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## Dimensions of vulnerability salient for health: a sociological approach

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### ABSTRACT

In this explicitly sociological contribution I discern and explore a number of dimensions of vulnerability with potential relevance to people's health, health-related quality of life and longevity. Reference is made here to (a) anomie, (b) alienation, (c) powerlessness, (d) marginalisation, (e) exclusion, (f) stigmatisation, (g) deviance, (h) cultural imperialism, (i) loneliness, and (j) symbolic violence. These are then explored further in light of the core sociological concepts of structure, culture and agency. In the penultimate part of the paper the mechanisms – or, “media of enactment” – that convert vulnerability into sickness, impairments and premature death are listed and discussed. The concluding paragraphs are committed to a consideration of the ramifications of the analysis for the effectiveness of policy interventions designed to protect people's health.

### KEYWORDS

Vulnerability; health and longevity; explanatory mechanisms; media of enactment; policy; permanent reform

### Introduction

Vulnerability comes in many shapes and sizes and can in the right circumstances lead to impaired health and even premature death. It can in other words insinuate itself into body systems and impair function and equilibrium. But though each of the types of vulnerability differentiated below can impact negatively on health, none is either a necessary or a sufficient condition for doing so. We live in a complex, unpredictable and messy world. I will introduce, define and comment briefly on *ten types of vulnerability*, but first a note or two of caution is required.

First, although my concern in this paper is explicitly sociological, social mechanisms that induce vulnerability can paint only part of the picture. Biological and psychological mechanisms are also in play, though social mechanisms do not reduce to them: genes, a multiplicity of the right kind of combinations of cells and an internal locus of control may well be crucial ingredients for winning performances at Wimbledon, but as yet only “people” have emerged victorious, and personhood can only be fully articulated in the context of social relations. What this means is that while the social is irreducible to the biological and psychological, it can only contribute a few pieces of an unbelievably rich jigsaw. *Biological, psychological and social mechanisms are simultaneously at play and each issues in causal tendencies.* Biological and psychological mechanisms can travel “upstream” to influence the social, and social mechanisms can travel

“downstream” to influence the psychological and biological; but they are each *distinct ontologically and epistemologically irreducible* (Scambler, 2018b). In a nutshell, in what Bhaskar characterises as an “open system” – in which multiple biological and psychological, let alone social, mechanisms are simultaneously at play – beneath-the-surface cross-strata causal mechanisms do not simply translate into – on-the-surface events (Bhaskar, 2016). Even within the independent or irreducible realm of the social, one mechanism (eg class) can annul the potential impact on events of another (eg ethnicity). And then allowance must be made for serendipity, happenstance and, I would contend, structured but never structurally determined agency. So this contribution to the analysis of vulnerability is: (a) confined to the social, and (b) must allow for contingency and agency, and (c) whilst being stand-alone, that is, irreducible to the psychological and biological, can in no way “wrap things up”.

A second preliminary remark is in order. The nine types of *social* vulnerability explored here are: (a) not mutually exclusive, nor (b) of particular relevance or interest to those affected. If you are a single mum with, say, a daughter who is dis-abled, it matters not whether your disadvantage is causally informed by anomie, alienation ... The motivation for identifying and separating different types of vulnerability is *analytic*. It is, I shall contend, “useful” for the construction of sociological explanations of vulnerability-induced health disadvantage.

## Types of vulnerability

The types delineated here are far from exhaustive and the list might have been compiled differently; but I hope that via it I might address many of the structural, cultural and agential instigators or precipitants of vulnerability impacting on health.

### Anomie

Most notably in his study of *Suicide*, Durkheim (1897) recognised and captured the sense of being *lost*, without compass, drifting, of being estranged (Durkheim's preferred descriptor) or as sociological convention now transcribes it "normless", that accompanied the structural, cultural and agential transition from the mechanical solidarity of traditional societies to the organic solidarity of modern industrial capitalism. No longer were many people – most notably in the more individualised, fragmented and disparate "Protestant" cultures – cushioned by joined-up communities and the all-encompassing narratives that afforded comfort and protective security. The question here is whether, or to what extent, anomie has been transmitted from industrial to today's post-1970s financial capitalism. There seems little doubt that it retains resonance.

