

Title

Infusing fundamental cause theory with features of Pierre Bourdieu's theory of symbolic power

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Abstract

The theory of fundamental causes is one of the more influential attempts to provide a theoretical infrastructure for the strong associations between indicators of socioeconomic status (education, income, occupation) and health. It maintains that people of higher socioeconomic status have greater access to flexible resources such as money, knowledge, prestige, power, and beneficial social connections that they can use to reduce their risks of morbidity and mortality and minimize the consequences of disease once it occurs. However, several key aspects of the theory remain underspecified, compromising its ability to provide truly compelling explanations for socioeconomic health inequalities. In particular, socioeconomic status is an assembly of indicators that do not necessarily cohere in a straightforward way, the flexible resources that disproportionately accrue to higher status people are not clearly defined, and the distinction between socioeconomic status and resources is ambiguous. I attempt to address these definitional issues by infusing fundamental cause theory with features of a well-known theory of socioeconomic stratification in the sociological literature – Pierre Bourdieu’s theory of symbolic power.

Commentary

Strong associations between indicators of socioeconomic status (education, income, occupation) and individual health are plentiful in the social determinants of health literature [1-4]. The theory of fundamental causes proffered by Bruce Link and Jo Phelan [5-9] is one of the more influential attempts to provide a theoretical infrastructure for these associations. Fundamental cause theory maintains that people of higher socioeconomic status (SES) have greater access to flexible resources such as money, knowledge, prestige, power, and beneficial social connections that they can use to minimize or avoid risks of morbidity and mortality and minimize the consequences of disease once it occurs. The application of these resources affects multiple disease outcomes through multiple risk factor mechanisms, and, importantly, the mechanisms linking resources to a specific disease outcome change over time as the proximal risk factors that affect the development of the disease are replaced by others. These tenets make SES a “fundamental” cause of disease. To date fundamental cause theory has been enthusiastically applied to a variety of diseases in a wide range of contexts [10-21].

The distinction between SES and flexible resources is foundational to fundamental cause theory: the persistence of associations between indicators of SES and morbidity/mortality is the problem and the application of flexible resources by higher status people is the solution to the problem. However, SES and resources are both underspecified in the theory. First, as others have previously noted [22-24] the notion of SES is an assembly of disparate indicators that do not necessarily cohere in a straightforward way. Accordingly for a given disease there is no obvious reason to focus on one indicator instead of another and the causal storyline for one indicator could be very different from that for another. Second, the resources that disproportionately accrue to higher status people are insufficiently theorized [25,26]. In particular, the flexible resources

catalogued by fundamental cause theory cannot all be clearly distinguished from one another, e.g., money, knowledge, prestige, and beneficial social connections can all be forms of power and the possession of wealth or knowledge can be prestigious. This conceptual ambiguity obscures the contributions of specific resources to causal processes linking SES to health. Third, the distinction between SES and resources is also ambiguous. For example, occupational prestige (an indicator of SES) is a subset of prestige in general (a resource), and income (an indicator of SES) and money (a resource) are much the same thing. More systematic definitions of socioeconomic status and resources would help to identify the full range of flexible resources available to higher status people and provide insight into the ways in which they are wielded to mitigate risk of disease.

One way of addressing these definitional issues is to jettison the notion of SES and focus exclusively on associations between singular resources and disease outcomes. To the degree that educational credentials and monetary income are flexible resources one could argue that much of the research inspired by fundamental cause theory implicitly adopts this approach. For example, Chang and Lauderdale's [12] finding from the United States that income disparities in cholesterol levels were positive before the era of statin use and negative afterwards is consistent with a causal explanation for cholesterol disparities based upon the application of flexible monetary resources to procure access to statins. Studies which report that associations between education and preventable causes of mortality are typically stronger than those between education and less preventable causes of mortality [7,10,19,20] are consistent with causal explanations that focus on the flexible application of prestigious academic credentials and/or knowledge obtained from educational experiences to produce good health and avoid illness. There are evident advantages to this strategy: it is analytically straightforward, resources can be considered in isolation of one another, and there is no urgent need for an accompanying theory of socioeconomic stratification.

