Contents

Series editors’ preface xiii
Acknowledgements xv
Notes on contributors xvii

Introduction 1

PART I: Explaining health inequalities 7

1 Understanding class and inequality 9
Margaret Miers
Introduction 9
Social stratification 11
Is inequality inevitable? 12
Functionalist theories of stratification 12
Marx on social class 15
Max Weber and social stratification 17
Class consciousness 19
Classes as contemporary and historical phenomena 20
Postmodernism and class 22
Bourdieu and types of capital 23
Social exclusion 25
Realism and the persistence of class 27
Conclusion 28

2 Measuring class and researching health inequalities 31
Margaret Miers
Introduction 31
The Registrar General’s definition of social class 32
5 Nursing, education and social class 99
  
  Margaret Miers
  
  Introduction 99
  Social class and education 101
  Education and health 102
  Class and classification in education: defining knowledge and skill 103
  Gender and curricula: implications for nursing 105
  Nursing, education and social class 108
  Discourses about women’s role 109
  Nurse education and higher education 111
  Discourses amongst nurse educators 113
  Discourses about education 114
  Nurse education discourses: nurse education and social trends 118
  Nursing and policy change 119

PART III: Addressing inequalities through nursing practice 123

6 Class inequalities in mental health nursing 125
  
  Paul Godin
  
  Introduction 125
  The asylum 126
  The mental hospital 129
  Community care 132
  New community care 136
  A third way 140
  Conclusion 141

7 Inequalities in the provision of children’s health services 145
  
  Valerie Watson
  
  Introduction 145
  Inequalities in health 145
  Uptake of health and education services 147
  Implications for children’s nursing 150
# CONTENTS

The role of children’s nurses in the 21st century ........................................ 152
The future........................................................................................................ 157

## 8 Income and health: implications for community nursing ................ 159

*Robert Hoskins*

- Introduction.................................................................................................... 159
- The relative income theory........................................................................ 160
- The individual/absolute income theory.................................................... 162
- The neomaterialism theory......................................................................... 164
- Discussion...................................................................................................... 165
- Implications for community nurse practice.............................................. 167
- New Labour’s response to reducing income inequality and tackling health inequalities ......................................................... 169
- Welfare benefits screening as a means of reducing income inequality......................... 171
- Does a welfare benefit payout boost health?........................................... 179
- Conclusion.................................................................................................... 179
- Appendix...................................................................................................... 181

## 9 Work and occupational health ......................................................... 183

*Margaret Miers*

- Introduction.................................................................................................... 183
- Why and how does employment affect health?.................................. 184
- Unemployment and people with severe mental illness.................... 190
- Health and physical working conditions............................................ 191
- Repetitive strain injury............................................................................. 193
- Coronary heart disease and work environment................................. 194
- Explanations for work related psychosocial stress............................ 195
- Organisational downsizing and employees’ health............................ 198
The occupational health of health professionals 199
Occupational health nursing 203
Coronary heart disease, nursing and occupational health 206

10 Public health policy and practice 213
Margaret Miers
Introduction 213
Social capital 214
Evidence based public health strategies 218
Tackling social exclusion 220
Social inclusion 223
Tackling health inequalities:
  developing a sustainable approach 225

References 229
Name index 257
Subject index 263
Part I

Explaining health inequalities
1 Understanding class and inequality

Margaret Miers

Introduction

In Britain, the beginning of a new century has been accompanied by the development of a programme of action to tackle inequalities in health. In 1998 the Government published the results of an inquiry into the nature and determinants of health inequalities in England. The recommendations of this Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson, have subsequently been incorporated into many of the policy initiatives promoted to tackle inequalities in health, a priority area for the National Health Service (NHS) (Acheson 1998). In Autumn 2001 a national consultation took place on a plan to ensure that national targets for reducing health inequalities in England can be met. Similar initiatives in Wales and Scotland demonstrate governmental acceptance that not only do inequalities exist, but that ‘many are avoidable and often unjust’ (Department of Health (DoH) 2001a: 7). The injustice lies in the fact that ‘such inequalities in health are a consequence of significant differences in opportunity, in access to services, and in material resources, as well as differences in personal lifestyle choices’ (ibid.: 7).

It is the findings and arguments of the social scientists and health researchers who contributed to the Independent Inquiry into Inequalities in Health which are informing the Government’s action plan. As the consultation document Tackling Health Inequalities: Consultation on a Plan for Delivery notes:

To summarise these findings, people who experience one or more of: material disadvantage, lower educational attainment and/or insecure employment are likely to experience worse health than the rest of the population. In addition there is evidence to suggest that living in materially deprived neighbourhoods contributes to worse health for individuals.
These differences are apparent from the beginning of life. Children born and brought up in families with low levels of educational attainment, material disadvantage or in lower socio-economic groups are likely to experience worse health in later life. Although this country has seen increased prosperity and reductions in mortality, the gap in health between those at the top and bottom of the social scale has widened, particularly between the mid 1970s and the mid 1990s. This is significantly avoidable and fundamentally unfair. (DoH op. cit.: 7)

Behind the above analysis of health inequalities lies an implicit description of the nature of British society. It is presented as a differentiated society in which different individuals, families and groups share different experiences, particularly in relation to material and economic resources. Sociologists would describe such a society as stratified. Individuals are ranked by their access to resources. Individuals’ position on ‘the social scale’ has implications for their health, and children’s experiences early in life appear to influence their health at a later age. The British Government in the 21st century sees the negative health consequences of lack of access to adequate resources as both avoidable and unfair. The action plan to reduce health inequalities concentrates on two aims. The first is to reduce the gap in mortality between manual groups and the population as a whole, starting with children. The second is to reduce regional differences in life expectancy. A range of national targets are seen as central to achieving these aims. These are: reducing the number of children living in child poverty; reducing smoking rates, and reducing the under 18 conception rate. These targets indicate that the explanations offered for inequalities in health include explanations relating to income and material inequalities as well as explanations relating to behaviour and lifestyle. The results of the consultation further support the importance of tackling these factors, described as ‘the wider determinants of health inequalities’ (DoH 2002a: 8).

It is important to note that in suggesting that health inequalities are unfair and avoidable, the Government is not suggesting that all inequalities are unfair or capable of being eliminated. There is, however, an assumption that society has a responsibility for an individual’s health. A review of different approaches to understanding and explaining inequalities in society provides the context for reviewing assumptions about societal and individual responsibility for health.
Social stratification

Sociology has traditionally used the concept of social stratification to explore inequality. Sociology textbooks, in chapters on social stratification, explain that all societies have divisions between people according to a hierarchical system, based usually on the amount of power and wealth individuals command (Giddens 1997, Haralambos and Holborn 2000). In some societies the divisions may be between age groups, gender, or ethnicity. In others, as in the Indian caste system, the divisions may be determined by religious beliefs. In industrialised societies the main basis of stratification has been socio-economic position, or, as sociologists have argued, social class. Up until the 1970s social class was commonly seen as the main form of social stratification in Britain, but since the 1970s there has been considerable debate about the importance of class in contemporary societies. Within sociology, Abbott and Wallace (1990) criticised the discipline for focussing too much on the male world of work and forgetting the importance of gender as a system of stratification. Throughout the 1980s and 1990s there has been a growing awareness of the importance of other differences between individuals and groups (Oliver 1990, Culley and Dyson 2001). Diversity and difference associated with ethnicity, sexual preference, ability and disability have led to both an interest in the complexity of social divisions and an emphasis on a growing individualisation of experience. Margaret Thatcher proclaimed ‘There’s no such thing as society’ (hence no social structure, nor social stratification), and John Major’s ‘classlessness’ was emphasised during his premiership; but sociologists, too, were pointing to the irrelevance of class as a concept in a world described by some as ‘postmodern’ (Featherstone 1991, Lash and Urry 1994). Social stratification involves the notion of a system, suggesting a structural determinism, which, it can be argued, fails to describe the pliable processes of social life. Touraine (1995) has argued that sociology needs concepts to describe fluidity rather than structure and suggests that social movements, not social class, should be a central category of sociological analysis.

All health professionals involved in implementing The NHS Plan (DoH 2000) face the challenge of understanding the
nature and genesis of health inequalities, which the present Labour Government acknowledges as avoidable and unfair. Exploring notions of social stratification, social class and social diversity and social movement, is part of that challenge.

Is inequality inevitable?