### Alienation

Within any version of capitalism, Marx claimed, people become alienated from their very humanity as they become thing-like, mere cogs in the machinery of production. In his early work he differentiated four specific types emanating from this insight (Marx, 1932; Yuill, 2005). First, workers become alienated from their product. Whether engaged in manual or mental labour, their work delivers not a product with use value, but a commodity with exchange value. And the beneficiary of this transmutation of product into commodity, via the creation of surplus value, is the owner of the means of production, the rentier capitalist. Second, the worker is alienated from the process of production. Labour may strike as "voluntary", but given the necessity for wages it can more accurately be characterised as "forced"; and the work itself affords no space for autonomous decision-making or practice. Third, workers are alienated from their *Gattungswesen*, their "species-essence" or human nature. It is as if they are robbed of all positivity. And finally, as workers are themselves transmuted into commodities, they are alienated from other workers. Does Marx's analysis carry over into post-1970s, post-industrial or financial capitalism? It clearly does to a degree.

### Powerlessness

Certainly alienation, but anomie too, might be regarded as correlates of – and sometime causal mechanisms inducing – powerlessness. In the terminology of Bourdieu (1980), powerlessness amounts to a lack of those forms of capital, social and cultural as well as material, that comprise the basic prerequisites of effective influence in and across diverse fields, ranging from negotiating wages and forging contacts to securing appropriate health and social care. But if powerlessness in its most extreme guise amounts to political impotence, it has many other and varied forms. Indeed, at its most mundane powerlessness can be a function of the absence of those "familiarity bonds" that bring solace, comfort and community- or network-based, health-bestowing sustenance (Scambler & Tjora, 2012). Moreover power is often exercised most vigorously in situations characterised by what Habermas (1989a) called "systematically distorted communication", that is, when all parties are acting in good faith but in accord with a pre-set agenda to the advantage of one or more or none of the participants.

### Marginalisation

Marginalisation is another concept with sufficient autonomy to resist accommodation to others within the kinship system of causes of vulnerability. Well educated but under-employed and/or under-paid migrants and members of Roma communities can fall into this category. These are collectivities pushed to the edge of society, putative "misfits" represented by stereotypes replete with errors of commission and omission. Their "othering" reinforces definitions of what is normal and acceptable. In the case of refugees seeking asylum in EU countries or Trump's USA marginalisation is currently accompanied or complemented by incarceration, in some cases involving the legally sanctioned separation of infants and children from their parents.

### Exclusion

People can be excluded socially in a myriad of ways, but there emerged in the 1990s an expedient post-left-versus-right – or "third way" – political rhetoric of "social exclusion" that served to disguise, and thus neuter, the inconvenience of enduring structural inequalities. The resultant policy initiatives oriented towards *social inclusion* were as attractive and appealing as they were: (a) effective in deflecting attention from social structure, and (b) ineffective in mitigating their impacts. Exclusion has proved both an umbrella term for estrangement and a corruption of many a political pursuit of inclusion.

## Stigmatisation

In Goffman's (1968) classic account, stigmatisation denotes non-conformance with norms governing how people should "be" rather than how they should behave. Scambler and Hopkins (1986) formalised this by suggesting that stigma be defined in terms of "ontological" rather than "moral" deficits: thus an individual rendered vulnerable by stigmatisation is one who possesses a socially undesirable and unacceptable attribute, trait or condition and infringes against norms of *shame*. Scambler (2009) differentiates between enacted, felt and project stigma, referring respectively to stigmatisation, an internalised sense of shame and a fear of enacted stigma, and a determination to contest enacted and felt stigma.

## Deviance

Stigma and deviance have commonly been deployed as synonyms in the sociological literature. There is an analytic case however for distinguishing between them. If stigmatisation issues from infringements against norms of shame, deviance might be said to emanate from falling foul of norms of *blame*. And blame is not the same as shame. Blame implies culpability: it is a moral not an ontological departure from normativity. Scambler (2009) elaborates on this distinction via his concepts of enacted, felt and project deviance, referring respectively to discrimination on the grounds of moral unacceptability, an internalised sense of blame and a fear of enacted deviance, and a conscious commitment to counter and defeat enacted and felt deviance (see Table 1).

