see gender or racial discrimination. Viewing them as just 'part-time jobs', as ways of associating themselves with a cool brand rather than support themselves or families, this growing group of affluent young workers is also less likely to complain about how little they're paid" (p47).

1.6. APPENDIX 1A - OFFSHORING

"Offshoring" involves "moving resources, practices, peoples and monies from one territory to another" (Urry 2014).

It can be both a positive and a negative thing. "Migrating across borders are not just consumer goods and new services, but terrorists, environmental risks, trafficked women, drug runners, international criminals, outsourced work, slave traders, asylum seekers, property speculators, smuggled workers, waste, financial risks, and untaxed income" (Urry 2014).

Urry (2014) goes further in highlighting the negative aspects: "The offshoring world is dynamic, reorganising economic, social, political and material relations between societies and within them, and more and more resources, practices, peoples and monies are made or kept secret. The global order is the opposite of a simply open world – it is one of concealment, of many secret gardens mainly designed by and for the rich class and its casual patterns of migration". The most obvious example being "tax havens".

1.7. APPENDIX 1B - DEFINING HEALTH

"Health" can be defined in different ways, including (Carter et al 2012):

i) Negative definition - disease is defined as "functional abilities below typical efficiency" and health is the absence of disease (Boorse 1997) [11].

[11] Cryonics, which deep freezes individuals for revival at a later date, practically concentrates on the brain on the assumption that "our memories, personalities and most other critical parts of our identities are in our brains" (Bridge 1995 quoted in Parry 2004). This process is known as neuro-suspension or neuro-preservation (Parry 2004). Does this mean that the absence of disease is the absence of disease that affects the brain?

ii) Positive definition - "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" (WHO 1946).

iii) "Mid-range" definition - health is the ability to "fulfil vital goals" (Nordenfelt 1995) or "realistic chosen and biological potentials" (Seedhouse 2001).

iv) "Contextualised" definition - health is the absence of illness, where illness refers "roughly to the object of healthcare practice rather than that of clinical science" (Cribb 2005).

1.8. APPENDIX 1C - EMOTIONAL, AESTHETIC AND SEXUALISED LABOUR

In relation to retail, hospitality, and service industries, "emotional labour" describes how the feelings of the employees are "organisationally appropriated and transmuted for commercial benefit" (Warhurst and Nickson 2009) [12], while "aesthetic labour" is where the appearance of the individual is also used (ie: having employees with the "right look") [13]. Warhurst and Nickson (2009) added "sexualised labour" to cover the "mobilisation, development and commodification of employee sex appeal".

Adkins (1995) quoted the example of a leisure organisation that required female workers to wear their dresses off their shoulders, and she reported seeing male managers physically pull down the dresses into that position.

Even more explicit is the case of the US restaurant chain called "Hooters". The waitresses wear short shorts and tight T-shirts. There is no doubt that the company "uses nubile young waitresses dressed in skimpy tops to attract customers" (Golding 1998 quoted in Warhurst and Nickson 2009).

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[12] "Emotional labour" was first described by Hochschild (1983) in a study of flight attendants. It requires "employees to manipulate both their own emotions and those of the customer as part of the employee's wage labour and for the commercial benefit of the organisation" (Warhurst and Nickson 2009 p387). In practice, this means rules for the employees to follow in their interaction with the customers (ie: to display the "right" emotion)(eg: "good-natured, helpful and friendly" and "positive, joyful and even playful"; Warhurst and Nickson 2007).

[13] "Employees are, for example, hired because of the way they look and talk; once employed, they are instructed how to stand while working, what to wear and how to wear it and even what words to say to customers, because such comportment, dress and language appeal to the senses of customers, most obviously visually or aurally..." (Warhurst and Nickson 2009 p389). Nickson et al (2001) used the term "style labour market" in designer retailers, boutique hotels, and style bars, cafes and restaurants. While Mills (1956) referred to a "personality market" in the retail industry where the employer "buys the employees' social personalities" (quoted in Warhurst and Nickson 2007). "With this approach employers attempt to employ the right staff at the point of entry rather than having to retrain them once employed, and to avoid possibly messy exits for those who are subsequently deemed unsuitable" (Warhurst and Nickson 2007 p105).

Warhurst and Nickson (2009) stated: "Using comportment, dress and language, Hooters has mobilised, developed and commodified the embodied capacities and attributes of its employees to appeal to the senses of its customers with a style of service based on a look featuring sexual appeal. The sexualised labour required of this service is a constituent of the waitresses' jobs: being a 'Florida Beach Girl'. As such, employee sexualisation is not only permitted; it is actively promoted and, significantly, organisationally prescribed as a deliberate corporate strategy" (p398).

Note that "sexualised labour" tends to have a gendered aspect, and to be heterosexualised (ie: female employees as attractive to male customers).

These processes go hand in hand with other changes in society, including McDonaldisation and post-emotional society. McDonaldisation is "the process by which the principle of the fast-food restaurant are coming to dominate more and more sectors of American society as well as the rest of the world" (Ritzer 1993). It is part of the rationalisation of society (eg: Weber 1970). "The fast-food restaurant represents a contemporary paradigm of this process of rationalisation. It involves increased efficiency, predictability, calculability and control of the labour process. The result is greater productivity, dehumanisation and homogenisation" (Herdman 2004 p96).

Mestrovic (1997) saw McDonaldisation as covering emotions, which are "bite-size, pre-packaged, rationally manufactured emotions – a 'happy meal' of emotions consumed by the masses" (quoted in Herdman 2004). It is a feature of "post-emotional society". "While individuals today have more knowledge than previous generations, Mestrovic argues that knowledge is not enough to result in action because action implies a link between emotions and intellect and in post-emotional societies that link has been severed. Post-emotional society introduces 'a new form of bondage, this time carefully crafted emotions'" (Herdman 2004 p96).

Herdman (2004) summed up: "Essentially, for Mestrovic, it was the confluence of television with other social forces that culminated in the cynicism, collapse of collective consciousness and social atomisation that constitute post-emotional society" (p96). This leads to little empathy and involvement with others: "The post-emotional stance absolves those who hold it from any sense of obligation, or sense of responsibility for what occurs" (Riesman 1997 quoted in Herdman 2004).