The view that some form of stratification is inevitable, or just, has a long history. In ancient Greece, slavery was perceived as natural for slaves and assumptions about women’s inferiority to men have only been challenged through legislation in the 20th century. Feudalism accepted and supported material inequalities between serfs and lords. The Hindu caste system is an obvious example of inequality being seen as divinely ordained. However the idea that human beings are born equal developed during the 17th century, alongside attempts to articulate the relationship between an individual and the state as a representation of a collectivity. Political theorists such as Hobbes (1588–1679), Locke (1632–1704) and Rousseau (1712–78) argued that democratic political systems would allow the authority of the state to protect individual rights. These changes were accompanied by industrialisation and the growth of capitalism, a process which many sociologists describe as leading to ‘modernity’, characterised by the growth of organisations, industry and capitalism (Crompton 1998). Social class became the dominant form of social stratification in this period of ‘modernity’. There are many definitions of social class but all involve an understanding of ranked collectivities of people sharing a measure of prestige or resources. These unequal shares can be seen as fair or unfair, avoidable or unavoidable, depending on explanations for the distribution and accrual of these resources.

Functionalist theories of stratification

Functionalists argued that resources are distributed in a manner which maintains social stability. Functionalism, as an approach to understanding how society works, draws on a biological analogy and describes society as a social system made up of
interrelated parts. Different ‘parts’ of society contribute to the maintenance of the order and stability of society as a whole. Social stratification, therefore, is functional for the integrated social system. Talcott Parsons (1951) believed that order and stability are based on consensus about what is valued in society and that value consensus is the basis of cooperation and integration within society. Evaluation of activities, skills and individuals is based on the consensus of the group and those who successfully perform highly valued activities will be held in high regard. The resulting status and prestige are usually accompanied by material rewards. Stratification and inequality are a means of reinforcing common values and thus help maintain social stability. Davis and Moore (1945) gave the most detailed account of how social stratification supports the effective functioning of social systems. They argued that all societies need a mechanism for ensuring that key roles are effectively allocated and performed. The most important roles in society must be filled by those best able to perform them. The most able individuals must receive appropriate training and the most important roles must be performed conscientiously. The promise of high rewards ensures that the most able individuals are attracted to the most important social roles. Such assumptions may underlie the allocation of professional roles. Davis and Moore argue that social stratification is a device by which societies ensure that the most able and qualified persons gain the most important positions. (For a summary and critique of this position in relation to the allocation of professional roles, see Wilkinson and Miers 1999.)

Davis and Moore’s functionalist account of the inevitability of social stratification has been widely criticised, most comprehensively by Tumin. Tumin (1964) noted that many occupations which are vital to society (hospital domestic, refuse collector, to name but two) are not valued and occupy a low position in a stratification system. He questioned the view that there is only a limited pool of individuals with the ability to perform some highly valued roles and the view that training for key positions involved sacrifice, given that the long term rewards of higher education were well known. Tumin argued that Davis and Moore had ignored the influence of power in the allocation of prestige and resources, suggesting that those groups occupying highly rewarded positions can restrict access
to their positions through controlling entry, thus creating demand for their own scarce skills and thereby increasing their own rewards. High status professions such as the medical profession are offered as exemplars of the self interested use of power. Stratification could therefore serve as inhibiting individual development and opportunity and serve to divide, not integrate, social groups.

Many commentators on functionalist theories of stratification have noted that:

such theories incorporate a moral justification of economic inequality which has been commonplace since the advent of economic liberalism — that is, in a competitive market society, it is the most talented and ambitious — in short the best that get to the top, and therefore take the greater part of societies’ rewards. (Crompton 1998: 7)

The moral justification includes the view that an individual’s social position is an individual’s responsibility. Similarly, individuals are responsible for their own health. This moral justification, however, is often based on assumptions about equality of opportunity, which as Crompton points out ‘is a powerful justification for inequality’ (op. cit.: 7). Governments can take measures to increase equality of opportunity through limiting the power of those with control over resources by various regulatory devices such as legislation against monopolies and legislation to protect employees. A further force that mitigates the divisiveness of stratification and promotes equality of opportunity is the development of social citizenship, that is, universal provision of education and welfare benefits. The current Government’s attention to inequalities in health can be viewed as an attempt to reaffirm a commitment to equality of access to health and health care for all citizens. Such a commitment is enshrined in the values of the NHS and the Labour Government’s concern is to identify the barriers to equal access to health care. In so far as the barriers are economic barriers, these are identified and action to address them is part of the action plan for tackling health inequalities. National policies outside of the NHS identified as being directed towards reducing health inequalities include:

- continuing to improve the position of the poorest working families by increasing the National Minimum Wage
• reducing the risk of ill health and excess winter deaths among older and disabled people by implementing *The UK Fuel Poverty Strategy*
• addressing the housing needs of deprived areas by bringing all social housing up to set standards of decency by 2010 (DoH 2001a: 26).

This is not, however, a challenge to Britain’s economic reward system.

**Marx on social class**

Karl Marx (1818–83) saw inequality as inevitable within capitalism. He saw capitalism as a social system characterised by private ownership of wealth. Sociologists in the 1960s and 1970s explored the writings of Marx as a radical alternative to functionalism. He observed that human beings must produce food and material objects in order to survive and to do so individuals develop social relationships with each other. As the ‘forces of production’, that is the raw materials, knowledge and tools used in production, develop, so will social relationships, the relations of production, change and develop. Groups come to occupy different positions in relation to the forces and relations of production, leading to an inevitable conflict of interests between social groups. This conflict of interests derives from a contradiction between the forces and the relations of production and class conflict becomes the driver of historical change. The forces and relations of production together form the economic base or infrastructure of society and the infrastructure shapes the ideas and values of society, including the structures supporting these ideas and values — the legal and political system, education, health and welfare services. Hence far from social structure and stratification being based on consensus, they are based on conflictual economic relationships between oppositional social groups. It is the ideas of those with the most economic power, which become the accepted, consensual ideas.

The oppositional social groups are classes. Marx and Engels, in *The Communist Manifesto*, proclaimed:

> The history of all hitherto existing society is the history of class struggles. Freeman and slave, patrician and plebeian, lord and serf, guild
master and journeyman, in a word, oppressor and oppressed, stood in constant opposition to one another, carried on an uninterrupted, now hidden, now open fight, a fight that each time ended either in a revolutionary reconstitution of society at large, or in the common ruin of the contending classes. (Marx and Engels 1967: 79)

In capitalist societies the capitalists (the bourgeoisie) own the means of production and the workers (the proletariat) own only their own labour which they hire to the employers (the bourgeoisie) in return for wages. The capitalist employer sells the products for more than the costs of the labour and the materials and the surplus value constitutes the capitalist’s profit. As Crompton (1998) explains, although human labour is unique, in that it has the capacity to create new value by transforming commodities, in a capitalist society labour has become a commodity like any other. It is purchased as a raw material for a price that does not take account of its transformative capacity to create new value. Thus it is in the interests of the employer to control the wages and in the interests of the worker to increase levels of pay. There is a contradiction between the forces of production (the ‘material’ used in production plus the collective labour power of the workers) and the relations of production (private and individual ownership and individual wage payments). The interests of workers as a collectivity are in conflict with the system of private and individual ownership. The conflict between the two opposed classes, Marx predicted, would lead, through revolutionary means, to the final epoch of history, a communist or socialist society in which the forces of production (collective labour) would be congruent with the relations of production, through collective ownership. Class conflict, oppression and exploitation would be eliminated. Contradiction would be resolved. It was the injustice in class relations which would lead to the ending of inequality.

Porter (1998) has illustrated the relevance of Marxism to nursing by reference to Bridges and Lynam’s (1993) Marxist analysis of informal carers. Bridges and Lynam identify ways in which the logic of capitalism affects the lives of informal carers. In a Marxist analysis, public expenditure (for example expenditure on the NHS) is a significant drain on profit and it is ‘therefore in the interests of the capitalist economic sector
to ensure that public expenditure is kept to a minimum’ (Porter op. cit.: 55). Bridges and Lynam interpret the move towards community care, relying on unpaid informal labour, as a move to reduce public expenditure, reflecting capital’s economic need to maximise profits. This economic need leads the producers of the goods (and services) that lead to profit to keep down costs and maintain their own structural position in the capitalist economic system. In health care it is the professionals who are the producers of the services and it is in their own interests to retain their economic position by neglecting the interests of service users and informal carers. Porter notes:

> given that carers tend to be disadvantaged and unsupported within the economic and social circumstances currently pertaining, there is likely to be a gulf between the needs of the carer and the ideology of the ruling class. Here we come to nurses’ dilemma of whether to act as an advocate, promoting the needs and desires of their clients, or to act in the interests of the bureaucracy for which they work. (Porter op. cit.: 56)

A Marxist analysis challenges nurses to acknowledge their own position in the stratification system and the implications of their own mode of professional practice. Nurses may also wish to consider whether their own labour has transformative power, capable of creating new value through improving health. Such a claim, if it can be made good, can be an argument for higher rewards. Godin, in Chapter Six in this volume, analyses the position of mental health nursing within the capitalist context of mental health policy and practice.