## Cultural imperialism

As announced by Young (1990), this refers to echoes (or worse) of historical and imperialist notions of ethnic superiority and superordination *over* those of ethnic inferiority and subordination. It applies only too readily to Occidental regimes trapped in and befuddled by what are readily portrayed by populist right-of-centre politicians as past glories but in fact recall institutions of extreme purposeful violence, slavery and exploitation. Racism is a conspicuous product of cultural imperialism and frequently

translates into "internal colonialism" (Pinderhughes, 2011). Churchill's 1930s philosophy that racial superiority naturally *and rightly* prevails survives and underpins racist thinking and praxis in the social orbits of Trump in the USA and Farage, May and Johnson in the UK.

## Loneliness

Loneliness, like suicide, strikes as an individual phenomenon, a proper subject for psychological rather than sociological investigation. But it has strong social determinants and can be the product of social structure and culture. Older people, even fourth-agers, in some societies and cultures, like Japan for example, remain respectfully absorbed in extended families, local neighbourhoods and communities, whilst in others they experience abandonment at the hands of enhanced social and geographical mobility, welfare fragmentation and the kind of individualism that pits aspiring consumer against aspiring consumer.

## Symbolic violence

Bourdieu's (1980) lynchpin notion of symbolic violence insists that coercive force is often not required for hegemonic ideologies to prevail. Politico-cultural groundwork (and its progeny, the occasional sleight of hand) can typically deliver what is desired and required by vested interests without resort to explicit threats. Conspiracies, C.W. Mills (1956) noted in his *Power Elite*, are exceptional because they are normally superfluous: what he named "tacit understanding" normally surfaces and fills in the political gaps. So there exists – for Bourdieu a class-based – "habitus" or predisposition to conform, and those who fail to conform are *rightly* castigated and exposed to public condemnation and sanctioning. There is more than a hint here of Durkheim here too.

To repeat, there is no claim that these ten types of vulnerability either exhaust all possibilities – they clearly do not – or that they are in any sense stand-alone. Moreover they can be causally inter-related in complex ways. Alienation can lead to loneliness whilst being politically disguised as a "natural" age-related form of social exclusion or as the product of happenstance. Cultural imperialism can transmute into a governmental creation of a "hostile environment" (as in the UK's Windrush scandal), in the process inducing vulnerability by means of a newfound powerlessness. An already marginalised Roma population can be stigmatised and subsequently be subject to a "weaponising of stigma" that occurs when charges of deviance are appended, that is, when blame is added to shame. What *this* listing does facilitate, however, is an explicitly *sociological*

**Table 1.** Notions of stigma and deviance.

<b>STIGMA</b> (offences against norms of shame)	<b>DEVIANCE</b> (offences against norms of blame)
<b>Enacted stigma</b>	<b>Enacted deviance</b>
Actual discrimination (shaming)	Actual discrimination (blaming)
<b>Felt stigma</b>	<b>Felt deviance</b>
Fear of discrimination and sense of shame	Fear of discrimination and sense of blame
<b>Project stigma</b>	<b>Project deviance</b>
Active resistance to enacted and felt stigma	Active resistance to enacted and felt deviance

analysis of those mechanisms most causally salient to the production and reproduction of vulnerability associated with health deficits.

### Structure, culture and agency

Sociology's past and present – and maybe its future too – come up against competing conceptualisations of structure, culture and agency. This is not the place to revisit longstanding and well-rehearsed rival stances within sociology, let alone to attempt to resolve them; but some comments are in order. Culture and agency are in my view structured without being structurally determined, that is, they do not enjoy the causal autonomy often – and often politically – attributed to them, but neither can they be reduced to structural outputs. Cultural shifts can occur independently of deep and enduring social structures, and free will too occasionally raises its head above the structural parapet.