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2. HEALTH INEQUALITIES

2.1. INTRODUCTION

Within countries, life expectancies at birth [14] vary by around twenty years (eg: Aboriginal vs White Australians), and between countries, it is nearer fifty years (ie: richest individuals in richest countries versus poorest individuals in poorest countries) [15]. For example, life expectancy at birth is 82 years in Japan compared to 34 years in Sierra Leone. While under-5 mortality varies from over 300 per 1000 live births in Sierra Leone to five in Japan (Marmot 2005) [16].

The response to such inequalities is usually to improve health services and the fight against disease. Marmot (2005) emphasised the need to also combat poverty [17] (including lack of calories, poor nutrition, and unclean drinking water) [18], and the social determinants of

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[14] Life expectancy is the average number of years an individual can expect to live (eg: at birth or at age 65 years). Health expectancy (or healthy life expectancy or health-adjusted life expectancy) is the estimated number of years of healthy life based on life expectancy and subjective health measures (Graham 2007).

[15] Within Europe, health inequalities are smaller in Spain and Italy, and larger in central and eastern Europe, for example (Mackenbach 2014).

[16] Preterm births are also associated with SES in developed countries like the UK - eg: higher admission rates to neo-natal units in most deprived areas and among most deprived groups (Gray and McCormick 2009). For example, mothers from the most deprived areas of the English East Midlands were nearly twice as likely to have a very preterm birth (born before 33 weeks of gestation) than mothers from the least deprived areas (Smith et al 2009). The reasons for the difference is still "poorly understood" (Gray and McCormick 2009). But access to neo-natal intensive care units blunts the effect of deprivation (ie: more very preterm babies survive) (Gray and McCormick 2009).

[17] There are also psychological consequences of poverty like shame (appendix 2A).

[18] The Global Burden of Disease project estimated death, disease, and injury in twenty-one regions of the world in 1990, 2005, and 2010. Comparative risk assessments were made for around sixty risk factors (Smith et al 2014).

One such risk factor was household air pollution (ie: the use of solid fuels for cooking), which was estimated to cause 3.5 - 4 million premature deaths in 2010. Solid fuels are coal, wood, charcoal, dung, and crop residues as opposed to liquid fuels (eg: kerosene), gaseous fuels (eg: natural gas), and electricity. Around 2.8 billion people use solid fuel for cooking worldwide. "Not only does household combustion of solid fuels subject cooks and their families to harmful pollution indoors, but - with

health (eg: social exclusion, stress, unemployment).

One key element of the latter is relative deprivation - "both material or physical needs and capability, spiritual, or psychosocial needs" (Marmot 2005) [19].

Marmot (2005) concluded: "Inequalities in health between and within countries are avoidable. There is no necessary biological reason why life expectancy should be 48 years longer in Japan than in Sierra Leone or 20 years shorter in Australian Aboriginal and Torres Strait Islander peoples than in other Australians. Reducing these social inequalities in health, and thus meeting human needs, is an issue of social justice" (p1103).

The continuation of health inequalities in wealthy countries can be explained by a combination of three factors (Mackenbach 2014):

i) Inequalities in material living conditions remain even when income inequalities are small.

ii) Social mobility has meant that the lower socioeconomic groups are "more homogenous in terms of disadvantage".

iii) Individuals in higher socioeconomic groups are often early adopters of new behaviours, including health-related ones.

2.2. TYPES OF INEQUALITIES

There are inequalities in health in modern societies based on income [20], wealth, and status, for example [21]. The

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pollutants exiting through windows, chimneys, or gaps in walls and roofs - it also contributes to AAP [ambient air pollution]" (Smith et al 2014 p191). The main health effects are lung and heart-related, and cataracts.

[19] Dorling et al (2007) found that income inequality had an impact on health around the world. Data on 126 countries from the World Health Organisation (WHO) were analysed. Mortality in five-year age bands and income inequality in a society were compared. Throughout the world, income inequality had the greatest influence on mortality for young adults (15-29 years in OECD countries and 25-39 years worldwide). Dorling et al (2007) concluded: "Although the direct mechanisms that operate are likely to be different between different countries, there does not seem to be a beneficial impact of social inequality on health anywhere".

[20] Shermer (2014) talked of the "myth of income inequality". Though the richest individuals have got richer in recent years (eg: in USA, richest 1% had 8% of income in 1979 up to 13% in 2010), society as a whole had got richer. This is because the "pie" (economy) had grown rather than remaining static.

Chambers et al (2014) argued that there is a tendency to overestimate differences between the richest and poorest individuals. For example, US participants estimated that the richest fifth in their country earned over thirty times more than the poorest fifth, when the figure is only fifteen times more (Shermer 2014).

Shermer (2014) concluded that "both income inequality and social mobility, though not as ideal as we would like them to be in the land of equal opportunity, are not as large and immobile as

Whitehall study of British civil servants, begun in 1967, was key in showing differences in health and mortality [22]based on employment grade [23]. Over ten years the highest had a mortality rate about one-third of the lowest grade (Marmot et al 1991).

The Whitehall II study investigated another cohort of London-based British civil servants between 1985 and 1988 - 10 314 35-55 year-olds (6900 men and 3414 women). Data were collected by self-rated questionnaires on health and lifestyle, and a medical examination. The findings confirmed the original Whitehall study - eg: the lower the employment grade the higher the rate of heart disease (Marmot et al 1991).

The differences in health between grades was a product of health-risk behaviours (eg: smoking) as well as the nature of the job (eg: level of control and satisfaction) (Marmot et al 1991).

Multi-morbidity (or co-morbidity) describes individuals with two or more chronic physical or mental health conditions [24]. Deprivation is associated with a higher prevalence at all ages on forty conditions (figure 2.1) (McLean et al 2014). This study used data from over 300 Scottish GPs.

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most of us perceive them" (p71).

[21] Health inequalities can be represented as absolute or relative differences (Graham 2007). In a hypothetical example, 200 individuals per 100 000 in the lowest social class suffer from a disease compared to 50 in the highest class. The absolute difference is 150 (200 - 50), while the relative difference is four times greater (200 ÷ 50) for the lowest social class. The relative difference is viewed as a better way of comparing health inequalities over time (Graham 2007).