Another strategy is to meld fundamental cause theory with a theory of stratification that carefully distinguishes between resources and socioeconomic status (or position). Some contending theories are Anthony Giddens' class structure theory [27], Erik Olin Wright's theory of contradictory class locations [28], John Goldthorpe's class schema [29], Kim Weeden and David Grusky's new class map [30], and Pierre Bourdieu's theory of symbolic power [31-34]. Of these Bourdieu's theory is perhaps the best suited to informing fundamental cause theory: it offers a coherent suite of resources that substantially overlap with the flexible resources delineated by fundamental cause theory, it provides a conceptualization of socioeconomic status that is not conflated with singular resources, and it offers a sophisticated means of dissolving the stark divide between individual agency and social structure that characterizes most health research [35]. The theory is primarily concerned with explicating the logic of *practices*. For Bourdieu, practices are purposeful albeit not always consciously so. They are interconnected with *habitus*, embodied dispositions that shape the practices; *fields*, systems of social positions with their own internal logics within which the practices attain meaning; and *capitals*, the material and symbolic resources for purposive action within fields that also position people in them. Society is comprised of many fields of struggle, e.g., the political field, the economic field, the scientific field, the literary field, and the religious field, each with its own habitus, capitals, and practices. Interpenetrating all of these fields, however, is the *field of power*, an overarching social space that shapes these other fields to greater or lesser extent but is also collectively shaped by them. It is in the field of power that positions are *class positions* and where the inhabitants of collections of these positions have the potential to form social classes, according to Bourdieu [32,34].

What might a fundamental cause theory informed by Bourdieu's theory of symbolic power look like? First, the Bourdieusian concept of capital could be used to theorize the range of flexible

resources available to people in social life. *Economic capital* is comprised of money and resources such as property that can be easily and directly converted into money. Highbrow cultural tastes and inclinations, lasting dispositions of mind and body, are *embodied cultural capital* while the possession of valued cultural goods is *objectified cultural capital*. Educational credentials, certificates of cultural competence, are *institutionalized cultural capital*. *Social capital* refers to resources embedded in social relationships – access to the capitals of others – that can be mobilized by an individual to pursue her goals in a field. Lastly, *symbolic capital* is any form of capital that is rooted in relations of power and domination but widely perceived to be legitimate and meritorious. For Bourdieu, these broadly conceived types of capital are all at play in the field of power and, in transformed form, in many or most of its subfields. So far so good. Flexible resources conceived of as capitals are not overly dissimilar to their original descriptions in fundamental cause theory and overlapping forms of capital are explicitly theorized: money is economic capital, certain kinds of knowledge are embodied cultural capital, some beneficial social connections are social capital, all forms of capital are instantiations of power, and all forms of capital that are misrecognized as legitimate in a particular context are also (prestigious) symbolic capital. This approach does, however, require distinguishing between resources that are widely valued manifestations of power in a given society, such as educational credentials or monetary income, and resources of a more prosaic (and less flexible) kind, such as knowledge about vaccines [16] or how to procure statins [12]. Presumably the latter would not be considered flexible resources from this perspective.

Second, SES could be replaced by position in the field of power. According to Bourdieu, the field of power is a multidimensional social space within which people are positioned relative to one another by virtue of their portfolios of the dominant capitals in a society. For example,

Bourdieu claimed that class positions are arrayed along the primary dimension of the French field of power by their total volumes of economic capital and cultural capital and along a secondary dimension by their relative compositions of these two forms of capital [32,34]. The upper class therefore possesses large amounts of both economic and cultural capitals while the lower class possesses little capital of either kind. However, greater wealth corresponds with relative advantage within classes, especially in the upper class part of the field where the wealthy industrialists dominate the intelligentsia high in cultural capital. The British field of power depicted by Mike Savage and colleagues [36] has high levels of economic and cultural capitals coalescing in a single class grouping at the top of the field of power and low levels of economic and cultural capitals joining in a single class grouping at the bottom, with several middle-class groupings characterized by their relative compositions of these forms of capital located between them. Patrick John Burnett and Gerry Veenstra [37] find that class positions are arrayed vertically in the Canadian field of power by their sum totals of economic and cultural capitals but that the relative composition of these capitals plays no role in structuring the field.