As far as culture is concerned, it seems apparent that the “relativised culture” associated with the latest – and conceivably terminal (Streeck, 2016) – phase of financial capitalism has taken an expedient or helpful form for governing oligarchies in the UK and elsewhere (Scambler, 2018). It is a culture that comprises an up-for-grabs multiplicity of “petit” narratives, once rationally compelling “grand” narratives – promising measured progress, improvement, enhanced wellbeing and the like – having forfeited much of their former discipleship. Paradoxically, this kind of “anything goes” relativism also allows for the re-emergence of religious or quasi-religious “fundamentalisms” as people turn to putative absolutes and certainties to compensate for the absence of the rationally compelling. It is especially pertinent to note in the context of this paper that the cultural shift identified here makes resistance to mechanisms and policies to reduce people's vulnerability that much more difficult to articulate in a persuasive, let alone compelling, fashion.

As for agency, a quote from Bourdieu (1990), writing as it happens on photography, is striking:

*by its very existence, sociology presupposes the overcoming of the false opposition arbitrarily erected by subjectivists and objectivists. Sociology is possible as an objective science because of the existence of external relationships which are necessary and independent of individual wills, and perhaps, unconscious (in the sense that they are not revealed by simple reflection), and which can only be grasped by the indirect route of observation and objective experimentation; in other words, because subjects are not in possession of the meaning of the whole of their behaviour as immediate conscious data, and because their actions always encompass more meanings than they know or wish, sociology cannot be a purely introspective science attaining absolute certainty simply by turning to*

*subjective experience, and, by the same token, it can be an objective science of the objective (and the subjective), ie an experimental science, experimentation being, in the words of Claude Bernard, 'the only mediator between the objective and the subjective.'*

In precisely this way is agency or free will., like culture, structurally circumscribed. The relations between culture/agency and structure are two-way, or dialectical, as indeed is that between culture and agency, but the default position is a causal debt to structure.

For the purposes of this contribution on the social determinants, prerequisites, dialectics and dynamics of vulnerability and health, these inter-relations of structure, culture and agency are critical. The next section commits to *how* this influence is exercised – the “media of enactment” of social mechanisms precipitating health disadvantage – while the following discussion offers both a frame for future sociological research and some specific hypotheses warranting further and more intensive empirical pursuit.

### “Media of enactment”

The sources or foci of vulnerability, the ten types salient for health and longevity earlier delineated, need to be set in perspective. They are not, to reiterate, mutually exclusive, and there is considerable definitional, experiential and causal overlap. But each, I am suggesting, can in its own right fuel susceptibility to sickness. I will come later to the sociological business of providing causal explanations, that is, of identifying the social mechanisms evidentially and tellingly implicated. But first I want to address what I have described as the “media of enactment” by means of which such social mechanisms sap health and even occasion premature mortality. Table 2 summarizes what I take to be the key media or “asset flows”. It is a Table with a critical agenda.

First, it seems apparent that the assets listed here are not simply possessed or not possessed, but rather that they vary over time. The concept of “flow” captures this: possession of, say, material assets varies not only with employment status, savings and welfare provision, but with parental support and the (anticipated) inheritance of capital. Spread and variation through the “lifecourse” matters, and the childhood years are exceptionally important. Second, it needs emphasising that strong asset flows can compensate for diminished flows elsewhere: for example, vigorous flows of one or another of biological, psychological, social or cultural flows can rescue a person from a strangulated flow of material assets.

It is important to register and re-emphasise the complexity of: (a) the open system in which social mechanisms are (among those) causally at play, and (b) the “fields” in which – whilst acknowledging