**Max Weber and social stratification**

Marx was not the only social theorist, of course, to write about class. Max Weber (1864–1920) also saw class as an economic grouping and defined class as a group of individuals who share a similar position in the market economy and as a result gain similar economic rewards. Individuals who share a market position share a class position. The highest economic rewards will go to those who have capital, property and skills which can be used, in Marx’s terms, as part of the forces of production. Market position depends on scarcity; highly valued and scarce professional skills (in medicine, the law) would attract
high rewards. It is relevant to note that Weber’s analysis has been used to explain the professional closure strategies used to protect professionals’ market position (Johnson 1972, Witz 1992). Weber, however, disagreed with Marx’s view that social status and political power derive from economic power. Weber identified three separate dimensions of stratification: class, status and party. He saw all three as phenomena of the distribution of power within a community:

Whereas the genuine place of classes is within the economic order, the place of status groups is within the social order, that is, within the sphere of the distribution of honour. From within these spheres, classes and status groups influence one another and the legal order and are in turn influenced by it. ‘Parties’ reside in the sphere of power. Their action is oriented toward the acquisition of social power, that is toward influencing social action no matter what its content may be. (Weber 1995 [1978]: 39)

To Weber, therefore, inequality has many dimensions. It is neither just nor unjust but an inevitable feature of society.

Functionalists, Marx and Weber are often described as constituting the classical tradition in sociology. These theorists have, as Roberts (2001) suggests, established the common denominators of any description of society that adopts a class analysis. All ‘are agreed that classes have an economic foundation: they are composed of people with common experiences of making their livings. So people are invariably “classed” on the basis of their occupations’ (Roberts op. cit.: 6). All would also agree that class matters. In health, it certainly appears that it does. Although life expectancy rose for all social groups between 1970 and 1996, life expectancy for men in social class 1 (professional and managerial) increased by 5.7 years but the gain amongst men in social class 5 (unskilled manual) was only 1.7 years (Hattersley 1999).

This does not mean that other social divisions such as ethnicity and gender do not matter. Economic differences, however, cross cut other inequalities, sometimes ameliorating and sometimes deepening disadvantage. This book is primarily about class and economic inequalities. Other books in the Sociology and Nursing Practice Series have explored other dimensions of stratification (Godfrey 1999, Miers 2000, Culley and Dyson 2001).
Class consciousness

Class theorists also share an assumption that class is not just an economic grouping. Class means something to individuals. Individual men and women identify themselves as belonging to a class and as sharing interests with those in the same economic grouping. Functionalists would see individuals in all social classes as sharing views about the meaning and fairness of the reward system which differentiates life experiences. Weber saw classes not as ‘communities’ but as possible bases for social action through shared ‘economic interests in the possession of goods and opportunities for income’ (Weber op. cit.: 32). For Weber, class situation is market situation and individuals may join together to preserve their market situation but this is not inevitable. Perceived membership of status groups, for example, may inhibit collective action. This is an issue which has been extensively discussed in the literature on race and class (Castles and Kozack 1973). Status divisions between majority and minority ethnic groups within Britain may have inhibited recognition of shared economic interests amongst unskilled workers.

Marx saw classes as social forces providing the means and momentum for historical change. He distinguished between the objective conditions of social classes, created by a group’s relationship to the means of production, and the subjective sense of belonging to a class and sharing class identity and interests. He distinguished between ‘class-in-itself’ — a group whose members share an economic position — and ‘class-for-itself’ — a group whose members share class consciousness and a sense of solidarity. A group becomes united, ‘and constitutes itself as a class-for-itself. The interests it defends become class interests. But the struggle of class against class is a political struggle’ (Marx and Engels 1995: 29). Marx anticipated that the political struggle between the proletariat and the bourgeoisie would result in revolutionary change and the development of a communist society that, through collective ownership of the means of production, would abolish the conditions which created social classes. All theorists see connections between class and politics. Marx saw classes as deriving from relations of power and hence inevitably part of the political process.
Functionalists saw the linking of higher classes with higher levels of prestige and influence as inevitable. Weber saw class and parties as separate but recognised that market position could be a position to be protected and that parties, as political groups, could be representing class interests or status interests. The protection of the market situation through the creation of organisations to serve as professional groups with political influence, such as the British Medical Association and the Royal College of Nursing, has been a feature of professional activity in Britain.

**Classes as contemporary and historical phenomena**

It should be made clear that it is not only sociologists who have discussed class at considerable length. It is significant that Marx wrote some of his major works while living in Britain, and Engels’ observations of working class life in northern England shaped his ideas and writings (Engels 1969 [1844]). British class divisions and class consciousness have been seen by other countries as a defining characteristic of the British nation, although it is often unclear whether what is being observed are, in Weber’s or Marx’s terms, class divisions, or an awareness of status distinctions. Devine (1997) has looked at the reality of class inequalities in Britain and the United States, arguing that there have been stereotypical assumptions about Britain being a class-bound society in contrast to the United States’ classlessness. She concluded that both stereotypes are misleading although class identification has had a greater influence on political attitudes and behaviour in Britain than in America. Economic restructuring has reduced the size of the working class in Britain and in both countries there has been a growth in poverty. Her conclusion that ‘social class has proved remarkably resilient over the twentieth century’ (ibid.: 264) would be supported by Roberts (2001).

Historians, as well as sociologists, have viewed Britain as a class society and have analysed its development in class terms. Thompson (1968) has adopted a Marxist approach, arguing that class is a historical category and inseparable from notions of class struggle. He traces the development of the working
class back through the 18th century. McKibbin (1990) explores the puzzle that despite the fact that ‘in 1901 about 85 percent of the total working population were employed by others, and about 75 percent as manual workers’, suggesting that ‘in the broadest sense Britain was unquestionably a working-class nation’ (ibid.: 2), there was no strong Marxist party in Britain. McKibbin explains this by the nature of the political system and the role of the state. The development of the National Health Service, for example, as part of the welfare state, can be seen as fostering shared values and shared culture despite economic inequalities. In recent decades economic change has been seen as resulting in the decline of the working class and a growth of the middle class, with a consequent diminution of differences between political parties seeking to represent public interests. Despite this, some writers identify continuing links between economic and political power (Scott 1997).

Class in decline?

The possible irrelevance of class in explaining inequalities, social diversity and social processes warrants careful consideration. Roberts (op. cit.) notes that class can be said to be in decline if one or more of three things happen. ‘First, there would be a decline in class if occupations ceased to be arranged in “clumps”’ (ibid.: 12), that is, there is no grouping of occupations according to market position or in terms of relations of production. Second, class would be irrelevant if occupations had no significance in individuals’ minds, that is, there is no consciousness of class situation. Third, class would cease to exist if ‘the clustering of occupations, and the associated forms of consciousness (and unconsciousness), were insulated from politics’ (ibid.: 12). He concludes his book on *Class in Modern Britain* by claiming that ‘class analysis has been, and still is, the key to understanding the links between the economy, politics and society, how these have changed in the past, and the alternative ways in which they might change in the future’ (ibid.: 251).

A fourth reason for the decline of class, however, could be if the clustering of occupations ceased to be linked to individual life chances. As Chapter Three of this volume demonstrates,
however, class appears to remain closely linked to individual chances of lifetime experience of good or poor health.