The diverse particularities of fields of power notwithstanding, measuring class position clearly requires measuring all of the relevant resources held by a person, and no resource can be examined in isolation of the others when investigating associations between class position and disease. The multidimensionality of a field of power also means that class positions are not necessarily arrayed linearly from high to low, which could represent a challenge for researchers accustomed to modeling “the gradient.” A greater challenge comes from the fact that explaining empirical associations between class position and disease requires investigation into the dynamics of the field of power [36,37]. Here the habitus and spillovers metamechanisms of fundamental cause theory described by Jeremy Freese and Karen Lutfey Spencer [25] come into play. The

habitus metamechanism refers to processes by which embodied dispositions (habitus) that generate healthy or unhealthy lifestyles become unequally distributed among class positions. It involves examining those field-specific processes whereby higher status people develop a habitus, a sense of what is right and natural for people like them, which is good or perhaps bad for their health. The spillovers metamechanism refers to processes by which higher status people achieve better health due to spillover benefits from the purposive actions of others in their social networks. It involves examining the health effects of network ties between people located near each other in the field of power. Both metamechanisms require attending to the health effects of features of different parts of social structures (fields) rather than the individual-level effects of applying a resource to some personal health-related end.

In conclusion, I suggest that fundamental cause theory needs clearer theoretical depictions of socioeconomic status and flexible resources before it can provide truly compelling explanations for socioeconomic health inequalities. Injecting features of Pierre Bourdieu's theory of symbolic power into fundamental cause theory produces functional definitions of resources (by way of capitals) and socioeconomic status (by way of position in the field of power) as well as a theoretically informed depiction of the relationship between them. From this hybrid perspective, causal pathways linking a given resource to a health-related outcome and linkages between the contextual specificities of class positions in the field of power and the health of the inhabitants of the positions can all be investigated. A fundamental cause theory informed by Bourdieu's theory of symbolic power might therefore have the following foundational tenets: Fundamental cause theory maintains that resources such as money, valued knowledge and credentials, and beneficial social connections, all manifestations of power in social life, are unequally distributed in society. Portfolios of these resources configured in particular ways minimize risks of morbidity and

mortality and curtail the negative consequences of disease once it occurs. The possession of these sets of resources affects multiple disease outcomes through multiple mechanisms, and the mechanisms linking the resource portfolios to a disease change over time as the proximal factors that affect the development of the disease are replaced by others.

References

- [1] Adler N, Buch NR, Pantell MS. Rigor, vigor, and the study of health disparities. *PNAS* 2012; 109: 17154-17159.
- [2] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: what the patterns tell us. *Am J Pub Hea* 2010; 100: S186-S196.
- [3] Braveman PA, Egerter S, Williams DR. The social determinants of health: coming of age. *Ann Rev Pub Hea* 2011; 32: 381-398.
- [4] Matthews KA, Gallo LC. Psychological perspectives on pathways linking socio-economic status and physical health. *Ann Rev Psy* 2011; 62: 501-530.
- [5] Link BG, Phelan JC. Social conditions as fundamental causes of disease. *J Hea Soc Beh* 1995; 35: 80-94.
- [6] Link BG, Phelan JC. McKeown and the idea that social conditions are fundamental causes of disease. *Am J Pub Hea* 2002; 92: 730-732.
- [7] Phelan JC, Link BG, Diez-Roux A, Kawachi I, Levin B. “Fundamental causes” of social inequalities in mortality: a test of the theory. *J Hea Soc Beh* 2004; 45: 265-285.
- [8] Phelan JC, Link BG, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy conditions. *J Hea Soc Beh* 2010; 51: S28-S40.
- [9] Phelan JC, Link BG. Fundamental cause theory. In: Cockerham W, ed. *Medical Sociology on the Move: New Directions in Theory*. Dordrecht: Springer Netherlands; 2013: 105-125.