**Table 2.** Types of asset flow salient for health and longevity.

- (1) Biological (or body) assets can be affected by class relations even prior to birth. Low-income families, for example, are more likely to produce babies of low birthweight; and low birthweight babies carry an increased risk of chronic disease in childhood, possibly in part through biological programming;
- (2) Psychological assets yield a generalized capacity to cope, extending to what is increasingly conceptualized as “resilience”. In many ways the “vulnerability factors” that Brown and Harris (1978) found reduced working-class women’s capacity to cope with life-events causally pertinent for clinical depression are class-induced interruptions to the flow of psychological assets;
- (3) Social assets have come to assume pride of place in many accounts of health inequalities and feature strongly in the work of Marmot and Wilkinson. The terms social assets or “social capital” refer to aspects of social integration, networks and support. The political use to which social capital is being put should not occasion its neglect;
- (4) Cultural assets or “cultural capital” are initially generated through processes of primary socialization and go on to encompass formal educational opportunities and attainment. Class-related early arrests to the flow of cultural assets can have long-term ramifications for employment, income levels, and therefore health;
- (5) Spatial assets have been shown to be significant for health by area-based studies. These have documented that areas of high mortality tend to be areas with high rates of net out-migration; and it tends to be the better qualified and more affluent who exercise the option to move;
- (6) Symbolic assets, representing the variable distribution of social status or “honour”, are known to impact on health via people’s (sense of) social position, especially relative to those others who comprise their reference groups;
- (7) Material assets refer to “relative deprivation” due to impoverishment and meagre standard of living. The relevance of material assets for health and longevity has long been stressed, although the mechanisms linking low income with health remain much debated.

Scambler and Scambler (2015)

**Table 3.** Stigma and/or deviance, shame and/or blame.

Stigma + Deviance + <b>Abjects</b>	Stigma + deviance - <b>Rejects</b>
Stigma - Deviance - <b>Normals</b>	Stigma - deviance + <b>Losers</b>

Bourdieu’s rightful assertion that the political is always causally “intrusive” – the different types of vulnerability differentially impact on people’s asset flows.

### A frame for theory and research on vulnerability: hypotheses and policies

Central premises of this brief contribution are that: (a) we humans inhabit what Bhaskar terms an open system; (b) beneath-the-surface social, psychological and biological mechanisms are simultaneously active and so cannot be simply read off from on-the-surface events; (c) social mechanisms cannot be reduced to psychological or biological mechanisms; (d) sociology cannot (it follows from (a) to (c)) “wrap up” our understanding of and explanations for vulnerability and its salience for health and longevity; and (e) the natural, life and social worlds we unavoidably dwell in are complex, dynamic *and can best be illuminated by scientific endeavour*. Sociology, I contend – for all the necessary, “logical” and cross-sciences

commitment to fallibilism (ie it is quite likely to turn out that we got it wrong, at least in part) – is no less scientific than, for example, neuropharmacology: it is just less easy for sociologists to secure “experimental closures” in the open system. The world is complex and messy.

So how best to address possible linkages between the social, vulnerability and health? And how best to pin down the most pertinent causal mechanisms? It is apparent that multiple social mechanisms are in the frame and that their salience varies by figuration or context. As intersectionalists rightly insist, feminist, post-colonial and dis-abled perspectives cannot be subsumed in (male, white and able-ist) sociologies. Also Bauman (2000) was right to note that what he wrote up as a transition from solid to liquid modernity introduced a new – financial capitalist – fluidity (and uncertainty) into the past as well as the present and future.

Sociology’s contribution can be via macro-, meso- or micro-theory and research (Scambler, 2018). In the paragraphs that follow I offer an illustration of the ways in which social change at the macro-level can lead to shifts at the meso- and micro-levels that ultimately permeate people’s bodies and impair their organs and their functions.

I have elsewhere characterised the transition from (postwar) welfare state to (post-1970s) financial capitalism in terms of a new *class/command dynamic*. This asserts that objective relations of class have been reinvigorated, even though class has become less important subjectively for people’s sense of who they are – that is, for identity formation – and concerning which social scripts they learn to recite and improvise around. The enhancement of an increasingly transnational core of “capital monopolists”, comprising a super-rich and “nomadic” or post-national clan of financiers, rentiers and CEOs, has meant that this “clan” is now conspicuously more able to buy policies favouring capital accumulation from the power elite at the apex of the state apparatus. Thus the term class/command dynamic refers to highly concentrated class forces purchasing policy from the state’s power elite, these forces and this elite together now constituting a governing oligarchy or plutocracy. The net effect of this dynamic is an extraordinary growth in wealth and income inequality. As Piketty (2013) shows, people who do not inherit capital are now condemned to a tough struggle to establish themselves as affluent and secure home-owners.

At the same time as postwar welfare state capitalism has been displaced by financial capitalism, a new cultural pattern has become established. Three strands are especially pertinent for this essay on linkages between types of vulnerability and health. First, a new and more radical US-style “individualism” has taken root.