Arguments about the decline in the significance of class include the embourgeoisement thesis, that is the argument that as manual workers earn more money they adopt the lifestyle of the bourgeoisie (Goldthorpe et al. 1969, Saunders 1990a,b). Margaret Thatcher’s Conservative governments of 1979–90 can be seen as having encouraged this through encouraging the purchase of former local authority owned homes and the widespread purchasing of shares through privatisation of state owned industries and the conversion of building societies into banks. A further argument suggesting a reduced significance of class and economic inequality is the development of a form of citizenship (Marshall 1963) which includes rights to a minimum income, to educational opportunities, to health care and to adequate housing. The development of this social citizenship has been pursued by a range of disadvantaged groups including women, minority ethnic groups, lesbians and gay men, disabled people and users of mental health services. Chapter Six discusses citizenship in relation to mental health nursing. The defence and extension of citizenship can be seen as crossing the boundaries of class or other social divisions, thus limiting the importance of particular economic groups. Additionally, social mobility is seen as limiting the significance of class by breaking down class barriers, although research into health inequalities (see Chapter Three) suggests that class of origin can have a lifetime significance for health (Blane 1999, Benzeval et al. 2000).

Postmodernism and class

A more fundamental critique of the relevance of class comes from arguments which suggest that class was a feature of modern industrial societies and that in postindustrial, postmodern societies, class ceases to be significant. The decline in labour intensive mining and manufacturing suggests that labour power is no longer as important as technological power, and consumption, not production, becomes significant in influencing an individual’s identity and lifestyle. There is an increasing
diversity of opportunity available through varied economic and cultural positions. Waters (1997), for example, argues that from 1975 to the present, intelligence and marketable attributes have become more important than material property; status groups differentiated by lifestyle more important than class, and cultural identity more important than material inequality. This ‘status conventionalism’ (Pakulski and Waters 1996) is underway through an increasing individualism resulting from economic globalisation, a process which reduces national control over the economy and thus leads to a postmodern society characterised by what Beck (1992: 127) has termed ‘a categorical shift’ in the relationship between individual and society. Beck argues that individual ability to manage one’s life in a ‘risk’ society has become more important than class position. Lash and Urry (1994) have argued that in the late stage of what they term ‘disorganised capital’, ‘flows’ of people, ideas, information, images, and capital are more important than structures, and culture rather than economic position brings meaning to self aware, reflexive individuals who shape and transform production and structure. For these writers, postmodern society is characterised by ‘instability, fragmentation, individualization and social fluidity’ (Crompton 1998: 131) and consumption is society’s driving force. Nevertheless within the ‘economies of signs and space’ (Lash and Urry op. cit.) are conflicts and inequalities. These ideas, particularly the emphasis on culture, have suggested new ways of exploring and understanding social forces which lead to significant inequalities in health.

Bourdieu and types of capital

The French sociologist, Pierre Bourdieu’s work has become influential in Britain, particularly through his inextricable linking of economic and social/cultural worlds in his formulation of the dynamic structuring of practice (Bourdieu 1977). Different conditions of existence are not separate from the perceptions and organising practices of those conditions. To discuss this, Bourdieu uses two terms, ‘field’ and ‘habitus’. ‘Field’ is a structural system of social relations at a macro and
micro level (such as the division of labour in health care). ‘Habitus’ is both the structured relations and the structuring process expressed through knowledge and action. Habitus is ‘a structured and structuring structure’:

The habitus is not only a structuring structure, which organises practices and perceptions of practices, but also a structured structure: the principle of division into logical classes which organises the perception of the social world is itself the product of internalisation of the division into social classes. Each class condition is defined, simultaneously, by its intrinsic properties and by the relational properties which it derives from its position in the system of class conditions, which is also a system of differences, differential positions. (Bourdieu 1986: 170–1)

Unlike Marx, Bourdieu sees class as indivisible from consciousness of class. Bourdieu also, significantly, identifies four different ‘forms of capital’ — economic, cultural, social and symbolic — which, as Crompton identifies, ‘together empower (or otherwise) agents in the struggle for position within “social space”’ (Crompton *op. cit.*: 148). Bourdieu sees classes as developing as a consequence of these empowerments. He uses the term ‘class’ as a general term for many social groups, sharing types of capital. Classes occupy a similar habitus. He is interested in the emergence of new groups and as such his views have been used to examine the emergence of new middle class groups developing through the growth of administrative, professional and managerial occupations. Within the literature on health inequalities, however, it is the role of social capital, loosely defined as involving ‘connections, networks and group membership’ (Anthias 2001: 841), which has attracted attention.

Putnam et al.’s (1993) study of engagement in community life in different regions of Italy has informed Wilkinson’s (1996a,b) important analysis of inequality and health. Wilkinson has argued that health tends to be less good among populations where there are greater income differences, suggesting a link between relative deprivation and poorer health (see Chapters Three, Eight and Nine in this volume). The perception of inequality and injustice may lead to further inequality through physical effects on health. Putnam found that income inequality/equality was related to his index of ‘civic community’. Equality is supportive of civic community,
but civic community declines if income inequality increases. Wilkinson (1999) has argued that analysis by Kawachi et al. (1997), showing that trust in others declines where income inequalities are bigger, suggests a ‘pathway from income distribution through quality of social relations to health’ (op. cit.: 261). Income inequality constrains connections and networks within and across groups. A hierarchical and unequal system of income and status distribution, as Wilkinson et al. (1998) have argued, cuts people off from the respect accorded to high status and leads to sensitivity about status issues, and readiness to defend one’s own position rather than support others. These ideas are reviewed extensively by Wilkinson (1996a, 1999) who argues that the stresses of hierarchy, hierarchical relations and structures of power and subordination are passed downwards with the result that ‘friendships and social networks atrophy as people feel increasingly vulnerable to the way they are seen by others’ (Wilkinson 1999: 267). This emphasis on the influence of the psychosocial environment on health, however, has prompted considerable debate (Lynch et al. 2000), discussed in Part Three of this volume.

Social exclusion

Interest in social cohesion and health is matched by concern about social exclusion and the possible development of an underclass. Such concern derives from the recognition that during the 1980s the political climate in Britain and the United States, led by Margaret Thatcher in Britain, drew on market approaches to economic management, disdaining Keynesian manipulation of the economy through government tax and investment schemes. The effect of the emphasis on the market as a way to regulate individual opportunities and income was a growing polarisation in income distribution. In 1999, Byrne claimed that:

in the UK the real incomes of the lowest decile after housing costs were taken into account are now substantially below their value of 1979, having declined by some 25 per cent ... the top decile of incomes in contrast saw an increase of more than 60 per cent. (Byrne 1999: 81, see also Westergaard 1995: 132–3, Goodman et al. 1997: 112)
Those in the lowest decile are disproportionately in areas of the country hitherto dependent on mining and manufacturing (South Wales, the North East of England), in which young people, particularly young men, struggle to find permanent employment. Governments in the 1980s and 1990s supported the growth of the flexible labour market and reduced the tax burden on the affluent, with the intention of increasing the supply of jobs. The benefits system has not contributed to a redistribution of income.

Within cities, there has been concern that spatial divides have contributed to social exclusion through building projects of urban regeneration which have disrupted working class communities already disempowered by the decline of manufacturing work. Byrne (op. cit.) argues that to understand the nature and significance of social exclusion it is important to understand the change in the nature of social life in post-industrial capitalism in the 1980s and 1990s. Whereas during a period of growth from the mid 19th century until the 1970s, standards of living rose, in the 1980s and 1990s individuals felt considerably less secure. Post the Second World War, full employment, welfare benefits and strong trade unions ensured rising standards for all workers. More recently the emphasis has been on personal skills and flexibility to maintain one’s position in the labour market. Social exclusion is seen as relating to those marked with personal deficits. In a market economy, there is no demand for their labour. Just as slaves could be seen as an underclass, in Marxist terms, since they did not own their own labour and thus had no position in the relations of production, so could some individuals be seen as falling into an underclass since they lack all forms of capital. The term ‘underclass’, however, has also been used by writers who have emphasised cultural factors which maintain the separation of social groups. Murray (1990, 1994) has argued that the poor develop a fatalism about their position in the world which reduces the capacity for self help. The importance of the term ‘social exclusion’ lies in its emphasis not on the behaviour of individuals or the culture of groups, but on the rights and entitlements that all citizens should have. The exclusion of some individuals from citizenship rights threatens all of us. As Crompton notes, ‘the defence of citizenship, therefore, cuts
across the boundaries of social class’ (1998: 201). Department of Health policies to improve services for people with learning disabilities and for those with mental illness can be seen as attempts to develop services on a more inclusive basis (DoH 1999b, 2001b). In Chapter Six, Paul Godin considers the significance of citizenship and social exclusion in the care of people with mental illness.

