Introduction: Health and Social Change Past and Present Evidence

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It is widely recognised that the health of individuals and populations is influenced by more than biological factors. Uncountable contributions from many disciplines have shown that the way a society functions, and the ways in which it changes, affects health positively or negatively. Comparing a selection of historical and contemporary processes of social change with each other in respect to their impacts upon health, is one way to further understand the mechanisms at work. That is the main purpose of this volume.

Before commenting upon the cases and some lessons we may learn from them, a few words need to be said about the two key concepts. '*Social change*' is, in this context, used in its wider sense to include socio-economic, cultural and political changes. Special attention is paid to times and places where these processes have been profound and occur with a certain speed. Attempts are made to identify certain elements within this spectre that are particularly important for health. At the same time the sophisticated interrelationship between different sectors of society must be acknowledged, which sometimes makes it difficult or impossible to estimate the exact weight of single factors. Even so, the authors believe that an analysis of a single case as a "narrative" based on theoretical assumptions about the mechanisms of the process, can provide valuable insights when compared with other narratives with similar ambitions.

When seen in connection with human societies, '*health*' must be defined as something wider than the deviation from biological normality. Good health is necessary for individuals and populations to fulfil reasonable vital goals. Social obstacles to fulfil these goals are not part of health itself but they might directly affect health negatively or, often, make certain pre-existing health problems worse. Refusal to provide support to those who are in greatest need, denying a certain group of people access to basic material and psychological resources, or stigmatising persons with certain health-related problems, are obviously examples of such obstacles. Modern studies, using standard forms to subjectively estimate "self-rated

health", is an example of the growing awareness of the incompleteness of biomedical tests and diagnosis in order to get a more comprehensive picture of the health of a population, especially in connection with theories about social stress and other psycho-social processes.

In quantitative comparison of a large number of cases, the goal is often to measure the likelihood of a certain outcome when one or combinations of independent factors occur. This provides the opportunity to generalise by calculating estimated "risks". Normally, the results are also evaluated in relation to their logical and theoretical credibility and previous results concerning the same question. This method can of course only be used when quantitative data is available, reasonably reliable and valid. None of these conditions are, however, easily fulfilled when the information emanates from different times and different systems of documentation. The number of potentially interacting variables must often be reduced to an extent that limits the possibilities to consider many other explanations. The cases presented in this volume will illustrate this, since the amount and character of available data vary from time to time and place to place. It does not exclude numerical comparisons, but the main goal has been to discuss the findings at a more holistic level, suggesting theoretical interpretations about processes and their links to repeated patterns or unique circumstances strongly influenced by contexts. This constitutes a starting point for the following brief presentation of the case studies as narratives with all their differences but also with similarities.

In *Cornia and Paniccià (eds*), *The Mortality Crisis in Transitional Economies*, cases of rapid social change in today's world are presented, discussed and summarised. Most of them concern former Soviet Union and its satellites in Central Europe. The authors show that the transition from the socialist system to western democracy and market economy, was signified by a, more or less, severe mortality crisis in all countries. This crisis has been halted and reversed in some countries, while it has continued for 15 years in Russia and other parts of former Soviet Union. The timing and other facts suggest that the decline is not primarily caused by cohort effects due to previous sufferings of certain generations, but clearly connected with the events before and after 1989. When summarising the factors that seem to have been strongly correlated to the decline in life expectancy, both similarities and differences are, as expected, found between the countries. Certain social groups have been more vulnerable to change than others, particularly men in their middle ages and among them especially unmarried persons and those who are in less privileged social positions. After a few years, the mortality trend slowed down, stagnated and even changed to the better in some countries, while it remained on a high level in other countries. Socio-economic factors and the stability or lack of stability of the political and social security systems seemed to influence the outcome.

Almost half a decade has passed since that book was published. In this volume *Vladimir Shkolnikov et al.* present results of their own and others updating developments in *Russia*. After a marked improvement during the first two decades after World War II, life expectancy stagnated and, after a while, started to decline slowly. That trend accelerated rapidly after 1989. Albeit with sharp fluctuations, life expectancy has continued to stay at a very low level, particularly among men. Insecure economic development, political instability and a low priority on welfare and health are still factors affecting those who are suffering most from the transition. All social groups tend to have less favourable life expectancy than their counterparts in Western Europe, but those who are at the bottom of the hierarchy economically and educationally suffer more than those who are better off. Middle-aged men still have the highest excess mortality largely contributing to the shortest average life expectancy of men – 59 years. The most striking connection in this group is between alcohol consumption and a number of major causes of death. A long tradition of binge drinking combined with male gender roles in the Russian society, contributes to this effect. According to the authors, unemployment, general insecurity and lack of trust in the political system are psychological factors, which encourage unhealthy drinking habits.

Among women, the greatest disadvantage compared with Western Europe occurs in ages above 60, when many single women are living under great economic constraints. Besides chronic diseases, typical for more affluent societies, infectious diseases are also becoming a growing threat, especially the rapidly growing incidence of HIV/AIDS and tuberculosis. The lack of resources both reduces access to recent technological inventions in medicine, aggravating the number of lethal outcomes of cardiovascular disease, and leads to inadequate resources for preventive and curative measures against infectious diseases. This problem is most evident for poor regions and individuals.

The presentation of the *Czechslovakian/Czech* case by *Petr Svobodný et al.* starts centuries ago and shows how political systems and socio-economic changes influenced health. Different political regimes made their imprints upon the systems, but certain traditions tended to survive. Even several reforms immediately after 1948 realised ambitions expressed during the inter-war Czechoslovak Republic. Having almost reached the western levels in the early 1960's, life expectancy started to lag behind, most clearly observed for men. However, compared with Russia, the 15-year-old Czech Republic suffered from a shorter and less severe mortality increase after 1989. Almost immediately, Czech life expectancy started to rise and continued to do so up to now (2004) - for men even more than for women.