This has had the effect, politically expedient for right-of-centre parties, of circumscribing compassion and caring for others. Second, long-held (European) Enlightenment orientations towards progress and the common good (whether capitalist, socialist or communist in ethos) have yielded to a pluralism of “choices” about what is good and right and about what represents progress. In other words, a form of “cultural relativism” prevails. This means, in effect, that it has become harder to offer rationally compelling challenges to the (financial capitalist, neoliberal) status quo, a point Habermas (1989b) has made.

And third, there is evidence that more and more people have become disaffected, cut off and isolated from their social milieux and prone to social anxiety, low esteem, an external locus of control and protracted feelings of hopelessness in a financial capitalism that has “left them behind”. They are structural and cultural by-products of what has been called “precarity”, a novel and profound – and Giddens (1990) has argued, “ontological” – insecurity (Standing, 2011). Not only have permanent careers and jobs given way to the likes of short-term zero hours contracts, in middle-class as well as working-class jobs, but people have become disoriented. It is in this context that I have coined the term *disconnected fatalism*.

I have written of disconnected fatalism for want of one more precisely indicative of a peculiar kind of “light-headed” detachment associated with cultural relativity and the era of financial capitalism. Drawing on Archer’s notion of fractured reflexivity, its usage captures a combination of hopelessness and an ineluctable feeling of being cast off and, most especially, rudderless: there appear to be no answers, no worthwhile prospects, no way back (Scambler, 2013). It has grown in strength through the “austerity politics” that have characterised right-wing Britain policy since 2010.

Several of the ten types of vulnerability listed at the outset of this piece – ranging from more structurally derived notions like alienation, anomie, cultural imperialism and symbolic violence to the more ubiquitous, all-inclusive notions like powerlessness, marginalisation, exclusion and loneliness, might be said to coalesce into or to be subsumed by this notion of disconnected fatalism.

I have focused elsewhere on the “contributions” of stigma and deviance to vulnerability to sickness and premature mortality (Scambler, 2018a). Differentiating between stigma, denoting shame, and deviance, denoting blame, I have argued that right-of-centre power elites, operating in line with financial capitalism’s class/command dynamic as governing oligarchies/plutocracies, have appended blame to shame, in the process facilitating an effective abandonment of people – single mums, the

dis-abled, the un- and under-employed – with predictably negative results for their sense of self, prospects and health (Dorling, 2018; Schrecker & Bamba, 2015). “Ideally” for the financial capitalist/neoliberal project, those redefined as “abjects” – that is, shamed and blamed, and thus effectively rendered beyond the pale – can be literally sanctioned, “punished” and then abandoned (Garthwaite, 2016). Abjection can strangle most of those asset flows known to be propitious for health and longevity (though a degree of inter-flow compensation might still be possible) (see Table 3).

This particular journey from structural via cultural change to the likes of disconnected fatalism, and for some the frightening endpoint of abjection, a journey which is entirely consonant with a multitude of empirical studies, quantitative and qualitative, can be traced along the motorways of financial capitalism. There are of course other routes, using A and even B roads, some of which have not yet been fully mapped or tested. And doubtless many of these roads, lanes and tracks can lead to one or more of the ten types of vulnerability with which this contribution began.

As sociologists have long maintained, and as inter-sectionalists more recently insist, structural and cultural “factors” or mechanisms do not act in isolation but *interact*, in society. This is picked up and grounded in Bhaskar’s critical realism and his concept of the open society. So to reiterate, and to stay with my analogy, all I have done here is describe, and prescribe, a single journey, almost all of it by motorway.

Gender and ethnic relations antedate those of class and state and remain perspicuous and independent structural inducements to vulnerability (Kelly & Nazroo, 2018; Scambler, 2018). It is not possible to review these considerable theoretical and substantive literatures here – which importantly extend beyond orthodox sociological to feminist and post-colonial studies (Scambler, 2018) – so instead I offer a single fictionalised case study to illustrate the invariably complex interplays of structure, culture and agency and their potentially negative effects on health via mixes of vulnerability types and the media of asset flows.

