Individualism as Habitus: Reframing the Relationship between Income Inequality and Health

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Abstract

Public health literature has demonstrated a negative effect of income inequality on a number of health outcomes. Researchers have attempted to explain this phenomenon, drawing on psychosocial and neo-materialist explanations. This paper argues, however, that these approaches fail to recognize the crucial role of culture, focusing specifically on the cultural value of individualism. Through a review of the literature and Pierre Bourdieu's theory of practice as a theoretical framework, I provide support for the proposition that an ideology based in individualism is the context within which income inequality, social fragmentation, material deprivation, and consequently poor health outcomes are produced. I further offer recommendations for continued research into the role of cultural determinants in the income inequality-health relationship.

Keywords: *culture; Bourdieu; income distribution; public health*

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I. Introduction

The association between income inequality and health is a widely cited and studied phenomenon in the field of social epidemiology (De Maio, 2012). Much of the literature's focus has also been devoted to understanding its mechanisms. Yet, while a variety of hypotheses have been proposed and tested to explain it, most have neglected to address population-level cultural orientations and their resulting ideologies as basic precursors to this relationship. Namely, the ways in which societies differ in their commonly-held beliefs or perspectives of the world may also be affecting the observed relationship.[1]

Therefore, using Pierre Bourdieu's theory of practice as a theoretical starting point, this paper discusses the role of societal cultural values as underlying causes of the income inequality-health relationship, with a particular focus on the cultural trait of individualism. I argue that—rather than starting with income inequality and tracing its effects on health through the hypothesized pathways of a breakdown of the social fabric or through its more tangible effects—both the occurrence and acceptance of income inequality as well as the social disintegration and structural changes that either follow or precede it are the result of and presuppose a common individualistic ideological stance rooted in culture. Moreover, I discuss the current lack of sufficient attention in the literature to this crucial aspect of society as a determinant of health and also attempt to describe opportunities and challenges for studying cultural factors.

II. Income Equality and Health

Despite some variations in findings, the assertion that income inequality may have negative impacts on health status appears to be widely supported; and evidence also suggests that this link may in fact meet several criteria for a causal relationship and is more than a mere association (Pickett & Wilkinson, 2015). Two predominant viewpoints have emerged to explain the observed relationship between income inequality and health (J. W. Lynch, Smith, Kaplan, & House, 2000). The first of these, which takes a psychosocial approach and is championed primarily by Richard Wilkinson, suggests that social cohesion mediates this effect. Specifically, income inequality is believed to promote a weakening of social ties and cohesiveness within society (R. G. Wilkinson, 1999a). This has been analyzed in terms

[1] To clarify, I assume that cultural values are characteristics of societies or groups of people while ideologies are philosophies or ways in which individuals think. However, these ideologies are heavily influenced and informed by culture. Thus, the two concepts are related. This view is in line with anthropologist Clifford Geertz who considered ideology to be a cultural system (LaCapra, 1988).

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of "social capital" as defined by Robert Putnam, one of its major theorists, based on measures of trust and participation in community groups (Lochner, Kawachi, & Kennedy, 1999; R. G. Wilkinson, 1999a). A similar explanation also suggests that relative differences in income lead people to compare themselves to one another and to other classes; and people's subsequent feelings of deficiency compared to those above them because of these constant comparisons function as a source of chronic stress (Kawachi & Kennedy, 1999). In either case, the understanding is that physiologic effects of stress related to differentials in status along with the rise of anti-social, unhealthy behaviors sparked by this social distance and comparison—such as violence, drug use, and crime—may be at the root of the health effects of inequality (R. G. Wilkinson & Pickett, 2006; Richard G Wilkinson & Pickett, 2009).

The second perspective to explaining the income inequality-health association is the neo-materialist approach promoted mainly by Muntaner and Lynch, which has as its premise that access to forms of capital, the quality of living environments, and expenditures on social services are at the root of the observed relationship (J. Lynch, 2000; J. W. Lynch et al., 2000). Moreover, the proponents of this position also place heavier emphasis on the reasons for income inequality, which hinge on social class divisions, how class affects social cohesion, and political systems (Carles Muntaner & Lynch, 1999; Carles Muntaner, Lynch, & Oates, 1999). These authors also argue that the emphasis on social capital detracts from these structural determinants and places the onus on the individual or groups in terms of health and well-being (J. W. Lynch et al., 2000; Carles Muntaner & Lynch, 1999; C. Muntaner, Lynch, & Smith, 2001). Alternatively, they emphasize an understanding of social capital that departs from the psychosocial perspective and more closely resembles the view endorsed by Bourdieu, which is based on the resources that are exchanged as a result of social affiliations, the distribution of these resources among sectors of society based on power, and the economic value of these resources (Bourdieu, 1986).