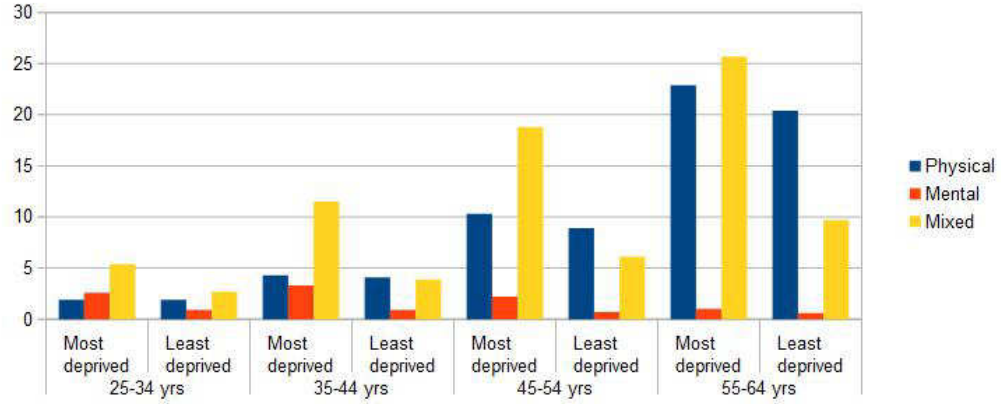
However, Graham (2007) noted that "what begins as a statistical comparison can quickly become a normative comparison, with the lives and lifestyles of poorer groups and communities judged against those of the best-off. Viewed in this way, lifestyle differences - higher rates of teenage motherhood, for example, or higher rates of cigarette smoking - can be seen as cultural deficits" (p34).

[22] The International Classification of Disease (ICD) (in its current version - ICD-10), from the World Health Organisation (WHO) has over 5000 codes for different causes of death. A single underlying cause of death from disease or injury is given. Having one cause (ie: "the disease which initiated the train of events leading to death"; WHO 1977) can mean that certain conditions are rarely recorded (eg: malnutrition) (Graham 2007).

Historical comparisons of proportions of deaths are difficult because each revision of ICD changes the categories (Graham 2007).

[23] Health inequalities were known and evident before this study. For example, using data for 1949-53 in England and Wales, the Registrar General's social classes I and II (professional, non-manual) had a standardised all-cause mortality 18% below the population mean, while social classes IV and V (manual - semi and unskilled) were 5% above the mean. The figures for infant mortality were even more unequal - social class I 37% below the mean and social class V 38% above the mean (1921-68) (Tudor Hart 1971).

[24] Physical only - eg: diabetes and hypertension; mental only - eg: depression and drugs misuse; mixed - eg: depression and pain.



(Data from McLeod et al 2014 table 1 p350).

Figure 2.1 - Percentages of individuals in selected age groups with multi-morbidity based on deprivation of neighbourhood.

One problem is what to use as the indicator of the individual's position in society or wealth - eg: socio-economic status (SES) [25], educational level, occupational grouping, or rural/urban divide. In the latter case, differences can be seen in length of survival of older adults with dementia and depression (Chen et al 2014). For example, in China, average income is 2-5 times higher in urban than rural areas.

Chen et al (2014) used data from the Anhui cohort study in China. Around 3000 over 60s living in a city or a village were followed for five years. All participants were given a medical examination at baseline.

During the follow-up period 565 participants died. Individuals with dementia and/or depression living in a rural area were about two times more likely to die than in an urban area. These inequalities were mediated by poorer medical facilities and less trained staff in rural areas.

Using other indicators of position in society, an Israeli study (Beeri and Goldbourt 2011), for example, found no difference in six-year survival rate with dementia based on educational level or occupational grouping.

SES can be assessed at individual and community level. For example, five-year survival rates after breast

[25] Socio-economic position can be summed up as "individuals are constrained by their position in the social hierarchy which, at the same time, is sustained by their actions... This means that external circumstances and self-made histories are inseparable aspects of inequality and inseparable aspects of daily life" (Graham 2007 p39).

cancer diagnosis have improved in developed countries in recent year. But the improvement is less for women who live in areas of low community-level SES (eg: high poverty rates and low levels of education) in the USA, say. This is due to a combination of factors like access to treatment, environmental factors, and lifestyle behaviours. For instance, women from lower SES groups have less regular screening, and are thus diagnosed at a later stage of the disease. Also women who participate in screening programmes may be healthier than non-participants. Women from lower SES groups are more likely to smoke, and/or to be obese (Sprague et al 2011).

In a study combining individual- and community-level measures of SES, Sprague et al (2011) examined breast cancer survival of women aged 20-69 years old in Wisconsin, USA, between 1995 and 2003. Individual-level SES was determined by household income, and community-level SES by number of families in poverty and percentage of the population without a high school diploma in a zip code area (ie: postal district). There were 5820 participants who were followed for up to seven years after diagnosis, and 690 deaths (469 from breast cancer).

In terms of community-level SES, women who lived in areas where more than one-fifth of adults did not have a high school education were over one and a half times more likely to die from breast cancer than women in areas where less than one-tenth of adults had no high school education. With individual-level SES, women who had household incomes less than two and a half times the poverty level were around one and a half times more likely to die from breast cancer than where household incomes were over five times the poverty level.

Adjustment for use of mammography screening, disease stage at diagnosis, and lifestyle factors (eg: smoking, weight) removed the income-based difference, but not the education-based difference in death from breast cancer.

Sprague et al (2011) admitted: "...we acknowledge the challenges in measuring SES at either the individual or community level. Education and income are crude measures of SES that fail to capture variation in prestige and quality of education and accumulated wealth. With assessment at only 1 point in time, we also failed to capture variation in SES at earlier life stages" (p1549).

Among community-dwelling over 60s in Singapore, depression was higher in low SES public rented housing than in higher SES owner-occupied housing. Within the low SES community, not being married, falls, visual impairment, and poorer social network were risk factors for depression (Wee et al 2014). SES was based on:

a) Employment status, receiving financial aid, and monthly household income (individual-level).

b) Percentages of families that are husband-wife, households on public assistance, annual household income above median, adults without secondary education, rented housing units, and adult unemployment (area-level).

SES differences have also been found in incidence of stroke [26], severity of [27] and mortality from stroke [28], but not stroke recurrence (ie: poorer people in a population and poorer countries suffer more) (Addo et al 2012 [29]).