The authors point at several factors that contributed to the positive Czech example: The health system was built on old traditions, blended with a considerable degree of equal access for all during the communist era. Even if it has been reformed and – in certain strategic areas – privatised after 1989, the egalitarian

ideology is still said to be strong among the citizens. Health services have been accessible to all independent of wealth – although private additional service is available for those who can afford it. Investments in the health sector as a percentage of GNP have almost doubled since 1989. That does, of course, not protect certain traditionally vulnerable groups – the unemployed, those who have the least educational and occupational resources or are too old to exploit the new opportunities – from being losers. The manageable size of the Czech nation, compared to the huge Soviet empire, and its sense of unity during the first years of national autonomy helped to create 'the velvet revolution'. With limited economic resources, the public sector tried to maintain a sense of "communality" and solidarity, balancing between market solutions and the protection of vulnerable groups.

During the last decades, the leaders in *China* have watched events in Eastern Europe carefully. Liberalisation of the economy, including privatisations, has been seen as a necessary condition for economic growth. The rapid erosion of the political system and social and economic chaos in Russia has, however, not been an attractive scenario. Basically, the political power remained in the hands of the party, while the economic and social transition accelerated year by year. Economic growth is rapid and the average standard of living has followed the same track. At the same time, *Hong Wang* shows that the process has not taken place without social implications for certain groups. The social security systems, including support to the sick and access to medical care, are no longer guaranteeing basic safety for everybody. Unemployment and withdrawal of social support from employers has left large groups without their previous, albeit limited, help. A stream of people migrates from the poor countryside, where the problems are worst, to the urban areas, where the jobs are created. Some become winners, others lose out.

A new system for social security, based more on private initiatives and solutions, has been implemented instead of the old one, which guaranteed support by the state and local collectives to everybody. Combined with growing individualism, weaker family ties, a weaker sense of collective responsibility for one's kin and less access to social networks, these reforms have increased inequality in access to health and basic welfare. New lifestyles are also contributing to health risks, for instance smoking, consumption of fatty food, sexual liberty and increased risks of being infected by HIV. Non-profitable public health supply has been suffering from the new market economy. The total effects on health from all these changes cannot be evaluated in exact figures. One alarming fact is, however, that infant and child morality has not improved since 1985 and average life expectancy has only risen slightly. In the author's opinion, economic growth and increased literacy has not been followed by the expected improvements in the nation's health, especially in poor regions and vulnerable population groups. His recommendations for future

health policies reflect a belief that institutional change has to accompany social changes in order to accommodate society to the new conditions.

Both Russia and China have recently opened their economies to the rest of the world. The same happened in *South Africa* when apartheid was abandoned and democracy and formal equality was granted to the majority population, symbolised by the first free elections in 1994. The economic and social problems following Freedom Day are rooted in previous times and democracy did not immediately lead to prosperity in previously disadvantaged populations. The starting point of *Mickey Chopra* and *David Sanders* is taken as the globalisation of the economy and free trade when the borders were opened to foreign competitors post 1994. Although an unavoidable event, it has caused domestic re-organisation of industry and agriculture and increasing unemployment especially amongst the unskilled.

Abolition of 'pass laws' opened the doors to mass migration from the countryside "homelands", where the majority population had been forced to live on insufficient means of production and seasonal migratory work. Rural areas have continued to suffer from an unfavourable age structure and split families. Impoverished, inadequately supplied and socially unstable urban suburbs host a flow of immigrants. As a result, economic and other inequalities have remained or even increased between the well to do and the poorest population. The health situation of the latter group remains very difficult. HIV/AIDS, in synergy with TB and other diseases, erodes family structures and robs the future of persons in their productive ages. Drugs and alcohol are painkillers, especially for men in socially uprooted societies, contributing to early deaths and general insecurity. Age-specific mortality data are gradually revealing the differentials between ethnic groups in a still geographically segregated country. AIDS is affecting both men and women and violence and other external causes are exceptionally high among young and middle-aged men. As in Russia, democracy alone is not able to bring immediate prosperity, when economic realities are difficult or even worse than before for the most vulnerable populations. This is unfortunately also true when the regime, as in South Africa, is taking affirmative actions in order to compensate for previous disadvantages. The authors of the case study argue that great efforts need to be made in order to create a policy that enforces the provision of safe and healthy communities and welfare for all.

A question is sometimes raised whether developing countries can learn from the history of the demographic and epidemiological transition that took place in Western Europe during the last two centuries. The authors of the South African case are at least not convinced that their country will automatically follow the historical example. It would, of course, be very naïve to claim that the question could be answered with an unequivocal "yes". But it does not mean that a comparison of the present and the past is completely without interest. The *Swedish* early nineteenth century experience, presented by *Jan Sundin* and *Sam Willner*,

undoubtedly expose patterns that are similar to the ones found in Russia and South Africa today. In all three cases, the transformation changed the social and economic conditions profoundly. Structural changes of the economic and social system meant that old customs and protective systems were no longer adapted to the new situation. Although on a quantitatively smaller scale, new groups of poor immigrants in the cities were facing social destabilisation and problems to make their living in early nineteenth century Sweden too. Kinship and family ties became fewer due to migration and less stable marital unions, which weakened their roles as networks for mutual protection. Persons living as singles and middle-aged men were the losers, socially and in average life expectancy. As in Russia and South Africa drugs such as alcohol were used to dull the pain and disappointment of the new society and its consumption was made easier than before, when informal social control was more lenient or disinterested. Crimes of poverty and violence also increased in all three cases.