- [10] Phelan JC, Link BG. Controlling disease and creating disparities: a fundamental cause perspective. *J Gerontol B Psychol Sci Soc Sci* 2005; 60: S27-S33.
- [11] Olafsdottir S. Fundamental causes of health disparities: stratification, the welfare state, and health in the United States and Iceland. *J Hea Soc Beh* 2007; 48: 239-253.
- [12] Chang VW, Lauderdale DS. Fundamental cause theory, technological innovation, and health disparities: the case of cholesterol in the era of statins. *J Hea Soc Beh* 2009; 50: 245-260.
- [13] Rubin MS, Golen CG, Link BG. Examination of inequalities in HIV/AIDS mortality in the United States from a fundamental cause perspective. *Amer J Pub Hea* 2009; 100: 1053-1059.
- [14] Willson A. 'Fundamental causes' of health disparities: a comparative analysis of Canada and the United States. *Int Soc* 2009; 24: 93-113.
- [15] Wang A, Clouston S, Rubin MS, Golen CG, Link BG. Fundamental causes of colorectal cancer mortality: The implications of informational diffusion. *Mil Quar* 2012; 90: 592-618.
- [16] Polonijo AN, Carpiano RM. Social inequalities in adolescent human papillomavirus (HPV) vaccination: a test of fundamental cause theory. *Soc Sci Med* 2013; 82: 115-125.
- [17] Saldana-Ruiz, N., Clouston, S., Rubin, M.S., Golen, C.G., Link, B.G. Fundamental causes of colorectal cancer mortality in the United States: Understanding the importance of socioeconomic status in creating inequality in mortality. *Amer J Pub Hea* 2013; 103: 99-104.
- [18] Rubin MS, Clouston S, Link BG. A fundamental cause approach to the study of disparities in lung cancer and pancreatic cancer mortality in the United States. *Soc Sci Med* 2014; 100: 54-61.

- [19] Mackenbach JP et al. Variations in the relation between education and cause-specific mortality in 19 European populations: a test of the “fundamental causes” theory of social inequalities in health. *Soc Sci Med* 2015; 127: 51-62.
- [20] Masters RK, Link BG, Phelan JC. Trends in education gradients of ‘preventable’ mortality: A test of fundamental cause theory. *Soc Sci Med* 2015; 127: 19-28.
- [21] Clouston SAP, Rubin MS, Chae DH, Freese J, Nemesure B, Link BG. Fundamental causes of accelerated declines in colorectal cancer mortality: modeling multiple ways that disadvantage influences mortality risk. *Soc Sci Med* 2017; 187: 1-10.
- [22] Deaton A. Policy implications of the gradient of health and wealth. *Hea Aff* 2002; 21: 13-29.
- [23] Lahelma E, Martikainen P, Laaksonen M, Aittomaki A. Pathways between socioeconomic determinants of health. *J Epi Com Hea* 2004; 58: 327-332.
- [24] Braveman PA, Cubbin C, Egerter S, Chideya S, Marchi KS, Metzler M, Posner S. Socioeconomic status in health research: one size does not fit all. *JAMA* 2005; 294: 2879-2888.
- [25] Freese J, Lutfey K. Fundamental causality: challenges of an animating concept for medical sociology. In: Pescosolido BA, Martin JK, McLeod J, Rogers A, eds. *Handbook of the Sociology of Health, Illness, and Healing. A Blueprint for the 21st Century*. New York: Springer Science + Business Media; 2011: 67-84.
- [26] Oversveen E, Rydland HT, Bambra C, Eikemo TA. Rethinking the relationship between socio-economic status and health: making the case for sociological theory in health inequality research. *Scan J Pub Hea* 2017; 45: 103-112.
- [27] Giddens A. *The Class Structure of the Advanced Societies*. London: Hutchinson; 1973.

- [28] Wright EO. *Class, Crisis, and the State*. London: New Left Books/Verso UK; 1978.
- [29] Goldthorpe JH. *Revised Class Schema*. London: Social and Community Planning Research; 1992.
- [30] Weeden KA, Grusky DB. The case for a new class map. *Amer J Soc* 2005; 111: 141-212.
- [31] Bourdieu P. *Outline of a Logic of Practice*. Cambridge: Cambridge University Press; 1977.
- [32] Bourdieu P. *Distinction. A Social Critique of the Judgement of Taste*. Cambridge: Harvard University Press. 1984.
- [33] Bourdieu P. The forms of capital. In: Richardson JG, ed. *Handbook of Theory and Research for the Sociology of Education*. New York: Greenwood Press; 1986: 241-258.
- [34] Bourdieu P. *Practical Reason*. Stanford: Stanford University Press. 1998.
- [35] Veenstra G, Burnett PJ. A relational approach to health practices: towards transcending the agency-structure divide. *Soc Hea Ill* 2014; 36:187-198.
- [36] Savage M, Devine F, Cunningham N, Taylor M, Li Y, Hjellbrekke J, Le Roux B, Friedman S, Miles A. A new model of social class? Findings from the Great British Class Survey Experiment. *Sociol* 2013; 47:219-250.
- [37] Burnett PJ, Veenstra G. Margins of freedom: a field-theoretic approach to class-based health practices. *Soc Hea Ill* 2017; 39:1050-1067.