UK governments, like in many countries, have commissioned reports into inequalities in health - eg: Black Report (DHSS 1980 [30]) and Acheson Report (Acheson 1998 [31]). The Black Report, for example, proposed that the best way to prevent inequalities in health was through measures in early childhood with fairer distribution of resources in society [32]. The Acheson Report made 39 main recommendations, including some specific measures like making nicotine replacement therapy available on prescription (Davey Smith et al 1998).

Davey Smith et al (1998) made three key criticisms of the Acheson Report:

i) An underemphasis on inequalities in wealth producing inequalities in health.

ii) Some recommendations are too vague - eg: "policies to reduce the fear of crime and violence".

iii) The cost of the recommendations were not calculated.

2.2.1. Service Use

The "inverse care law" is where the individuals who use the health services are less ill (eg: middle-class) [33], and those who are more ill make less use of the services (eg: more deprived individuals) (Crinson 2005)

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[26] For example, the lowest SES group had over one and a half times more than the highest group in a meta-analysis of seventeen studies (Kerr et al 2011).

[27] Eg: higher education was associated with better recovery during inpatient rehabilitation after stroke in a European study (Putnam et al 2007).

[28] In China, for example, lower SES was associated with higher mortality in the three years after a first-ever stroke (Zhou et al 2006).

[29] Addo et al (2012) reviewed all relevant studies published in English between January 2006 and July 2011.

[30] Called Black Report after chair of working group, Sir Douglas Black.

[31] Inquiry chaired by Sir Donald Acheson.

[32] Eg: £1500 m a year of Government expenditure to eradicate child poverty (Davey Smith et al 1998).

[33] Jones (2012) was direct: "The reality is that we live in a society rigged in favour of the middle-class at every level" (p171).

[34].

Lower socio-economic groups have two disadvantages in relation to the use of health services - (i) in making first contact with the services (eg: not visiting doctor or presenting at a later stage of illness), and (ii) after contact (eg: lower rates of referral to secondary or tertiary care) [35] (Crinson 2005).

The New Labour government in the 2000s in the UK suggested that empowering patients with informed choices would remove these disadvantages [36] [37]. Crinson (2005) felt that this strategy was unlikely to reduce inequalities in health care use. "The consequence of this strategy for patients is that with 'empowerment' comes a new set of personal responsibilities. But what happens to those individuals who do not make appropriate choices about their health needs, does this represent a system failure or an individual one?" (Crinson 2005 p510).

Individuals in the lowest income group experience a greater amount of mental disorders than those in the highest income group (eg: neurotic disorder - 7% vs 3% in UK in 2001; Holman 2014). But lower class sufferers are less likely to access psychotherapy ("talking treatments") and more likely to use prescription medication than higher class individuals (Holman 2014).

Why is this so? Hollingshead and Redlich (1958), for example, suggested that lower class individuals preferred a treatment that gave immediate relief, did not focus on the inner psychological life, were wary of authority figures (in this case, therapists), and did not believe that such treatment would help anyway.

On the other side, therapists tend to be middle-class, and prefer to work with individuals who are "well-educated, articulate and socially responsible... and are eager to do something about their problems" (Caine and

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[34] "This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources" (Tudor Hart 1971 p405). Tudor Hart was working in Port Talbot, south Wales (an area of high deprivation) where adult deaths and infant mortality were well above the average for England Wales over a large part of the mid-20th century.

[35] This could be seen in one-year survival rates after diagnosis for different cancers in England, for instance, which vary three-fold - eg: lung cancer: 15 vs 44% (Mayor 2009).

[36] "Simply offering more choices is beside the point if the choices are deemed unattractive or are not what is needed" (Hunter 2008 p113).

[37] Petrova et al (2006) noted that modern health care in the West is expected to be patient-centred, and inclusive of carers and the community, as well as evidence-based, continuous and co-ordinated across settings, and ethically sound and regulated.

This links to the growth of "participatory medicine" - "a movement in which networked patients shift from being mere passengers to responsible drivers of their health, and in which providers encourage and value them as full partners" (Frydman 2013 quoted in Prainsack 2014). Prainsack (2014) questioned the role of medical professionals in relation to encouraging participatory medicine.

Smail 1969 quoted in Holman 2014). Also "middle-class therapists find it difficult to relate to the circumstances of poverty and when people from such circumstances do use talking treatments, they are much less likely to explore their inner worlds with therapists" (Holman 2014 p532).

In terms of seeking medical help generally, "hard-to-reach groups" vary in their appraisal of the symptoms (as serious or even as a problem). For example, older individuals may view the symptoms of depression as the ordinary misery of life, and so do not seek help until much later (Holman 2014). Other factors include stigma in using services among the social group, and navigating the services themselves (Holman 2014).

It is often assumed that the removal of structural barriers to service use will increase the participation of groups that use such services less. But attitudes and perceptions of individuals are important. Bourdieu (1977) talked on "habitus" - "a wide-ranging concept that denotes ways of thinking, feeling, acting, speaking, perceiving, understanding and knowing; in short, ways of experiencing and being in the social world" (Holman 2014 p533). Habitus is a product of particular "conditionings of existence" (Bourdieu 1990), and so individuals having the same habitus are a social class. Thus, habitus (and social class) influence the interaction with health services (and the power relations).

Holman (2014) interviewed eighteen individuals in the UK about their views of talking treatments, of which six were categorised as working-class. Four themes emerged about the use and benefits of such treatments:

i) Verbalisation and introspection - ie: how individuals talk about and reflect on their feelings and experiences. The working-class respondents either gave shorter answers, attributed external causes for problems, or "were very talkative but the content was not particularly introspective" (Holman 2014).

ii) Impetus for emotional health - for example, middle-class interviewees talked of seeking help because "they felt they had to get better" (ie: they were attuned to emotional health), which was less so for the working-class respondents.

iii) Relation to medical authority - middle-class individuals were more aware of how to get talking treatments via their doctors (GPs), and that services varied between GP areas. This included challenging the GPs in some cases. "The critical, conscious engagement with health services requires a certain amount of cultural capital... Working-class interviewees, on the

other hand demonstrated a certain deference to the authority of the GP and adherence to their recommendations" (Holman 2014 p540).

iv) Practical orientation to the future - "People engage in a wide range of coping strategies for mental distress, with some of these being very much practically oriented, that is, focused on what can be done in the here and now to tackle the problem. In some ways this orientation runs counter to the ethos of talking treatments" (Holman 2014 p541). So working-class respondents were too practical. "Tom", for instance, said: "...what help can you get talking to somebody? You basically know all the answers anyway...".