It took about two generations before the conditions were visibly improved in Sweden, a point in time that has no yet been reached in Russia or South Africa. In certain respects, Sweden was, however, in a better position. Even if the country did not have the material resources to handle the socio-economic crises, the political system was relatively stable and the local administrations continued to work with unbroken authority and willingness to adapt to the new public health messages. The plagues from infectious diseases decreased, which contributed to the decline of mortality among infants, children and young women. Although producing losers, the proportion was considerably smaller in nineteenth century Sweden than in Russia and South Africa during the recent decades. Problems existed, but on a smaller scale and in a more favourable context.

Reasonable economic resources are a necessary precondition for social welfare and health and economic growth increases the chances for improvements. But is this enough to produce a positive outcome, always, for all and within a reasonable time? In the traditional Swedish agrarian society, the cornerstones of social protection were families, households, villages, craftsmen's guilds and parishes. This protection did not exist for many members of the growing proletariat. During the early phases of population growth without much industrialisation, the national and local elites did not recognise the causes of the changing situation, defining the poor as immoral, undisciplined, causing their own problems and socially dangerous. The winners became more prosperous and were seldom ready to share their wealth with the poor. Manchester liberalism and laissez-faire provided arguments for non-intervention in social affairs, especially during the first half of the century.

Industrialisation gave the working class better conditions in Sweden during the last three decades of the nineteenth century. A difficult problem emerged, when the urban areas could not handle the hygienic problems as fast as immigration created them. This "Klondike" situation was, however, quickly overcome after a couple of

decades. Family structures became more stable, new informal networks and associations created new forms of social safety and trust, which was beneficial for the health and survival of adults and, indirectly, for children. The mortality of both sexes and all age groups went down almost without interruption. But a simultaneous changing attitude among the elites in the local society, who had to take the decisions and pay for sanitary reforms and a minimal support for the poor, was also important.

Simon Szreter demonstrates how industrialisation caused a disruption for the majority population in *Great Britain*. Economic growth alone was not enough to change that situation. Looking on its early modern period, he concludes that the English poor law was actually an effective instrument to provide the population with reasonable security even for the landless rural population, illustrated by an early disappearance of famine mortality. Health and welfare became an engine for economic growth, instead of being only a product of the same growth. Agricultural growth became a precondition for the industrial revolution but, ironically, urbanisation and anonymity of the urban immigrants eroded the poor law system's protective force. The industrial proletariat got little support and turned into objects of social control, as could also be observed in Sweden during the beginning of the nineteenth century. Like in Sweden, "undeserving" poor were sentenced to compulsory work at public institutions.

Before the middle of the century, Edwin Chadwick and others advocated the need for social and sanitary reforms, not just for the poor but also for the society as a whole. As in Sweden during the same period, the effects of such ideas did not materialise immediately. It was in the local societies that things had to improve and their political elites had to agree and act. The mental and social gap between those who had and those who did not have was too big for a policy of mutual trust and support. Only when democracy was successively brought to a wider group of the population, new associations emerged, mobilising and voicing the interests of the less privileged majority of citizens, and new generations entered the leading positions within local governments, did the hygienic revolution speed up during the last decades of the century. The effects on the urban population's health and rates of survival were eminent. Szreter compares the nineteenth century experience with the development during the last decades of the next century, an era of economic and social change making previous social systems less functional and creating new groups of winners and losers. As in early nineteenth century political distrust for collective interventions have emerged.

The *French* case by *Patrice Bourdelais* also covers the late nineteenth-century era of urban public health and "hygienism". The author underlines that the timing, the importance of the local nature of problems and reforms, and the social impacts of the development are key components for the understanding of the process of change. Industrialisation and a rapid influx of migrants to industrial cities caused a

mortality crisis and a decline in life expectancy. It affected most age groups and both sexes, but particularly women and children. There was also a social gradient with the highest mortality figures in the poorest part of the population. The trend was reversed during the last three decades of the century. Mortality declined and life expectancy increased in all groups. This was to a large extent accomplished through a combination of paternalistic interventions from industrialists and a new political regime at the local level. The new political bodies were suspicious of welfare provisions organised by catholic institutions or other private associations. Instead they favoured public interventions with standardised rules for social benefits for all in need. The previous indifference towards poverty, sanitary problems and bad health in the cities by the elite was replaced by social conservatism and social liberalism. It was partly based upon the fear of socialism and radicalism, but undoubtedly for some also caused by a real concern for the humanitarian aspects of the bad conditions. The ideological heritage from Enlightenment and the notion of "citizenship" that had emerged during the French revolution did also have an impact on policies. Some reforms, for instance the supply of water could also be good for economics, giving the companies in charge a nice profit.

In many ways, the early phase of industrialisation in France followed the same road as in England or Sweden although with differences in its timing. A period of crisis, with losers among those with the least resources to handle the transition, was followed by political and ideological change and a more positive attitude towards public interventions and social reform. This was implemented on the local scale with arguments and support from a growing number of professionals, "the social engineers", armed with statistical evidence and recommendations by international experts, gathered at hygienic conferences. Public health was a product of nineteenth century ideologies and scientific ideas within a gradually professionalized state on national and local levels.

There has been a convergence of demographic developments and political engagement in welfare policies on national and local levels in Western Europe during the last 150 years. The timing of the process has, however, varied. On the Iberian peninsula, the organisation of population statistics came later than in the north western parts of the continent and social change has been relatively slow. Data on *Portugal,* presented by *Teresa Rodrigues Veiga et al.*, show that most of the mortality decline in that country did not start until the end of the nineteenth century. Little industrialisation, a slow growth of the economy and a climate that is favourable for certain infectious diseases are some explanations why the mortality decline did not start earlier. In spite of a lesser degree of industrialisation, however, big waves of migrants and urbanisation created serious sanitary and health problems in the cities, familiar to what happened in pre-industrial Sweden during the first half of the same century.