Realism and the persistence of class

Scambler and Higgs (1999) maintain that ‘real class relations’ persist in Britain in the sense that class is real because of the relationships between persons. This is a position similar to Marx but deriving from Bhaskar’s (1989) critical realism, a philosophical approach which recognises, as Porter (1998) explains, ‘that there are objects of knowledge that exist independently of our thoughts’ (ibid.: 171). Class relationships continue to hinge on relationships of ownership and control of the means of production. The realist approach to understanding social structure and social action accepts that social structures (such as relations of production) impose constraints and enablements on individuals’ freedom to act in their own interests. Realism, however, does not see economic relations as of prime importance as Marx argued. Social structures such as patriarchy also affect relationships between persons. In open social systems different structures affect action, thus bringing choice not constraint; nevertheless social reality is not grounded in individual consciousness. Class may not be central to individual experience but its significance remains real.

The importance of class relationships as underlying factors in the causal pathways to inequalities in health remains a topic of considerable debate. The relationships between groups in a social structure have consequences for individuals’ material circumstances (housing, income, access to services and amenities) and for their sense of security, social position and self worth. Later chapters discuss the significance of material pathways and psychosocial pathways in determining health through considering the evidence and arguments of health inequality researchers. Discussions of underlying social processes,
through arguments about postmodernism or realism, lie in the domain of sociology, with its responsibility to observe general processes of social cohesion, social differentiation and social stratification.

**Conclusion**

This chapter has introduced a range of approaches to understanding social class and inequality. The different approaches provide different answers to questions which are central to an understanding of social stratification and of nurses’ position in a social hierarchy. Relevant questions include: how do the skills individuals have and the work individuals do relate to their social status and their position in a social class hierarchy? How do economic resources relate to work and skill? Do economic resources relate to the processes of wealth creation in types of social structures? To understand the significance of social class and nursing practice, nurses need to consider both their own class position and the position of their clients. Hugman (1991) helps explain the position of nursing and other caring professions amongst the middle class. Although caring professionals are selling their emotional and manual labour for income in a way that connects them to the working class, their professional education, ‘career patterns and work autonomy (so far as that has been achieved) all serve to separate these occupations from the working class’ (*ibid.*: 127). It is the claims to knowledge that establish class position and legitimise professional power. If knowledge is clearly demarcated, professional power is greater and is not dependent on organisational position. Hence doctors and lawyers have particularly clear professional status, partly through their ability to practise independently. Hugman argues that ‘where the demarcation of an area of knowledge is weak then the organisational position is made more explicit’ (*ibid.*: 128). It has been the organisational basis of employment that has preserved the power of nurses and caring professionals over clients. Power derived from knowledge and from organisational position has been buttressed by what Hugman terms ‘ideological power’, a process which shapes the images and meanings concerning
client/professional relationships. Caring professionals maintain their own status and economic interests by placing the client in a disadvantaged position. If health inequalities result in a majority of service users coming from lower social classes, it is easy for caring professionals to maintain a social distance from their clients, a social distance which can sustain the professional’s self image and stigmatise the user (as incompetent, irresponsible or immoral).

In recent years, however, there have been considerable challenges to professional power, from the users of services, from policy and from challenges to professional boundaries. Within this context, health inequalities and professionals’ responsibilities to contribute to their reduction are receiving considerable attention. The challenge for nurses is to understand their own position within the stratification system and the implications of this for self and others. This book suggests that our material resources, our employment and our class relationships can affect the health of all of us, as professionals and as service users. Part One looks particularly at the evidence for the social determinants of health; Part Two looks at nursing’s position in the class system and the factors that influence this; and Part Three encourages nurses to consider their own role and responsibilities in recognising the significance of clients’ positions in relation to resources for health, and finding ways of enhancing not reducing those resources.
### Name index

<table>
<thead>
<tr>
<th>Name</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott P</td>
<td>11, 104</td>
</tr>
<tr>
<td>Abbott S</td>
<td>179</td>
</tr>
<tr>
<td>Abel-Smith B</td>
<td>81, 93, 94</td>
</tr>
<tr>
<td>Acheson D</td>
<td>9, 48, 63–8, 145, 150, 169, 171, 179, 183, 215</td>
</tr>
<tr>
<td>Ackroyd S</td>
<td>185</td>
</tr>
<tr>
<td>Anthias F</td>
<td>24</td>
</tr>
<tr>
<td>Baggott R</td>
<td>45–7</td>
</tr>
<tr>
<td>Bagguley P</td>
<td>117</td>
</tr>
<tr>
<td>Baird K</td>
<td>149</td>
</tr>
<tr>
<td>Bajekal M</td>
<td>216</td>
</tr>
<tr>
<td>Baker S</td>
<td>139</td>
</tr>
<tr>
<td>Baly M</td>
<td>86</td>
</tr>
<tr>
<td>Bannon E</td>
<td>185</td>
</tr>
<tr>
<td>Barclay J</td>
<td>94</td>
</tr>
<tr>
<td>Barham P</td>
<td>134</td>
</tr>
<tr>
<td>Barker D J P</td>
<td>58</td>
</tr>
<tr>
<td>Bartley M</td>
<td>62, 164, 167, 168, 188, 189</td>
</tr>
<tr>
<td>Basaglia F</td>
<td>133</td>
</tr>
<tr>
<td>Baumann L C</td>
<td>208</td>
</tr>
<tr>
<td>Beattie A</td>
<td>56</td>
</tr>
<tr>
<td>Beck U</td>
<td>23, 139, 140</td>
</tr>
<tr>
<td>Bedford Fenwick E</td>
<td>81, 87, 89, 92</td>
</tr>
<tr>
<td>Beenstock S</td>
<td>225</td>
</tr>
<tr>
<td>Ben-Shlomo Y</td>
<td>58</td>
</tr>
<tr>
<td>Benzeval M</td>
<td>22, 38</td>
</tr>
<tr>
<td>Berney L</td>
<td>43</td>
</tr>
<tr>
<td>Beynon H</td>
<td>185</td>
</tr>
<tr>
<td>Bhaskar R</td>
<td>27</td>
</tr>
<tr>
<td>Bissell G</td>
<td>149</td>
</tr>
<tr>
<td>Black Sir Douglas</td>
<td>47, 48, 51</td>
</tr>
<tr>
<td>Black S</td>
<td>223</td>
</tr>
<tr>
<td>Blackburn C</td>
<td>175</td>
</tr>
<tr>
<td>Blane D</td>
<td>22, 38, 44–9, 57, 58, 62, 164, 185, 186</td>
</tr>
<tr>
<td>Blaxter M</td>
<td>52, 54–6</td>
</tr>
<tr>
<td>Blazys D</td>
<td>199</td>
</tr>
<tr>
<td>Bloor M</td>
<td>59, 205</td>
</tr>
<tr>
<td>Boddy F A</td>
<td>39</td>
</tr>
<tr>
<td>Bond M</td>
<td>220, 221</td>
</tr>
<tr>
<td>Bosma H</td>
<td>197</td>
</tr>
<tr>
<td>Bourdieu P</td>
<td>23–4, 102</td>
</tr>
<tr>
<td>Boyd Orr Sir J</td>
<td>42</td>
</tr>
<tr>
<td>Bradley H</td>
<td>187</td>
</tr>
<tr>
<td>Brander N</td>
<td>148, 149</td>
</tr>
<tr>
<td>Brittain V</td>
<td>97</td>
</tr>
<tr>
<td>Britten N</td>
<td>37</td>
</tr>
<tr>
<td>Brown J</td>
<td>209</td>
</tr>
<tr>
<td>Brown P</td>
<td>115, 116</td>
</tr>
<tr>
<td>Brunner E</td>
<td>197, 199</td>
</tr>
<tr>
<td>Bucquet D</td>
<td>55</td>
</tr>
<tr>
<td>Burke L</td>
<td>107</td>
</tr>
<tr>
<td>Burrows R</td>
<td>138</td>
</tr>
<tr>
<td>Busfield J</td>
<td>129</td>
</tr>
<tr>
<td>Byrne D</td>
<td>25–6</td>
</tr>
<tr>
<td>Cadbury M</td>
<td>82</td>
</tr>
<tr>
<td>Callery P</td>
<td>152</td>
</tr>
<tr>
<td>Canaan J E</td>
<td>193</td>
</tr>
<tr>
<td>Carmichael C L</td>
<td>55</td>
</tr>
<tr>
<td>Carpenter M</td>
<td>82, 131</td>
</tr>
<tr>
<td>Carstairs V</td>
<td>39</td>
</tr>
<tr>
<td>Carter D</td>
<td>172</td>
</tr>
<tr>
<td>Cartwright A</td>
<td>55</td>
</tr>
<tr>
<td>Castles S</td>
<td>19</td>
</tr>
<tr>
<td>Chadwick E</td>
<td>45</td>
</tr>
<tr>
<td>Chamberlain R</td>
<td>147, 148</td>
</tr>
<tr>
<td>Channing D M</td>
<td>56</td>
</tr>
<tr>
<td>Chapman H</td>
<td>116–18</td>
</tr>
<tr>
<td>Cheng Y</td>
<td>199, 200</td>
</tr>
<tr>
<td>Chiang T-L</td>
<td>160</td>
</tr>
<tr>
<td>Child Poverty Action Group  (CPAG)</td>
<td>146, 149, 170</td>
</tr>
<tr>
<td>Chua W-F</td>
<td>79, 81, 95</td>
</tr>
</tbody>
</table>