"Working- class lives have historically been tough and short... In such circumstances, it makes sense to seek instant gratification wherever it is available, a propensity that might help to explain coping with emotional health problems by drinking or taking illicit drugs, using medication or ignoring the problem versus using talking treatments" (Holman 2014 p543).

2.3. HEALTHISM

Health inequalities in the UK, for example, take place in a context of "healthism" (ie: the consumerisation of health with images of youthfulness and vitality) (Burrows et al 1995) [38]. Burrows et al (1995) stated: "In the 1960s a list of 'health-related' commodities would have included items such as aspirins, TCP, Dettol and plasters. Today, however, it would include: food and drink; myriad health promoting pills; private health; alternative medicine; exercise machines and videos; health insurance; membership of sport and health clubs; walking boots; running shoes; cosmetic surgery; shampoo (for 'healthy looking hair'); sun oils; psychoanalysis; shell suits; and so on. The list is seemingly endless" (pp1-2).

Featherstone (1991) described a process where commodities have been "transvalued". Certain non-health commodities have become associated with "health" (eg: from decorative to "health-enhancing" cosmetics), while some health-related products have become important in general social and cultural meanings (eg: sports clothing worn in everyday life).

[38] Bates (2006) observed: "Consumer-driven models of healthcare may be becoming the standard for 'good' medical practice... When consumerism becomes the model, medical professionals may lose control of their work, and the state and corporations may increasingly control the practice of medicine... 'Healthcare' as opposed to the bio-psycho-social needs of patients and providers may enact a Fordist system in which physicians are only one part of 'assembly-line' medicine" (p386). Put another way, the "physician as a mechanic".

More than that, the promotion of healthy lifestyles is "emblematic of wider contemporary social and cultural changes - changes which are characteristic of the acceleration of the processes associated with late modernity..., the rise of the risk society... and the growing preoccupation with the body, lifestyle and consumer culture..." (Burrows et al 1995 p3). The term "late modernity" could be used to describe Western society currently, or post-modernity. Whichever, Giddens (1991) talked of a "runaway world" (appendix 2B) with fast-paced and profound changes in social practices and behaviours.

How do individuals explain social inequalities in health? Not necessarily the actual reasons for the differences, but the perceived causes of ill health variations in the population. Analysing answers from the British Health and Lifestyle Surveys of 1986-7 and 1991-2, Blaxter (1997) found that behaviour was the most common cause cited for health and illness (eg: lack of exercise, diet). "Causes of health and illness outside the individual's control - housing, the environment, personal poverty or prosperity - were rarely mentioned, for good or ill, as important in one's own life" (Blaxter 1997 p748) [39].

Blaxter (1997) took these findings to show that "the self-responsible lessons of health promotion appear to have been widely accepted" [40]. But it was "the more advantaged who appear to be, additionally, aware of the structural factors - income, work, the environment - which the social epidemiological evidence has implicated in inequalities in health" (Blaxter 1997 pp749-750).

There is the "prevention paradox" [41] in terms of the

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[39] Packman (2013) described a new aspect of modern poverty, namely the growth of "payday lending" (or "small dollar lending"). This is the short term loan of small amounts of money to low income individuals and/or those with poor credit history (ie: groups traditionally ignored by banks). The growth of such lending, in the UK in particular, has been since 2007 (ie: the global financial crisis) (from £100m in value in 2004 to £2-4bn in 2013; Packman 2013). Real incomes in the UK have stagnated or declined since 2005 for the bottom half of society, in particular.

Surveys in 2012 by the union Unite of its members found that payday lenders were used for everyday living as monthly salaries ran out by the third week of the month. The average amount borrowed in this situation was £200 in March 2012, and up to £335 in September 2012 (Packman 2013).

[40] Bunton (1992) criticised health promotion, not only for "victim blaming", but as a new form of social regulation and control. For example, health promotion surveys collect data on many aspects of lifestyle, while Healthy Cities projects control urban space. "Health promotion programmes have entered the detail of everyday time and space in ever more ambitious ways. The incursion has been carried out with little concern for the moral or political issues, even though there would appear to be several iatrogenic aspects of this work" (Bunton 1992 p9). Davies (1991) referred to "health fascism" (appendix 2C).

[41] Carter et al (2012) pointed out that "populations contain many people at low to moderate risk of developing a disease, and few at high risk of developing that disease. The prevention paradox is that greater population health improvement may be obtained via widespread small improvements in those

epidemiological data and the individual. For example, for heart disease, less than 10% of men viewed as "high risk" actually develop problems in the following five years, and the vast majority remain well. In fact, only about of future cases have displayed the risk factors (Blaxter 1997). Rose (1992) saw this as a problem with predicting for individuals from population data. "Risk factors for the group provide no necessary predictors for the individual: lay experience is well aware of this fact" (Blaxter 1997 p754).

It should be noted that "health" is not necessarily perceived as the opposite of "illness". Herzlich (1973) stated: "Illness comes from a way of life and from society... health, on the other hand, is simpler: it is contained within the individual and never lies outside him" (quoted in Blaxter 1997). While Crawford (1980) pointed out that in "an increasingly 'healthist' culture, healthy behaviour has become a moral duty and illness an individual moral failing" (quoted in Blaxter 1997). Herzlich and Pierret (1984) talked of a "right to health" which makes the individual responsible for their health, including strategies to deal with the "pathogenic effects of modern life".

So, individuals suffering health inequalities have a problem to resolve in the world of "healthism". Blaxter (1997) stated: "In the face of the moral imperative in Western society to be healthy... it is those who are most exposed to 'unequal' health who will be least likely to talk readily about their risk status. Instead, they will talk... about coping with illness, about not giving in to illness, and about the principle of mind-over-matter... If one cannot deny the reality of one's own disease, one can at least respond 'healthily' to it" (p756).

2.4. APPENDIX 2A - POVERTY AND SHAME

Chase and Walker (2012) argued that shame experienced by individuals in poverty is co-constructed - "combining an internal judgement of one's own inabilities; an anticipated assessment of how one will be judged by others; and the actual verbal or symbolic gestures of others who consider, or are deemed to consider, themselves to be socially and/or morally superior to the person sensing shame" (p740).