*Marcia’s grandfather came over to London in the early 1960s in response to an advert for bus drivers placed in a local newspaper in Jamaica. He was joined later by his wife and their two children, one of whom was to become Marcia’s mother. The family were met with a degree of racial prejudice and hostility but this was compensated for by the supportive closeness of the black community and “subculture” in South London. By the mid-1970s, in a more competitive job market, Marcia’s father found himself out of work and under material and other resultant pressures her parents split up. Marcia was aged two when this occurred (and is now in her early 40s). She left school at 16*

*and worked in a local supermarket prior to meeting her partner and moving to rental accommodation outside of “her” neighbourhood. She has had two children with her partner. She works as a hospital cleaner but her hours have been cut, she has no sick or holiday pay and no work-related pension to look forward to; and her partner has only found occasional temporary work. Her daughter, with whom she was very close, moved away to attend a northern university and has since found work and set up home there. Her son has been less fortunate, has struggled during and between zero hours contracts and still lives with Marcia and her partner. He is currently unemployed and his GP has diagnosed a depressive disorder. Life has become a struggle for this trio, the more so since the introduction and ramping up of policies of “austerity” since 2010. The benefits they were once entitled were cut back, and they are losing out again with the rolling out universal credit. They have had no benefit payments now for over a month, they are behind with the rent, their landlord, an MP, is threatening them with eviction. Marcia’s partner and son have been told they must demonstrate a will to work or continue to suffer the consequences, this despite the fact that her partner daily searches for any form of paid work. The outlook is bleak. Marcia voted for Brexit in the referendum – “We need change. We can’t go on like this!” – but now fears the possible consequences. The omens seem bleak and Marcia herself finds it harder and harder to hold things together, let alone retain any sense of optimism for the future. She is glad her daughter “escaped”. It seems like the final straw that a week ago she received an official letter from the Home Office challenging her right to remain in Britain in the apparent absence of any written proof of her right to do so.*

The class/command dynamic, its companion cultural shifts and the notion of disconnected fatalism have purchase here, as do vulnerability via alienation, anomie, stigmatisation and the weaponising of stigma by means of its transmutation into deviance. But it is clear that Marcia’s lot cannot be explained sociologically in the absence of the causal input of, in particular, ethnic and gender relations and other types of vulnerability. In fact, setting aside questions around alienation, anomie, stigmatisation and deviance, all six other types of vulnerability may well be pertinent. Marcia is likely to experience, to feel, to embody, powerlessness, marginalisation and, exacerbated by the separation from her daughter, loneliness. But it is especially instructive to focus on cultural imperialism and symbolic violence. Britain remains as demonstrably racist as it is multicultural: indeed rhetorical resort to seemingly liberal commendations of “multiculturalism” can serve to disguise this, not always innocently. Marcia, educated by her family’s oral histories, is reflexive as well as fatalistic about this. Her lived and embodied experience is of cultural imperialism and internal colonialism, somewhat less conspicuous since her grandparents arrival in the 1960s but incontrovertibly more vital post-Brexit

and now epitomised in the correspondence from the Home Office. The “Windrush scandal”, which is the cutting edge of an explicitly racist government policy to create a “hostile environment” for migrants unable to buy their way to citizenship, feels to Marcia like a nail in her family’s coffin. It is also an example of Bourdieu’s symbolic violence.

Violence is only exceptionally physical and life-threatening in countries like Britain (though disproportionately racist). Marcia’s life-story, it should be noted, is statistically commonplace. However, she is not just rendered vulnerable by her colour and ancestry; her gender is also salient. Hospital cleaning has long been as low-paid as it is important, and women, albeit most notably women from ethnic minorities, have long provided cheap labour, a trend not only perpetuated but exploited yet further by private contractors for whom oppressive governments since 1979 have acted as agents. In financial capitalism working conditions, incorporating security as well as pay and benefits, have been eroded; and this has had the greatest effect on occupations traditionally dominated by women. Financial capitalism runs on deep and forbidding grooves carved out by gender as well as ethnicity relations long before its birth during the long sixteenth century. Women, and the more so those from ethnic minority communities, are still circumscribed and constrained by ubiquitous swathes of institutionalised varieties of symbolic violence every bit as damaging, not least to health and longevity, as in more overtly coercive and physical formats.