For a long time during the nineteenth century, the organisation of welfare and health in Portugal was still not centralised in the hands of secular public authorities to the same extent as in for instance France. Religious institutions were still responsible for a large part of these duties, which may have provided the State with a reason to pay more attention to colonial matters than its interior affairs. Political instability and periods of autocratic government also contributed to a situation that did not favour mobilisation, at all levels, for the population's health problems. Instead resources focused upon military spending and need to invest in an apparatus for political and social control.

Mortality started to decline in Portugal after 1900, but it was still comparatively high by the middle of the twentieth century. The new political regime during the last quarter of that century coincides with a re-direction of the policy towards a welfare system more similar to the one in other Western European countries. Portugal's integration into the European Union is another potential reason for the remarkable improvement that has taken place economically, socially and demographically. Life expectancy for women is today at the same level as in the rest of the Union, while it lags behind with a few years for men. The case of Portugal needs further investigation and analysis before it is possible to give a more precise explanation for this progress. It does, however, show that rapid social change does not necessarily have to cause a health crisis. The commitment of public institutions to invest in the protection and support of potential losers is, according to all examples in this volume, a way to smoothen the path of transition. If politics can enhance social cohesion, stability and trust in the society, the negative effects may also be less severe.

The last case in this volume consists of a discussion by *Bruce Fetter* about aspects of health and social change in the *United States* since the 1880s – "a mixed system and a mixed blessing" according to the author. Between 1880 and 1930 life expectancy increased rapidly, mainly due to reduced infant and child mortality. US cities were as unhealthy as European ones during the period of heavy in-migration and the urban-rural divide was large at the beginning of the period. The medical profession was, according to Fetter, less well educated than its European colleagues and the main reason for the improvement was public health reforms, particularly improving the cities' infrastructure for water supply, sewerage and waste disposal. The engagement of the federal government and the states in welfare and health supply was very limited compared with Europe but numerous voluntary associations helped to maintain social security for its members. The crisis came during the great depression of the 1930s when unemployed members were unable to pay the fees, paving the way for the Social Security Act of 1935 and the State accepted greater responsibility. The weakness of the system was, consequently, that it worked reasonably well for those who had jobs and could invest in their own health, but less well for the most vulnerable populations. This is clearly seen in the

mortality divide between whites, with the most favourable figures, versus Afro-Americans and Latin-American immigrants. During the early years of the period, the difference was dramatic and it was still there at the end of the period, even if it had become smaller. Overall all groups benefited, but some won more than the others.

Life expectancy has continued to rise in the U.S. during the twentieth century, mainly because of mortality declines in the ages 5 to 50 (later above 50). The ethnic divide between whites and black still exists, especially among male adults. Even average life expectancy of whites is lower than what would have been assumed in the world's wealthiest nation. Wilkinson and others have seen this as a proof that relative inequality in the distribution of wealth, independent of the absolute per capita levels, may be a threat even for the wealthy. A constant health problem still exists in poor uprooted communities, where the social cohesion and political voices are weak. Today, Latin-American immigrants represent a striking contrast. Although they do not belong to the wealthiest part of the population with possibilities to invest in the most sophisticated health care, their mortality equals that of the white population. A selection of the strongest among these migrants and an underestimation of mortality due to the return of the weak to the homelands before dying have been proposed as potential explanations. It is, however, also possible that these groups carry with them stronger traditions of close social networks and family ties that are supportive for their mental and physical health.

The American social security system is, for those who cannot finance it themselves, based on minimum levels, in contrast to many welfare arrangements in Europe. Medicare and Medicaid provides for the solution of this goal with some unattended "white spots". Private solutions remain as the major option for the middle class. North America has, on the one hand, been able to receive an unprecedented flow of immigrants and integrate them successfully in a new affluent society. Private and voluntary solutions have been seen as the first option compared with the European model of public supply of welfare and health. Fetter's perspectives indicate that the system works best for those who are a bit above the level of subsistence, while the access to welfare and health is not yet solved for many descendants of a population once brought there without its own consent.

Hence, certain common themes tend to emerge in the cases histories. First of all, there is, as expected, a close connection between the welfare and material resources of a certain population, or groups within it, and health. However, periods of rapid social change disrupt the equilibrium, including the distribution of these resources, usually to the detriment of those who have the least abilities to adapt to the new socio-economic situation. Even processes that we find positive in the long run may in periods of transition, produce losers. This has been the case in the former socialist states in Eastern and Central Europe and in South Africa during the last decades. Political freedom needs time to establish its institutional frameworks for

social safety. Legacies of a difficult past do not disappear overnight. Adaptations to new economic systems take time and need new solutions. In the meantime, unequal competitive resources among nations and individuals cause painful structural effects. China has consciously taken a more controlled path towards the opening of its country to the new economy, but even there we find winners and losers. The Czech case indicates that possibilities to keep certain safety nets in a reformed version and the preservation of social cohesion during the transition may reduce the transitional costs.

Early nineteenth century Sweden, Great Britain and France faced another transition from the predominantly agrarian ancient regime to an industrialised and urbanised society during the nineteenth century. In all three cases, this did not occur without social problems. In Sweden, industrialisation came later than the proletarianisation of the countryside and the first wave of urban immigration. The national and local government was intact and managed to implement certain improvements for the survival of children and women but uprooted poor families were still exposed to tuberculosis and other infectious diseases. Many middle-aged men did not manage to cope with the uncertainty of life. A second short period of mortality crisis occurred during the fist industrial boom after the middle of the century. Overcrowded areas of migrants were unhealthy places, especially for children and women, like problems that had already occurred half a century before in Great Britain and France. In all three cases the history was similar during the last decades of the nineteenth century: a hygienic movement among medical doctors and public professionals, an increased ideological concern for the improvement of social conditions in the cities based either on fear of socialism or human compassion, technical systems for sanitation and the successive mobilisation of the new industrial classes for their interests and protection. Many roots of the welfare state were planted before the advent of the twentieth century.