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many at low risk, rather than via dramatic change in those few at high risk" (p17).

Simplistically, poverty limits the attainment of possessions, which is key in modern capitalist societies, and shame emerges from that. This can lead to withdrawal from social interactions to avoid such shame.

Chase and Walker (2012) interviewed forty-two adults classed as living in poverty in south-east England. The interviewees rarely used terms like "poor" or "poverty", and preferred to talk of "struggling" and "going round and round in circles". Likewise the term "shame" was not used, but terms like "embarrassed", "worthless", and "dirty". Chase and Walker (2012) called these terms, the "colloquialisms of shame" (which denoted the emotion without naming it). Interestingly, "people's narratives often revealed significant self-criticism of their abilities to cope financially, despite evidence to the contrary of their extensive efforts to carefully manage scarce resources" (Chase and Walker 2012 p743).

Chase and Walker (2012) noted different situations where shame was experienced:

a) Family - eg: "Hilda" said: "I am a mum now myself and I should not have to go to my mum all the time just for a pint of milk or a loaf of bread" (p744). "Similarly, there were numerous other descriptions of the painful public exposure of straitened circumstances with respect to children. Having to watch other children on the housing estate eat ice cream and not be able to buy one for their own children, having to apply for a hardship fund to pay for a child’s school trip, or being unable to meet the demands of children for sweets when out shopping all had the same detrimental impact of instilling a sense of failure as parents" (Chase and Walker 2012 p744).

b) Social interactions - "A lack of money also frequently impacted on the ability to maintain appearances, which in turn damaged confidence and self-esteem and meant that people constantly anticipated feeling shame in social contexts..." (Chase and Walker 2012 p745). For example, "Tony" was embarrassed that he could not afford a haircut.

c) Interactions with bureaucracy - for example, through the benefits system.

The interviewees showed a number of responses to the poverty-induced shame:

i) Pride - eg: doing voluntary work when no paid jobs available.

ii) Withdrawal - eg: "Sonia" said: "Sometimes there ain't no point in socialising, 'cos what are you going to

talk about? Your bills? Your debt? So, yes, that does make you withdraw I suppose … there's nothing to talk about except that you feel a bit depressed, you haven't got enough money to pay that bill or eat that day" (p748).

iii) Pretence - eg: "Sonia" admitted: "I don't like people knowing I am on benefits. If I didn't know you, I'd tell you I worked. I class this as a proper job (working as a volunteer), that's why I wear the identity badge that way (back to front) so no one sees that I'm volunteering … so it looks like I'm doing a proper job" (p748).

iv) Loss of agency and control - eg: the sense of powerlessness in the face of financial struggles.

An important discourse that emerged from the interviews was "them" and "us". "Essentially, the 'them', in the first instance, referred to people with power and money, considered far removed from the circumstances of research participants. They had 'no idea' or 'no clue' about how much they were struggling and, it was felt, would have 'no chance' surviving on such limited resources. This 'them' and 'us' discourse laid the basis for a social stratification within which participants positioned themselves and others. While the 'us' shared an understanding of their difficulties, were 'in the same boat', and would help when they could, the 'them' would not" (Chase and Walker 2012 p749).

But there were other layers to this distinction. The individuals who were working distanced themselves from those they considered to be happy not working and claiming benefits. Among these individuals, they distinguished between those on benefits because of difficult circumstances and "scroungers" ("capable of working and they choose not to"; "Tessa"). Chase and Walker (2012) felt that "this process works against fostering social solidarity among people in shared difficult circumstances and, instead, divides the 'us' into multiple 'others'" (p750).

Chase and Walker (2012) summed up: "This co-construction of shame, the internal sense of inadequacy combined with the externally imposed disapproval for failing to live up to society's expectations, appears to have potent ramifications. The dominant public, policy and media discourses described above serve ultimately to differentiate those deemed as socially deserving of support from those who are undeserving – social constructs surrounding poverty that have been sustained for centuries and certainly since the introduction of the Elizabethan poor laws" (p752).

2.5. APPENDIX 2B - CHANGING WORLD

Hanlon and McCartney (2008) felt that the health of populations was influenced more by long-term economic and social change than by changes in medical technology and health services or short-term health policies, but most attention is paid to the latter. The authors argued that climate change, and "peak oil" (or "Hubbert's blip") "have the potential to cause impacts on health that will eclipse the relevance of most other current health debates" (Hanlon and McCartney 2008 p647).

"Peak oil" refers to the production peak of oil resources (not when oil supplies run out) [42], and the upshot is a future with more expensive oil. This will have effects on economic growth and globalisation.

Hanlon and McCartney (2008) stated: "It is known that economic growth creates health, and recession destroys health. Historical data have shown that economic growth is the most important associated factor in determining health improvement. There is also evidence that economic shocks destroy health, as was seen in the health trends of the population in the former Soviet Union and with Scottish de-industrialisation in the 1970s and 1980s" (pp650-651). Continuing and changing wealth inequalities will impact on health.

On the other hand, there could be benefits from "peak oil": "There will be an opportunity to move away from the profit-driven, stress-laden globalised system to which we have become accustomed, and this could impact on wellbeing through a range of intermediate factors such as changing work patterns or increased local community co-operation" (Hanlon and McCartney 2008 p651).

2.5.1. Precarious Employment

Precarious employment (PE) covers "employment insecurity, individualised bargaining relations between workers and employers, low wages and economic deprivation, limited workplace rights and social protection, powerlessness to exercise workplace rights" (Benach et al 2014 p230). It is the opposite to the "gold standard of the secure full-time, year-round, well-compensated, and socially protected employment contract" (Benach et al 2014).

PE has existed for many years (since mid-1970s), and it varied between countries (developed and less developed), and between workers (manual and non-manual [43]). Benach et al (2014) highlighted the changes as a

[42] There are sceptics about "peak oil" who argue that such "scare stories" have existed for many years, and the world can adapt (eg: use of bio-fuels).

[43] Eg: PE was lowest among older male Spanish non-manual workers and highest among young female

consequences of the economic crisis of 2008 in increasing PE - eg: redundancies, lower wages, restructuring, and increased outsourcing. All of these changes and PE generally affects the health of workers, families, and communities. PE has health consequences in three main ways - poorer working conditions (that often go with PE), less control over job, and wider deprivation (Benach et al 2014).