It might be over-egging it to proffer an account of precisely how Marcia’s health might be compromised by the inhibition of asset flows. Indeed she might be the fortunate recipient of an ineluctably strong, compensatory biological asset flow or a steady flow of psychological assets! It is consonant with decades of cumulative epidemiological research, however, to suggest that seemingly inevitable constrictions of flows of her material, social and spatial (she moved away from a neighbourhood of familiars), as well as continually slight flows of cultural and symbolic asset flows are likely to work to her disadvantage. This is what the statistics tell us, though with the obvious proviso that one cannot infer to individual cases (Bartley, 2017; Smith, Hill, & Bambra, 2016).

### Lessons and conclusion

I have maintained in this paper that social mechanisms contribute causally to health disadvantage via different types of vulnerability, in the process insisting that the world we collectively inhabit admits of causal instruction from a profusion of mechanisms deriving from different and (stand-alone or epistemologically irreducible) biological



through psychological to social ontological strata. It has also been argued that social structural and cultural mechanisms have been neglected, the more so as quantitative sociology transmutes into social epidemiology. In fact, much of the published literature on “social determinants of health” mentions structural and cultural “factors” only to allow them to sidle into the background in positivistic research studies. When putative “lifestyle factors” are not held directly responsible for health inequalities, attempts to embed such factors in their structural and cultural settings tend to be cursory and ritualistic. This explains the present emphasis on structures or relations like class, state or command, gender and ethnicity. Singly or in combination such structures frequently underpin types of vulnerability known to be negatively associated with health status and life expectancy. Asset flows – which tend to clustering, most potently in childhood, and can be variable through the lifecourse as well as allowing for across-flow compensation – were commended as their media of enactment.

A worthwhile research project would be to extend the line of argument in this short contribution by examining whether or not there exist identifiable *constellations* within the ten types of vulnerability introduced here that are: (i) particularly prevalent in financial capitalism, and (ii) causally decisive for health and life expectancy. If the data suggest positive responses to (i) and (ii), then this would encourage the development of fruitful middle-range theories linking macro- with micro-factors salient for health inequalities.

It remains only to comment briefly on: (a) agency, and (b) the ramifications of this analysis for effective policy interventions. Following Bhaskar (2016), I take agency to be a mechanism in its own right, possessed of causal and even transformatory power (Scambler, 2018). Agency, then, is enabling as well as constrained by structure: it is structured but never structurally determined. However, while this allows for individual resistance, as with project stigma and deviance for example (see Table 1), affecting those social changes required to reduce health inequalities *via the exercise of collective agency* is no straightforward matter. Class, command, gender and ethnic relations are not so easily diverted. The implications of this for policy interventions are severe.

Policy initiatives to reduce health inequalities are often pitted against vulnerabilities subsumed under the umbrella term of “exclusion”. This is resonant of the third way attempt to neutralise left/right antagonisms; and it disguises reconciliation with the neoliberal ideology that characterises a financial capitalist infrastructure that generates ever-greater wealth, income and health inequalities, and therefore a reconciliation with the status quo. In other words,

such initiatives rule out precisely those social changes that are a necessary condition for arresting and reducing health inequalities.

This is not to dismiss well-intentioned “reformist” attempts to bring about change by ad hoc policy interventions (like discouraging individuals from smoking). But it is to highlight types of vulnerability – most conspicuously the likes of alienation, anomie, cultural imperialism and symbolic violence – that are undeniably and deeply rooted in structure and culture. The challenge is to orient policy in such a way that those structures most relevant to the production and reproduction of health inequalities are exposed and countered. To this end I have written of a need for *permanent reform*, that is, for a strategic progression from those reforms most “amenable to introduction” to those demanding shifts that begin to call into question transnational financial and corporate interests. It is a progression made the more appealing by emergent indications of an imminent crisis of political legitimation and even of “the end of capitalism” (Scambler, 2018; S. Scambler & Scambler, *in press*; Streeck, 2016; Wallerstein, Collins, Mann, Derluiguan, & Calhoun, 2013).

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