257
258 NAME INDEX

Clarke M 111
Clegg S 79, 81, 95
Clement W 186
Clifford P 134
Cole T J 148
Coleman P 222
Colhoun H 67
Connor J 164
Cornwallis E 173
Craig P 172
Crombie D L 56
Crompton R 12, 14, 16, 23–4, 27, 33, 37
Crowther R E 190, 191
Culley L 11, 18, 51
Dacey Smith G 160, 161, 166, 210, 220
Davies C 118
Davis I 159, 172
Davis K 13
Davison C 209, 210
Daykin N 191
DeBell D 153
Denny E 4, 77, 99, 100, 105, 110, 152
Department of Health (DoH) 4, 5, 9, 10, 11, 16, 27, 62, 65, 72, 108, 112, 113, 119, 120, 126, 141, 145, 146, 150, 153, 154, 200, 213, 216, 217, 226
Department of Health and Social Security (DHSS) 172
Department of Social Security (DSS) 47
Department of Work and Pensions 172
Devine F 20
Diez-Roux A V 163
Digby A 127
Dingwall R 87, 91–3
Ditton J 185
Dorling D 60, 218, 219
Duckworth D 79
Duncombe M 152
Dunham H W 135
Dunkley K 222
Dusseldorf E 207
Dyck D 204
Easterhouse Money Advice Centre (EHMAC) 177
Ellaway A 69
Engels F 15–16, 19, 20, 125
Ennals S 172
Eriksson J G 168
Eyer J 60
Ezzy D 117, 185, 188, 190
Faris R E L 135
Farr W 45
Fatchett A 222
Featherstone M 11
Ferrie J E 198
Fichtenberg C M 192
Fogelman K 59
Fothergill A 202
Foucault M 127, 185
Fox A J 41, 53
Fox N 185, 187, 188
Fraser S 226
Freidson E 83, 100
Gaze H 224
Giddens A 11
Gidron Y 207
Gillis A 119
Glantz S A 192
Godfrey J 18
Godin P 4, 17, 27, 125
Goffman E 132
Goldblatt P 41
Goldthorpe J H 22, 34–5, 37
Goodman A 25
Goulding J 152
Graham H 32, 38, 62, 175
Greenslade M 172
Gresenz C R 218
Griffiths S 173
Grundy L 118, 119
Guardian, The 35, 36
Gunnell D J 42
Hackman J R 184
Hadfield G 36
Hallam J 110
Halsey A H 101
Hampshire M 224
Haralambos M 11
Harker L 163, 176
Harris D 107
Hart A 2
Hart J Tudor 55, 136, 223
Hattersley L 18
Health Committee 157
Heaney C A 184
Heath A 37, 117
Hemingway H 207
Hentinen M 207
Hewitt J B 204
Hicks C 106, 107, 109
Higgs P 27, 185, 188
Higher Education Funding Council for England (HEFCE) 115
Hirsch F 116
Hobbes T 12
Hobby L 172, 179
Hockley C 201
Holborn M 11
Hollingshead A 125
Hope K 35
Hoskins R 4, 72, 161, 170, 172, 178–80, 186, 220
House J S 184
Howarth C 170
Hugman R 28, 104
Hunt S 54
Hutt J 157
Hutton W 139
Illsley R 57, 58
Jackson P 153
Jackson P R 188
Jahoda M 189
Jarman B 176
Jarvis M J 103
Jenkin P 51
Jenkins P M 56
Johanning E 192
Johansson M 205
Johnson T J 18, 100
Jones K 131
Judge K 165, 166
Kagamimori S 195
Kaplan G A 165
Karasek R 196
Kawachi I 25, 160
Kearns A 69
Kehrer B 164
Kennedy B P 165
Kennedy I 150, 157
Kevles D J 130
Khilji N 193
Kirby M 36, 101
Kitson A L 112
Kivimaki M 198
Knight I 58
Kohn M 184
Koopman J S 163
Kozack G 19
Kuh D J L 58
Langer T S 135
Lash S 11, 23, 117
Lawler E E 184
Lees F 85
Lehan A F 190
Lelean S R 111
Lindsay B 90, 91
Lloyd L 203
Locke J 12
Lockey R 2
Logan W P D 44
Lomax M 130
London
Metropolitan Archive 97
Lukkarinen H 207
Lynam J 16–17
Lynch J W 25, 60, 70, 161, 163–6, 214
Lynch P 53
Macfarlane G J 193
MacGuire J M 94
Macintyre S 38, 48, 62, 68, 69
Macleod J 206
Mags C J 79, 92
Major, John 11, 147
Marsh G N 56
Marshall T 210
Marshall T H 22, 126, 131
Martin J 37
Marx, Karl 15–21, 27, 34, 184
Mayall B 149
McCulloch A 217
McInnes B 201
McKenna H 139
McKibbin R 21
McLoone P 39
Mellor-Clark J 201
Meltzer H 65, 190
Messing K 192
Michael S T 135
Middleton J 173
Middleton S 105
Miers M 9, 13, 18, 31, 51, 73, 84, 99, 106, 183, 185, 213
Milligan F 119
MIND 133
Ministry of Agriculture, Fisheries and Food (MAFF) 61
Ministry of Health 94, 150, 151, 157
Mitchell D 90
Moher M 207
Montgomery S M 188, 189
Moore A 221
Moore W E 13
Morris J K 188
Morris R 39
Moser K A 189
Muir J 149, 157
Muller A 70, 103, 218
Multiple Risk Factor Intervention Trial Research Group 46
Murphy R 115
Murray C A 26
Myles J 186
Naidoo J 175
National Health Service (NHS) 1, 5, 9, 14, 21, 36, 89, 125
Naumanen-Tuomela P 203–4
Nightingale F 79, 81, 85
Nolan P 89
Nordenmark M 190
North F M 196
North Tyneside Citizens’ Advice Bureau 173
Nursing Times, The 174
Nylen L 188, 189
Oakley A 104
O’Brien M 55
O’Connor J 132
Oelmann B J 53
Office for National Statistics (ONS) 4, 31, 34, 35, 40, 41, 101, 170
Office for Population Censuses and Surveys (OPCS) 34, 53, 57
Oliver M 11
O’Loughlin J L 210
O’Neil J 173
Oppenheim C 161, 176
O’Reilly K 34
Osler M 163
Pakulski J 23
Pantry S 184
Paris J A G 172, 173, 178
Parish C 221
Parkin F 78, 115
Parmley W W 192
Parsons T 13
Partanen T 205
Paterson I 166
Pearce L 202, 203
Pelling M 45
Pendleton D A 55
Philhammer Andersson E 113, 114
Phillimore P 39, 56
Pilgrim D 129
Player D 172, 173, 178
Popay J 45
Poppius E 208
Porter R 126
Porter S 2, 16–17, 27
Power C 40, 58
Prandy K 35
Prescott-Clarke P 67
Prior L 133
Purdon S 216
Putnam R D 24, 213
Pyramid Trust 154
NAME INDEX