Benach et al (2014) summarised the issues and research on PE:

1. Organisational restructuring and downsizing - This includes the anticipation of job loss (which can be as stressful as actual job loss), and the impact of organisational changes on the downsizing "survivors" (ie: employees who keep their job). During the anticipation phase, declines in subjective health are reported, and increases on body mass index, and blood pressure, for example, along with "presenteeism" (ie: working while ill).

The survivors of downsizing often experience adverse health effects from greater workload, reduced job control, and increased job insecurity, for example.

2. Perceived job insecurity - This is "a process of cognitive appraisal of the uncertainty existing for the organisation and the employee" (Quinlan et al 2001 quoted in Benach et al 2014). It occurs in relation to organisational changes as well as the general economic situation. It is a subjective experience, which varies between individuals, and can be independent of any objective threat (Benach et al 2014).

One meta-analysis, for example, found a small correlation with physical health problems, and a medium correlation with mental health problems (Sverke et al 2002).

3. Temporary (or fixed-contract) employment - eg: more psychological problems than permanent-contract employees. But the effect of temporary employment varies with the rights of such workers, and temporary employment is not always the same as PE. For example, Scandinavian temporary workers had equal health status with permanent workers because of a strong welfare system (Kim et al 2012).

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immigrant manual workers in a study in Spain (Vives et al 2011).

2.6. APPENDIX 2C - SOCIOLOGICAL CRITIQUES OF HEALTH PROMOTION

Nettleton and Bunton (1995) distinguished between a sociology of health and medicine (eg: understanding adherence to medical advice by patients) and a sociology for health and medicine (eg: exploring the assumptions of health policies).

Nettleton and Bunton (1995) noted that "the changing nature of health programmes within the health promotion project serves to contribute to the construction of a new type of patient who has a different range of responsibilities. When people entered the sick role they were encouraged to interact with medical specialists – preferably doctors – whereas today, under the rubric of health promotion, people are often encouraged to actively interact with community groups, media campaigns and take responsibility for their *own* health regimes" (p41).

Nettleton and Bunton (1995) outlined three sociological critiques of health promotion:

i) Structural - A focus on preventing illness and promoting health only ignores the social and environmental conditions in which individuals live (eg: poverty, industrial pollution). "The structural critique is therefore about power [44]. It draws attention to the fact that ideas about healthy living are promulgated by those who are white, middle class and often work within sexist, racist and homophobic value systems. This has the effect of contributing to the marginalisation of certain social groups who may be earmarked as 'targets' or 'deviant' groups..." (Nettleton and Bunton 1995 p43).

ii) Surveillance [45] - Many policies of health promotion involve monitoring and regulating populations [46]. For example, Castel (1991) described a shift in medicine "from dangerousness to risk" with less focus on

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[44] Doctors are seen as a powerful group, but the power of doctors in society is complex because power is relational, and so "physicians use power and are manipulated by power" (Bates 2006). This is based on Michel Foucault's view of power.

[45] "Surveillance Medicine" instead of "Hospital Medicine" (Armstrong 1995).

[46] Double (2002) noted the contradiction in relation to mental health in recent years in the UK that there had been a reduction in psychiatric hospital beds but an increase in individuals in prison with a mental disorder. This is explained "either as the 'psychiatricisation' of criminality or as the increasing diagnosis of mental illness in prisoners not previously recognised as being mentally ill" (Double 2002 p901). Double (2002) leaned towards the latter, suggesting that mental health care has become a panacea for personal and social problems. Also known as the "medicalisation of everyday life" (eg: Illich 1976) (table 2.1). The idea is that "the things that people traditionally did or organised for themselves were being expropriated by governmental institutions and the so-called disabling professions. Institutionalised health care - medicalisation - impaired health in the same way that 'schools impeded learning; transportation contrived to make feet redundant; communications warped conversation'..." (Aronson 2009 p904).

the symptoms of patients and more concentration on their risk profile [47].

iii) Consumption - Health and medicine have become part of consumer culture with the development of health as part of lifestyles. For example, "products of health promoters - such as fitness programmes and diets - are 'aesthetisised' under consumer culture and may become a means of communication of status and group identity..." (Nettleton and Bunton 1995 p47).

- "Social iatrogenesis is at work when health care is turned into a standardized item, a staple; when all suffering is 'hospitalized' and homes become inhospitable to birth, sickness, and death; when the language in which people could experience their bodies is turned into bureaucratic gobbledegook; or when suffering, mourning, and healing outside the patient role are labelled a form of deviance".

- Medicine is a "radical monopoly" where "social control of the population by the medical system turns into a principal economic activity".

- "Medicine is a moral enterprise and therefore inevitably gives content to good and evil. In every society, medicine, like law and religion, defines what is normal, proper, or desirable. Medicine has the authority to label one man's complaint a legitimate illness, to declare a second man sick though he himself does not complain, and to refuse a third social recognition of his pain, his disability, and even his death. It is medicine which stamps some pain as 'merely subjective', some impairment as malingering, and some deaths—though not others — as suicide. The judge determines what is legal and who is guilty. The priest declares what is holy and who has broken a taboo. The physician decides what is a symptom and who is sick. He is a moral entrepreneur, charged with inquisitorial powers to discover certain wrongs to be righted. Medicine, like all crusades, creates a new group of outsiders each time it makes a new diagnosis stick. Morality is as implicit in sickness as it is in crime or in sin".

- "Medicine undermines health not only through direct aggression against individuals but also through the impact of its social organisation on the total milieu".

- "The medical profession is a manifestation in one particular sector of the control over the structure of class power which the university-trained elites have acquired. Only doctors now 'know' what constitutes sickness, who is sick, and what shall be done to the sick and to those whom they consider at a special risk".

Table 2.1 - A sample of Illich's (1976) view on social iatrogenesis and the "medicalisation of life".

[47] Carter et al (2011) pointed out two issues with health promotion campaigns:
i) Coercion - eg: playing on guilt to effect a behaviour change.
ii) Stigmatisation - eg: lead to blaming unhealthy individuals for their health problems.

Post-modern approaches are critical of "bio-medicine" (the medical view on health, illness, and the body) which "constrains and closes down other more promising options, possibilities, choices, rendering us, in effect, (fixed) bodies with organs" (Williams 2006 p9) (or "bodies-with-organs"; Deleuze and Guattari 1989). These approaches prefer to emphasise the social construction of bodies (and subjectivities - ie: subjective experience of them) through discourses in society.