This trend was universal in the wealthy parts of the world with certain lags and peculiarities depending on the economic and political situations in different countries. It was a convergence towards the increased involvement of the state and – maybe less recognised – gave a paramount role to local communities in the protection of social security and health. It helped to double the average life expectancy of men and women during the last 100-150 years.

Table 1 compares three very different historical and geographical contexts presented in this book. It summarises empirical patterns of profound social change observed in early 19th century Sweden versus contemporary Russia and South Africa. The Swedish process was mainly initiated and driven by demographic growth and a changing socio-economic system. In Russia and South Africa, the stagnation and crisis started because of political and economic dysfunctions in oppressive states. The negative effects outlived the old systems and even accelerated in some respects. The mortality crisis in Sweden only affected adult men, since the

stability of central government and local administration offered a way to assimilate new ideas about improvements propagated by enlightened pioneers of public health interventions. In Russia many public institutions are still under reconstruction. South Africa's institutional infrastructure was taken over by a democratic government with good will and representing the majority population. Both in Russia and South Africa, these agencies on central and local levels have to struggle with limited financial resources, unemployment, social inequalities, mass migration and the terror of HIV/AIDS (a growing threat in Russia as well) and other infectious diseases.

In all three cases, a mortality crisis occurred among young and middle aged men, maybe the most visible sensitive "thermometer" during periods of rapid social change. Expected to be the primary breadwinners and more exposed to unhealthy lifestyles due to the gender system, they became the vulnerable sex. Women were and are, of course, equally affected by poverty and exposure to infectious disease, but their gender roles tend to act as a protective "vaccine" against certain lethal health risks. The traditional position as caring and forming networks in the closest life circles is said to help them to find positive social capital among kin, neighbours and friends instead of looking for it at pubs or living out their agonies through drugs and serious violence.

However, even women can of course live out their frustration in unhealthy ways and patriarchal power structures can put them in situations they cannot control. The HIV/AIDS epidemic exposes women's lack of control over their own sexuality in patriarchal societies. They are forced into unwanted and unprotected sex within and outside marriage. The weak labour market and total poverty force some women into prostitution although they are aware of the almost certain fate of contracting a mortal disease. The immediate need for survival next day of oneself and one's offspring is paramount to risks that may materialise months or years ahead.

The time horizon for the realisation of vital goals becomes very short for vulnerable groups during rapid social change, which explains behaviours that seem irrational to those who are in better positions to make choices.

Many theoretical perspectives can be applied on the findings. One important aspect would be to try and understand how different resources, essential for health and welfare, are produced and reproduced and how selective mechanisms create winners and losers. Certain patterns are clearly seen - with variations depending on specific epidemiological, economic, cultural and political contexts. First of all, *class differences* made themselves seen in the mortality figures. Further more, transformation of one's way of life from old norms and structures to new circumstances is evidently difficult for young and middle-aged men in many cases. This is confirmed in early nineteenth century Sweden and in Russia and South Africa today. A large part of this surplus mortality is caused by *gender* in the form of male behaviour – excessive drinking, heavy smoking, drug abuse, violence or other

Table 1. Social change in 19th Century Sweden, Russia and South Africa today

Factor	**Early 19th C. Sweden**	**Russia**	**RSA**
Political change	Moderate	Yes	Yes
Economic & Social Change			
Changes in production	Yes	Yes	Yes
Changes in agriculture	Yes	Yes	Yes
De-industrialization	No industrialisation yet	Yes	Yes
Employment crisis	Yes	Yes	Yes
Pauperization	Yes	Yes	Yes
Increased inequality	Yes	Yes	Yes
Welfare provision crisis	Yes	Yes	Yes
Demographic Change			
Population size	Up	->down	->down
Migration to cities	Yes	Yes	Yes
Infant & child mortality	Down	Stable?	->up
Adult female mortality	Down	Up	Up
Adult male mortality	Strongly up	Strongly up	Strongly up
Family/household structure Crisis	Crisis	Crisis	
Epidemiological change			
STD's/HIV	STD's high	Up	Up
Tuberculosis	High	Up	Up
Other infectious diseases	High>down	Low>up	High>?
Health differentials			
By gender	Yes	Yes	Yes
By marital status	Yes	Yes	Yes?
By class/ethnicity/"race"	Yes	Yes	Yes
By region	Yes	Yes	Yes
Urban/rural	Yes	Yes	Yes?
Socio-cultural change			
Uprooted societies	Yes	Yes	Yes
Norm crisis	Yes	Yes	Yes
Social losers`	Yes	Yes	Yes
Abuse of alcohol and drugs	Up	Up	Up
Violence	Up	Up	Up
Juvenile delinquency	Up	Up	Up
Other crimes	Up	Up	Up
Summary			
Political change	Moderate	Yes	Yes
Economic & social change	Yes	Yes	Yes
Demographic change	Yes	Yes	Yes
Epidemiological change	Yes	Yes	Yes
Health differentials	Yes	Yes	Yes
Socio-cultural change	Yes	Yes	Yes

types of risk behaviour. *Sheila Ryan Johansson* talks about '*positive and negative rights*' as two concepts, which can help us to understand how these roles and resources have an impact on health (Johansson 1991). Rights can be seen as privileges: economic, cultural and social resources invested in men or women through gender roles. Positive rights are resources enhancing health. They do, for instance, provide the means to buy clothes, a decent house and food. They are also enhancing the knowledge about healthy and unhealthy food and other substances (narcotics, alcohol and tobacco) and other habits that are a "gift" from one's cultural and social milieu and upbringing. Negative rights can, on the other hand, consist of possibilities to consume too much food or to buy unhealthy drugs. In that sense, gender and health become parts of a complex net in a specific cultural and socio-economic context.