Quick A 171
Rae M 136
Rafferty AM 80, 88
Ramon S 130
Read J 139
Reading R 147
Reay D 102
Redlich RC 125
Reid A 176
Richards HM 210
Roberts H 146, 150
Roberts J 93
Roberts K 18, 20–2, 33, 101
Robertson D 108, 119
Rogers A 129
Roithmayer T 204
Rose D 34
Rose G 53
Roskell DE 121
Rousseau H 12
Royal College of Nursing (RCN) 1, 5, 20, 49, 167, 174, 175, 202
Royal College of Paediatrics and Child Health 150, 151
Ruskin J 199
Sadler C 223
Salmon D 154
Salve J 112
Saunders P 22, 138
Savage M 100, 102, 111, 117
Scambler G 27, 185, 188
Schooler C 184
Scott J 21
Scottish Executive 174
Scottish Office Department of Health 174
Scull A 126, 129, 130, 133
Sedgwick P 133
Sewell G 193
Sharp I 206
Shaw M 159, 166, 168, 178
Shibuya K 161
Shipley MJ 43
Shopland DR 192
Shorter E 129
Sidey A 149, 157
Siegrist J 197
Silverston H 199
Skeggs B 105
Skipworth M 36
Sladden S 135
Smith D 205
Smith LN 178, 180
Smith R 121
Smithson S 193
Snow J 45
Social Trends 4
Sokojima S 195
Somerville J 109, 110
Stansfeld S 198
Stanworth M 37
Stepoe A 207
Stewart A 35
Storey P 147, 148
Sturm R 218
Strandh M 190
Syme SL 43
Szreter S 33
Tellier L 204
Thatcher, Margaret 11, 22, 25, 51, 110
Theorell T 196
Thompson DR 106, 113
Thompson EP 21
Thompson P 185
Thompson WT 200
Thomson H 219
Tod AM 209
Touraine A 11
Townsend P 38, 39, 47, 52–8, 60, 61
Tumin M 13
Uchata T 195
United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 102, 109, 112, 113
Universities UK 108
Urry J 11, 23, 117
Usher R 117
Vahter M 192
Veitch D 173, 176, 179
Virtanen P 198
Wadsworth M 40, 58, 102, 103, 185–7
Wallace C 11, 104
Wamala SP 208
Wardle J 103
Warner R 128, 132
<table>
<thead>
<tr>
<th>Name</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warr P</td>
<td>188</td>
</tr>
<tr>
<td>Wasling C</td>
<td>207</td>
</tr>
<tr>
<td>Waters A</td>
<td>36, 121</td>
</tr>
<tr>
<td>Waters M</td>
<td>23, 26</td>
</tr>
<tr>
<td>Watson R</td>
<td>106, 113</td>
</tr>
<tr>
<td>Watson V</td>
<td>4, 145, 154</td>
</tr>
<tr>
<td>Watterson A</td>
<td>191</td>
</tr>
<tr>
<td>Webb C</td>
<td>110</td>
</tr>
<tr>
<td>Webb J</td>
<td>117</td>
</tr>
<tr>
<td>Weber M</td>
<td>17–20, 34, 63, 78, 100, 115</td>
</tr>
<tr>
<td>Webster C</td>
<td>47</td>
</tr>
<tr>
<td>Weller B</td>
<td>152</td>
</tr>
<tr>
<td>Westergaard J</td>
<td>25</td>
</tr>
<tr>
<td>Whitaker S</td>
<td>203</td>
</tr>
<tr>
<td>White S</td>
<td>188</td>
</tr>
<tr>
<td>Whitehead M</td>
<td>46, 52</td>
</tr>
<tr>
<td>Whithouse C R</td>
<td>55</td>
</tr>
<tr>
<td>Whiteman M C</td>
<td>209</td>
</tr>
<tr>
<td>Whiting M</td>
<td>150, 156</td>
</tr>
<tr>
<td>Wiles R</td>
<td>208</td>
</tr>
<tr>
<td>Wilkinson B</td>
<td>193</td>
</tr>
<tr>
<td>Wilkinson G</td>
<td>13</td>
</tr>
<tr>
<td>Wilkinson R</td>
<td>24–5, 38, 43, 47, 60, 69, 70, 160–3</td>
</tr>
<tr>
<td>Worrnip J</td>
<td>80</td>
</tr>
<tr>
<td>Wright C</td>
<td>107</td>
</tr>
<tr>
<td>Wright E O</td>
<td>35</td>
</tr>
<tr>
<td>Wright L</td>
<td>208</td>
</tr>
<tr>
<td>Wright R L</td>
<td>208</td>
</tr>
<tr>
<td>Wills J</td>
<td>175</td>
</tr>
<tr>
<td>Winter J M</td>
<td>162</td>
</tr>
<tr>
<td>Witz A</td>
<td>18, 87, 88</td>
</tr>
<tr>
<td>Wolf Z R</td>
<td>96</td>
</tr>
<tr>
<td>Wolfensberger W</td>
<td></td>
</tr>
<tr>
<td>Wolfson M</td>
<td>163</td>
</tr>
<tr>
<td>Wolin V</td>
<td>164</td>
</tr>
<tr>
<td>World Bank</td>
<td>163</td>
</tr>
<tr>
<td>World Health Organisation (WHO)</td>
<td>47, 63</td>
</tr>
</tbody>
</table>
Subject index

Absolute income theory 162–4
Access to/uptake of services 147
Accidents 66, 146–7
Acheson Report (Independent Inquiry into Inequalities in Health) 9, 48, 63, 68, 145, 150, 169, 171, 179, 183, 215
Action for Sick Children 151
Artefact explanation for inequalities in health 56–7
Asylum system 125–32
Athlone Committee 93
Attendance allowance 176–8
Black Report, The 47–59
Boyd Orr Cohort 42
British Birth Cohort Study 41
British Household Panel Survey 42, 215
Bullying 201
Cancer and Leukaemia in Children (CLIC) 156
Capital (forms of – Bourdieu) 24
Social capital 24, 70, 213–18, 227
Capitalism 59, 125–8, 131, 141
Care management 136
Care programme approach (CPA) 137
Carstairs Deprivation Index 39
Census 40, 42
Child Poverty Action Group (CPAG) 146, 149
Children 145–58
Accidents 146–7
Children’s health services 145–58
Children’s rights 157
Mortality 146
Poverty 146
Children Act The 150
Citizens’ Advice Bureau (CAB) 172
Citizenship 26, 126, 127, 132, 134, 137
Civil servants (Whitehall Studies) 42, 43, 194–6
Class 9–29
and children’s nursing 90, 152
class conflict 15–16
class consciousness 19
and education 3, 101–2
and division of labour in health care 104
and health inequalities 44, 51–73
and mental illness 125, 135
and nursing 77–97, 108