A desire to overcome biological determinism and reductionism [48], Williams (2006) observed, has led to "discourse determinism" or reductionism where everything is "reduced to the social".

Carter et al (2012) raised four issues about health promotion:

a) Health promotion as limiting or increasing the freedom of individuals (ie: coercion or empowerment).

b) The collective benefits of health promotion.

c) The risk of health promotion leading to victim blaming among the ill and disabled.

Holland (2007) pointed out that "an individual is not a free-floating entity whose lifestyle can be understood and explained in isolation from the factors beyond their control - upbringing, culture, society, wealth status, genome, etc - that mould them. It is wrong to think that people are free to choose healthier options, because such factors which are outside of the individual's control, determine their behaviour" (p115).

This is a challenge to the view that many aspects of disease are self-inflicted by unhealthy behaviours, which supports the case for change individual behaviours and even whole lifestyles. "Attempts to modify whole lifestyles are more controversial because they raise some very deep questions about how one should live one's life; as philosophers put it, what is the good life for a human being?" (Holland 2007 p112).

d) The distribution of the benefits of health promotion fairly.

2.6.1. Coercion versus Nudging

Some have argued (eg: John Stuart Mill) that

[48] White (2009) noted three assumptions that do not help in understanding the "social production of disease - genetics-only explanations of disease, sickness leads to poverty through downward social mobility, and the view that lifestyle choices are unaffected by social factors.

coercion [49] generally is permissible to prevent harm [50] to others. While Conly (2013) felt that "it can be morally permissible to coerce people into doing what is good for their own health" (ie: what is known as paternalism [51]). This is "hard paternalism" as opposed to persuasion ("soft paternalism"). "Soft paternalists try to influence individuals not to make that self-destructive choice, but leave them the freedom to do the self-destructive thing if they nonetheless want to do that" (Conly 2013).

An example of coercive paternalism is the ban on selling sodas over a certain size (16 ounces) in restaurants in New York city. Though this is more a case of "impure paternalism" (Dworkin 1983 - ie: "targeting the producers, rather than the consumers, of goods that are bad for us, it avoids sanctioning individuals whose flaw is no more than imprudence" (Conly 2013 p243).

Jonas and Thornley (2011) raised the issue of potentially harmful parental practices and State intervention, like exposing children to environmental tobacco smoke (ETS) in domestic settings. Where does parental discretion end and State intervention begin in the case of a conflict (eg: making it illegal for parents to smoke in the presence of a child)?

Jonas and Thornley (2011) identified seven considerations in this situation:

i) The practice to be regulated should be clearly identifiable.

ii) The severity of harm should be high.

iii) The probability of happening should be high.

iv) There should be strong scientific evidence.

v) Any unavoidable aspects to the risk (eg: transporting children in a car is a risk, but unavoidable with the needs of travel in modern society)?

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[49] The Harm principle - "the only purpose for which power can rightfully be exercised over any member of a civilised community, against his will, is to prevent harm to others" (Mill 1974 quoted in Jonas and Thornley 2011). This principle can be used to support a smoking ban in enclosed, but not non-enclosed public spaces, for example, Fitzgerald (2008) argued.

[50] Feinberg (1984) described three meanings to harm - damage, "harm-to-interests", and violation of rights. Distinguishing harmful from non-harmful acts is not easy sometimes. One way is to have a comparison - ie: harm is when a person is worse off than before the event, or if the event had not occurred (Jonas and Thornley 2011).

[51] "The objectionable character of paternalism of this sort is not that those who seek to benefit us against our wishes are likely to be wrong about what really benefits us . . . It is, rather, primarily a failure of respect, a failure to recognise the authority that persons have to demand, within certain limits, that they be allowed to make their own choices for themselves" (Darwall 2006 quoted in Conly 2013).

vi) Is it possible to change practice without direct coercion (eg: parent stops smoking through voluntary cessation programme)?

vii) Will there be unintended consequences to regulation?

Brownsword (2013) preferred a "stewardship" view of the State. It is the State's task to maintain and protect the "infrastructure of human wellbeing". Put another way, to guard against future catastrophes caused by overeating of unhealthy foods or the consequences of smoking, for example. A public health system overwhelmed by diseases caused by these unhealthy behaviours would struggle to provide care for the whole community. In this context, coercion could be seen as acceptable.

Alternatively, a currently fashionable approach to health promotion is the idea of "nudging" (or incentives) - ie: subtly influencing populations to choose healthy behaviours. The origin of the idea is a book by Richard Thaler and Cass Sunstein (2008). They defined nudges as "any aspect of the choice architecture that alters people's behaviour in a predictable way without forbidding any options or significantly changing their economic incentives" (quoted in Prainsack and Buyx 2014).

The tools of nudging have been used by advertisers and retailers over many years to influence purchasing behaviour. They draw upon principles in behavioural science. One example from Iceland is the LazyTown scheme began in 1996. Children are encouraged to eat healthy by a superhero character, and they receive points for doing so along with being active. Other nudging techniques include calling fruit "sports candy". Rates of childhood obesity have been reduced by the programme (McDaid and Merkur 2014).

Schmidt (2014) proposed four rationales for policymakers using incentives to promote health behaviour:

- Health promotion
- Curbing health care expenditure
- Competitive advantage as a country
- Promoting moral values.

Prainsack and Buyx (2014) argued that incentives linked to solidarity [52] (ie: aimed at everyone) are better

[52] "Because solidarity focuses on similarities between people, it is not so much concerned with 'chasing the offender' - ie: punishing those who engage in 'bad' health behaviours - but with ensuring that all of us live in conditions that facilitate healthy lifestyles" (Prainsack and Buyx 2014 p16).

than those aimed at specific groups - "nudges where the distinguishing features used for defining the target group carry the risk of stigma, or if the nudge itself is likely to increase existing stigmas. Examples of this would be nudges aimed at groups whose members are seen as deficient in some sense (economically, intellectually, or morally; an example for the latter are smoking pregnant women). In such a case the nudge itself can increase stigma; examples are financial incentives such as vouchers or small cash payments to nudge such women to stop smoking" (Prainsack and Buyx 2014 p16).

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