Men usually control larger shares of economic capital than women, either directly as private owners or indirectly through their dominance in economic and political affairs. In spite of that, male surplus mortality has to a great extent been caused by negative gender factors. Male roles and resources invite them to get involved in many risks – wars, automobile accidents and 'rash' lifestyles. Female subordination often reduces their access to food and other material goods, but their roles as the prime caretakers of children and family tend to foster a more careful and healthy lifestyle. In the era of HIV/AIDS, though, the protective effect of such roles is being overwhelmed by gender power imbalances leading to high female levels of infection.

A possible insight into these mechanisms is maybe open by examining the reasons for the particularly high mortality amongst unmarried men. One reason might be *the selective factor*: Just because they suffer from bad health or their behaviour makes them less attractive on the marriage market, certain persons may be unmarried, never married or divorced. That factor might be part of the truth, especially if unhealthy male lifestyles are also correlated with the possibility of being married. Men with alcohol problems or other risky behaviours could, for instance be less successful in finding a willing partner or be left with candidates who share their lenient attitudes towards health. The mortality disadvantage of unmarried persons (especially males) tends to increase from age 20 to age 45, which could be a sign that the least healthy individuals are "left over" on the marriage market. The high mortality of widows and widowers could of course also depend on some negative factor common for both themselves and their partners.

The increasing unmarried/married mortality ratio over age can, however, also depend on the delayed mortality effect of lifestyles that are an effect of being unmarried or emanate from psychosocial problems caused by traumatic experiences of becoming divorced or widows/widowers. *Emile Durkheim*, the father of modern sociology, claimed that marriage strengthens male *social control* and gives them a feeling of *responsibility* as breadwinners and protectors of their families (Durkheim

1991). The marriage ritual signifies a step into a more positive social role and a supportive network. In Durkheim's eyes, the marriage is also providing '*meaning*', a positive goal in life beyond the individual self. Females are already before marriage educated to become the responsible and caring part, more self-controlled and taught practical skills, valuable for the everyday survival. Historical and contemporary studies have also shown that females are often "administrating" the more intimate part of the family's social networks, while men are in charge of the "business side". In times of crisis, women seem to be more trained in finding improvised solutions in collaboration with other women.

Both the selection on the marriage market and the benefice of marriage are plausible and complementary explanations of the low mortality rates for married persons. In many societies, the successful man has to find a woman, have children, protect and support the family. Not living up to that role indicates a lack of social status. That would explain why adult male mortality increases during periods of social change, especially among the non-married with the weakest social networks. They run the risk of compensating by association to subcultures where drug abuse, alcoholism and violence are common. It is therefore logical to expect that the social and medical problems start to become visible at the ages when men are trying to establish themselves on the labour market and become husbands. In urban areas, where social change is often – but not uniquely - manifested in the forms of in-migration, uprooted societies, anonymity, diversity of norms and a choice of more or less healthy lifestyles, some male groups tend to loose out.

A common concept to describe the negative health consequences of social pressure is "*social stress*". It signifies the negative psychosocial effects upon individuals, groups and societies by living through these kinds of pressure. For individuals, it can result in psychological and physiological health problems, reduced capacity to cope with difficulties, frustration, lack of hope for the future, violence, drug abuse, etc. Using Durkheim's term, social and political systems and discourses can be affected by '*anomie*', a negative consequence of change. In former communist Europe after the fall of the Berlin wall in 1989, many respondents feel the pressure of unemployment. They are also expressing a pessimistic view concerning the government's ability to promote better times, neither the political system of the past nor the new regime, squeezed between the need to support the welfare system and the demands to keep a strict public budget in an economy in tough competition on the global market. The result is pessimism caused by forces people feel are outside their influence. Frustration emanating from great hopes for rapid improvement and slow progress may also result in similar feelings in countries like South Africa, even if it is not the name people would normally put on their problems.

Biomedical research has recently become interested in this intriguing connection between social structures, social stress, psychosocial reactions and biological

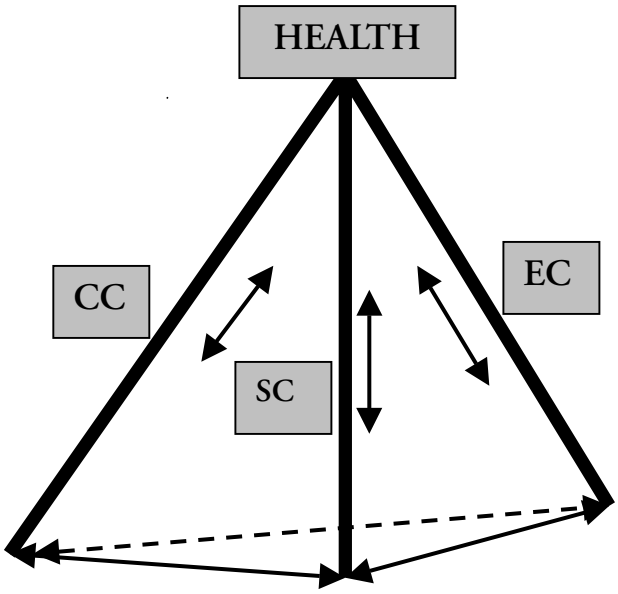
responses, which even leads to serious physiological health problems. We may see it as the link between biography and biology. It is well known that depression affects the immune system negatively, thereby increasing the risk of infections and probably also the risk of diabetes and cancer. Stress has, since long, been seen as one of the causes of gastro-intestinal problems, stroke and different types of cardiovascular diseases among adults. The first signs of a dysfunction may be aggressiveness due to frustration, but in the end vital exhaustion, passiveness and depression emerges, a theory that has been supported by recent studies. The biological link provides us with a reasonable explanation why there is a connection between psychosocial reactions and health risks over a wide scale. The documented risks of drug abuse, alcoholism, frustrated aggressiveness or passive ignorance of normal care of one's own person that are significant for many cases of stress and depression, increase the number of health problems, many of which have been labelled as caused by lifestyles.