263
| Class – continued | Community profiling | Our Healthier Nation | 146 |
| and use of health services | Competency based education | Saving Lives: Our Healthier Nation | 71, 213 |
| middle class | 28, 36 | Department of Social Security (DSS) | 172 |
| Registrar General’s classification | 32–3 | Deprivation index | 38–9 |
| theories; functionalism, 12–14 Marx | 44, 51, 137 | Diet and health | 67 |
| 15–19 Post-modernism | John Major 11, 147 | District nursing | 85 |
| 22–3 | Margaret Thatcher 11, 22, 25, 51, 110 | Dual closure | 78, 88 |
| Weber 17–19 women in classification schemes | Coronary heart disease | 43, 206–11 |
| working class | Credentialism | 116 |
| 20, 36 | Crime and criminal justice | 215 |
| Classification of Occupations and Directory of Occupational Titles (CODOT) | Cultural/behavioural explanations for inequalities in health | 61–2 |
| Clothier Report, The 150 | Cultural capital | 101 |
| Cohort studies | Demarcation | 78 |
| 39–42 | Department of Health | 113 |
| Community mental health care/ community psychiatric nursing | Health of the Nation strategy | 62, 145 |
| 171–8 | | 78, 100, 115 |
| | | Exercise | 67 |
Feminism 110
Field (Bourdieu) 23–4
Free school meals 148
Functionalism 12–14, 20, 58
Gender 105
General Household Survey (GHS) 42, 53–4
General Nursing Council 88
Habitus (Bourdieu) 23–4
Health Action Zones 174, 216, 222
Health capital 102
Health Divide, The 47, 52–6, 61
Health Education Council 52
Health and employment 184–5
Health and Lifestyle Survey 42, 52, 54
Health inequalities 9, 10, 51–72
class inequalities 51–6
DoH plan and targets 9–10
explanations (Black Report) 56–62
geographical inequalities 72
and housing 68
Health Survey for England 42, 52, 215
Health variations research programme (ESRC) 32, 48
Health visitors 154, 155, 217, 221
Healthy Citizens 216
Hierarchy 161
Higher Education Funding Council, England (HEFCE) 115
Homelessness 138
Household Reference Person 37
Housing and health 68, 219
Improving Working Lives Standard 200
Income 69, 72
relative and absolute income 160, 164
Independent Inquiry into Inequalities in Health see Acheson Report
Inequalities in health 51–73
Inverse care law 55, 136, 223
Kennedy Report, The 150, 157
Labour government 70, 108, 140, 169–71
Liberal view of education 119
Life course 186
Life expectancy 71
and income distribution 160–1
Low birth weight 149
Marx and Marxism 15, 17–19, 59, 63
The Communist Manifesto 15
proletariat 16
bourgeoisie 16
neo-Marxism and occupational health 185
Relationships of production 15–16
Materialist explanation for inequalities in health 59–61
MMR immunisation 153
Medical model of education 86
Medical Officers of Health 46, 47
Medico-Psychological Association (MPA) 91
Mental Deficiency Act 1913 90
<table>
<thead>
<tr>
<th>Subject</th>
<th>Page Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan Association</td>
<td>86</td>
</tr>
<tr>
<td>Midwifery</td>
<td>2</td>
</tr>
<tr>
<td>Millennium Cohort Study</td>
<td>40, 41</td>
</tr>
<tr>
<td>MIND</td>
<td>133, 139</td>
</tr>
<tr>
<td>Mining and South Wales Miners</td>
<td>205–6</td>
</tr>
<tr>
<td>Ministry of Agriculture, Fisheries and Food (MAFF)</td>
<td>61</td>
</tr>
<tr>
<td>Moral treatment</td>
<td>127, 128</td>
</tr>
<tr>
<td>Morbidity</td>
<td>53–4, 65</td>
</tr>
<tr>
<td>Mortality</td>
<td>52–3, 63</td>
</tr>
<tr>
<td>Adult</td>
<td>52–3, 64</td>
</tr>
<tr>
<td>Infant and children</td>
<td>53, 64</td>
</tr>
<tr>
<td>National Asylum Workers Union</td>
<td>89</td>
</tr>
<tr>
<td>National Child Development Study</td>
<td>40, 41</td>
</tr>
<tr>
<td>National Service Frameworks</td>
<td>72, 141</td>
</tr>
<tr>
<td>National Statistics Socio-Economic Classification (NS-SEC)</td>
<td>35</td>
</tr>
<tr>
<td>National Survey of Health and Development</td>
<td>39, 41</td>
</tr>
<tr>
<td>Neoliberalism</td>
<td>137</td>
</tr>
<tr>
<td>Neomaterialism</td>
<td>164–5</td>
</tr>
<tr>
<td>Nightingale, Florence</td>
<td>79, 81, 85</td>
</tr>
<tr>
<td>Normalisation</td>
<td>134</td>
</tr>
<tr>
<td>Nurse education</td>
<td>99–119</td>
</tr>
<tr>
<td>Nurse probationers</td>
<td>81–83</td>
</tr>
<tr>
<td>Nurse registration</td>
<td>87</td>
</tr>
<tr>
<td>Nursing asylum nursing</td>
<td>125–32</td>
</tr>
<tr>
<td>district</td>
<td>85</td>
</tr>
<tr>
<td>children's 90–1, 145–58</td>
<td></td>
</tr>
<tr>
<td>community</td>
<td>167–9</td>
</tr>
<tr>
<td>history</td>
<td>77–95</td>
</tr>
<tr>
<td>mental handicap</td>
<td>90</td>
</tr>
<tr>
<td>occupational health</td>
<td>199, 203</td>
</tr>
<tr>
<td>psychiatric nursing</td>
<td>125–42</td>
</tr>
<tr>
<td>public health nursing and research</td>
<td>106–7</td>
</tr>
<tr>
<td>Parenting education</td>
<td>154</td>
</tr>
<tr>
<td>Platt Report, The</td>
<td>95, 150, 157</td>
</tr>
<tr>
<td>Postmodernism</td>
<td>22, 187</td>
</tr>
<tr>
<td>Power</td>
<td>28, 116</td>
</tr>
<tr>
<td>Primary care</td>
<td>172–3</td>
</tr>
<tr>
<td>Professions</td>
<td>112</td>
</tr>
<tr>
<td>Project 2000 (nurse education)</td>
<td>91, 112</td>
</tr>
<tr>
<td>Psychiatria Democratica</td>
<td>133</td>
</tr>
<tr>
<td>Psychosocial environment</td>
<td>195–203, 219</td>
</tr>
<tr>
<td>Public health</td>
<td>45–8</td>
</tr>
<tr>
<td>Pyramyd Trust, The</td>
<td>154</td>
</tr>
<tr>
<td>Registrar General's classification of social class</td>
<td>32–4</td>
</tr>
<tr>
<td>Relative income theory</td>
<td>160</td>
</tr>
<tr>
<td>Repetitive strain injury</td>
<td>193</td>
</tr>
<tr>
<td>Royal College of Nursing</td>
<td>151</td>
</tr>
<tr>
<td>Defining nursing</td>
<td>1</td>
</tr>
<tr>
<td>Subject</td>
<td>Page(s)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Royal College of Nursing – Presidential</td>
<td>1</td>
</tr>
<tr>
<td>Taskforce on Education</td>
<td></td>
</tr>
<tr>
<td>Royal College of Paediatrics and Child Health</td>
<td>150, 151</td>
</tr>
<tr>
<td>St John’s House</td>
<td>81, 84</td>
</tr>
<tr>
<td>Saving Lives: Our Healthier Nation</td>
<td>153</td>
</tr>
<tr>
<td>School nurses</td>
<td>152–4</td>
</tr>
<tr>
<td>Seebohm Committee</td>
<td>47</td>
</tr>
<tr>
<td>Self esteem</td>
<td>68</td>
</tr>
<tr>
<td>Skills escalator</td>
<td>108, 121</td>
</tr>
<tr>
<td>Smoking</td>
<td>66, 175</td>
</tr>
<tr>
<td>Social capital</td>
<td>70, 213–18, 227</td>
</tr>
<tr>
<td>Social closure</td>
<td>78–9</td>
</tr>
<tr>
<td>Social exclusion</td>
<td>25, 26</td>
</tr>
<tr>
<td>Social inclusion</td>
<td>223–5</td>
</tr>
<tr>
<td>Social selection and inequalities in health</td>
<td>57–9</td>
</tr>
<tr>
<td>Social stratification</td>
<td>9–29</td>
</tr>
<tr>
<td>Socio-economic theories</td>
<td>12–29</td>
</tr>
<tr>
<td>groups (SEG)</td>
<td></td>
</tr>
<tr>
<td>Standardised mortality ratios</td>
<td>32, 44</td>
</tr>
<tr>
<td>Strategies for Practice in Disadvantaged Areas (SPIDA) project</td>
<td>220</td>
</tr>
<tr>
<td>Sure Start</td>
<td>71, 155, 169</td>
</tr>
<tr>
<td>Survey of Psychiatric Morbidity</td>
<td>65</td>
</tr>
<tr>
<td>Thomas Coram Research Unit</td>
<td>147</td>
</tr>
<tr>
<td>Townsend Deprivation Index</td>
<td>38–9</td>
</tr>
<tr>
<td>Underclass</td>
<td>26</td>
</tr>
<tr>
<td>Unemployment and health</td>
<td>188–90</td>
</tr>
<tr>
<td>and mental health</td>
<td>190</td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
</tr>
<tr>
<td>Central Council for Nursing, Midwifery and</td>
<td></td>
</tr>
<tr>
<td>Health Visiting</td>
<td>102, 109, 112, 113</td>
</tr>
<tr>
<td>Usurpation</td>
<td>88</td>
</tr>
<tr>
<td>Voluntary Aid</td>
<td></td>
</tr>
<tr>
<td>Detachment (VAD)</td>
<td>93</td>
</tr>
<tr>
<td>Voluntary hospitals</td>
<td>93–4</td>
</tr>
<tr>
<td>Weber</td>
<td>17–19, 63</td>
</tr>
<tr>
<td>Welfare benefits/ screening/ Welfare rights</td>
<td>171–8, 221</td>
</tr>
<tr>
<td>Whitehall Studies</td>
<td>42, 43, 57, 194–8</td>
</tr>
<tr>
<td>Work conditions and health</td>
<td>191–9</td>
</tr>
<tr>
<td>Workforce/Workforce planning</td>
<td>120</td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td></td>
</tr>
<tr>
<td>Workforce/Workforce planning</td>
<td></td>
</tr>
<tr>
<td>World Health</td>
<td></td>
</tr>
<tr>
<td>(WHO)</td>
<td>44, 70</td>
</tr>
</tbody>
</table>