Problems of inequity and lack of resources for a healthy life tend to reproduce themselves for long periods from generation to generation. Long after the abolition of slavery, only part of the population with ethnic roots in Africa enjoys the same safe lives as the average North American. *Legacies* of colonialism and apartheid cast their shadows over the majority population in democratic South Africa. These are drastic examples, but "the social heritage" is also having an impact upon other vulnerable populations. The transfer of material resources from generation to generation is of course one of the reasons. Other than purely material factors must, however, also be understood in order to explain the still unsolved issue of inequality and health even in welfare states.

The French sociologist *Pierre Bourdieu* was contemplating the fact that the new generations of wealthy and influential elites were mainly recruited from the same source as the previous ones. His conclusion was that there are, besides with economic resources immaterial resources (capital) that help to produce this result. For Bourdieu, "c*ultural capital*" is "knowledge", even knowledge by doing or "tacit knowledge" provided by upbringing and life experiences. It is knowledge of "how things are or work" in practice or in the dominant perceptions among the people around you or – if you belong to the self-appointed elite – among "the people that matter" in a specific context. In relation to health it can for instance be the obvious advantages of knowing how to feed a child properly or, in general, to have access to the best available information how to protect one's health. Cultural capital is not shaped in individual vacuum. It is provided by formal institutions and family, but also by other informal groups or networks from the cradle to the grave of each individual: voluntary associations, churches, trade unions, political parties, social clubs, neighbours, friends, colleagues at work, and other networks.

This explains why cultural capital is so closely linked to what has been called "*social capital*", Bourdieu's second major concept. Social networks can provide a

Figure 1. Health, economic capital (EC), cultural capital (CC) and social capital (SC)



CC = cultural capital; SC = social capital; EC = economic capital.

feeling of "belonging" (as opposed to isolation), identity, security and therefore also more self-confidence. Shared cultural capital, homogenous norms and beliefs tend to strengthen networks and contribute to mutual trust, a valuable asset for individuals and social coherence. However, it can be hurt, erode and disappear for an individual, for a social group or for a whole society, when the social fabric changes.

In conclusion, the social fabric affects the health of human beings through a process where economic capital, cultural capital and social capital interact with psychosocial and biological mechanisms in a certain epidemiological context. Socio-economic change intervenes in these processes with a capacity to either strengthen or weaken the health of individuals and populations. When putting the different human resources together in a simple model, we have to return to health as the first resource or capital (*Figure 1*). Health is an important – sometimes the most important - resource for the individual. A healthy population is essential for the wealth of families, local communities and nations. Bad health means less productivity and increased expenditure in care and cure independent of who is paying the bill – the individual herself, the family, local community or the state. If health is preserved, work and money can be used for other urgent items, necessary for people's well being.

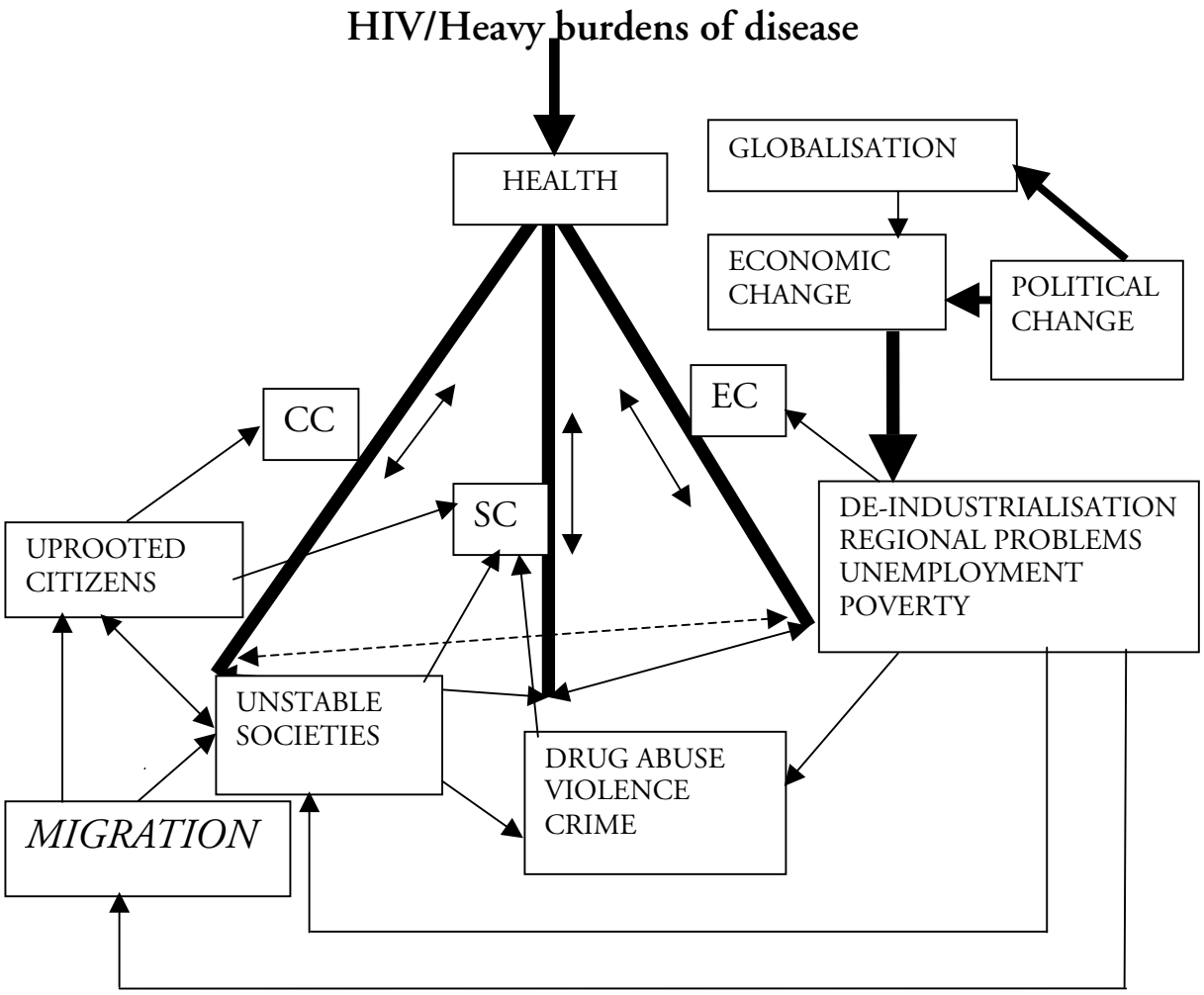
Robert Putnam, an American political scientist*,* turned his attention towards local communities, social networks and their impact on effective political life and a healthy milieu for economic progress. He interpreted the results as proof that social

networks and social capital further trust and a general willingness to collaborate in matters of importance for the local society. Comparing different places in the US, he finds evidence that trust, political participation and even health are positively correlated with the degree of social networking and social capital – in communities and among individuals. Putnam distinguished between two forms of social capital, the first being '*bonding social capital*', characteristic of socially and culturally homogenous groups where the network's first objective is to strengthen the identities and interests of its members. The early modern artisans' guilds in Europe can be used as a typical example of bonding capital, trying to preserve their interests and excluding others from their privileges. Bourdieu's cultural and social capitals can mostly be seen as representations of the 'bonding' typ. There are, however, according to Putnam, other networks, which are creating '*bridging social capital*'. These networks consist of less homogenous groups with limited objects and lesser attachment to specific values, for instance citizens in a local community taking care of the playing ground of their children, a bridge club or a sports club. They increase feelings of mutual belonging to the greater society and create an atmosphere of open-mindedness to other groups, values and ways of living.

One of the contributors to this volume, *Simon Szreter* (Szreter 2003) has pointed at the potential negative effects of bonding capital, for instance organizations aiming at goals of exclusion. He also questions the potential positive strength of bridging social capital, especially if class differences are taken into consideration. Instead, he gives more credit to '*linking social capital*' established by networks, associations and institutions sharing common ideologies. Bonding and bridging social capital work horizontally, while linking social capital is "vertical": Those who have help those who do not have. Politics and public authorities on all levels can participate in linking social capital. In order to be truly beneficial for the whole society, even informal networks and voluntary associations need to act according to an idea of equality and compassion with fellow citizens of different kinds. According to this view, politics and public and private institutions can play a role to create – or undermine – social capital for those who need it, but ideology will be an important part of the process. To conclude, political and voluntary institutions can influence

- The distribution of economic capital
- The forms, quantity and quality and distribution of cultural capital
- The forms, strength and distribution of social capital
- The quantity, quality and distribution of health care and other health services

Figure 2. Health, resources and social change – Russia and South Africa.



CC = cultural capital; SC = social capital; EC = economic capital.

Politics and institutions can, by acting or being passive, to a considerable extent decide the forms and consequences of economic and social change. Linking social capital can therefore have an impact on all parts of the health pyramid. Politics and institutions are tools, accessible and beneficial for different groups and individuals to a lesser or greater extent. It can be used – by legal instruments or in praxis – in order to direct resources (or other forms of capital) in the interest of different groups for more or less altruistic goals.

Figure 2 depicts some important elements affecting people's different types of resources (capital) that will be described in the case studies of dramatic social change in Russia and South Africa. With slight alterations and adjustment of the magnitude, it can also illustrate the situation in Sweden about 200 years ago. The economic, cultural and social capital is endangered for large groups in the society. People themselves and public authorities have problems to keep pace with the process: building houses, providing electricity, water, sewerage, health care, etc.

Consequently, the health situation is in danger. HIV/AIDS, tuberculosis and a generally heavy burden of disease are external epidemiological factors making the situation even more complicated from a health perspective, a progressively growing concern for Russia as well. The loop is complete when deteriorating health reduces the productive strength of present and future generations. Most evidently, this is seen in the growing dependency ratio created by premature deaths from AIDS and dangerous lifestyles.

In the following case stories, the authors fear neither figures nor qualitative entities when composing their accounts. Together they show the ways in which good and bad legacies from the past are setting the scene for the present and the future. As expected, they demonstrate that economic resources are very important for health. But, especially when the economic capital is limited in weak economies, other resources are also essential. Health can be badly hurt or it can be protected, restored or enhanced by the distribution of the society's cultural and social resources. These resources are not automatically distributed in an egalitarian way. Instead they tend to be reproduced from generation to generation within the same privileged groups. Politics and wide grass-root participation in public affairs can empower individuals and vulnerable groups, making it possible for them to get the proper resources in order to fulfil their vital goals. Popular participation, engagement and social coherence have proved to be pivotal for success, especially when activated on the local level. One essential task for central governments is therefore to have the will and knowledge to establish trust and empower local societies so that they can fulfil this role.

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