Coburn (2000) takes the neo-materialist approach a step further and addresses Wilkinson's hypothesis by arguing that neoliberalism in particular is behind income inequality, tolerance of this inequality, and greater social disintegration; and this occurs primarily through the weakening of welfare state policies. Thus, neoliberalism and its heavy reliance on market systems provide the context within which both income inequality and social disunity occur.

III. Culture and the Missing Ideological Perspective

While the various perspectives on the causes of the income inequality-health relationship are useful, neither has adequately accounted for the role of underlying ideologies—in essence, commonly-held beliefs and cultural values—that shape and give rise to societal structures and the social environment that the two camps consider to be the explanatory factors. While Coburn and other neo-materialists do go beyond income inequality as the starting point to get to the root of inequality, their main focus is on economic and political institutions. For example, in response to Coburn's proposition and in light of Wilkinson's hypothesis, Lynch (2000) states that:

> The role of informal social networks should not be discounted, but their importance for public health and health inequalities needs to be placed in the broader context of *institutional structures* [emphasis added] that place limits on the deployment of health-enhancing resources, knowledge and power across those informal networks.

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Moreover, while Coburn does discuss ideological aspects of neoliberalism including individualism, his primary concern is from a political-economic standpoint; and in a subsequent article he refines his argument in what he describes as a "class/welfare regime model" based on global capitalist trends, illustrating the greater emphasis on social systems and structures rather than mindsets and cultural orientations (Coburn, 2004).

However, these approaches may not be the full story. The importance of ways of thinking for societies as a whole have profound impacts on social organization but are often overlooked (Glass, 2006; C. L. Mansyur, Amick, Franzini, & Roberts, 2009). Yet, for any representation of the association between income inequality and health—or other social processes for that matter—to be complete, these factors are deserving of attention as well. I therefore suggest that recognition of a common ideology, specifically related to the cultural value of individualism, underlying both the production and acceptance of income inequality and social disintegration is necessary in order to understand the effects of income inequality on health. In other words, I believe that a society's individualistic propensities impact the extent of income inequality and its subsequent health effects on the population.

Bourdieu's theory of practice (1990) provides a guiding framework for understanding this proposition. In summary, the theory describes the construction of human behavior and puts forth the concept of the habitus—which Bourdieu defines as a "system of dispositions"—for explaining how this occurs. According to the theory, the habitus is the factor through which structures generate practices. More specifically, these dispositions are created and ordered by the conditions of society and subsequently structure the way people view and act within the world. Furthermore, the habitus results from past experiences and constrains the world humans create such that subsequent experiences align with it. This causes positive feedback and self-reinforcement and leads to continuity in the course of history, replication of the past, and maintenance of society's structures. Additionally, the habitus operates on a class level, which emerges from a shared history and leads to the synchronization of behavior within society. It also allows for individuals to internalize the social structures and institutions that result from this common history.

In applying this theory to the income inequality-health relationship, the habitus, or dispositions, can therefore serve as the link between the political, economic, and social structures that affect the behaviors or practices related to income inequality, social disintegration and health status. Thus, these outcomes emerge from ideological roots. In other words, income inequality and social fragmentation are both symptoms of an ideological underlying cause. In effect, this approach accommodates both the neo-materialist and psychosocial perspectives by integrating the structures advocated by neo-materialism and the practices emphasized by the psychosocial viewpoint. While one could debate whether social structures or dispositions precede the other and while Bourdieu's theory might also suggest that dispositions are secondary to structures, the cyclical and reinforcing nature of these elements indicates that the two are inextricably linked and may be impossible to distinguish temporally. Rather, there is a constant interchange between them.

On a population level, these ideologies can be interpreted through the lens of culture, and in fact, Mansyur, Amick, Franzini et al. (2009) similarly utilize Bourdieu's theory to directly translate the concept of *habitus* as culture. In their article, they likewise bemoan the inadequate attention given to cultural attitudes in understanding the connection between income inequality and health and echo the fact that these values form its basis, asserting that "political systems reflect culture" and that "social structure reflects the cultural dimensions of society," though they

also acknowledge the existence of a bidirectional relationship. Thus, they lend support to the idea that both the neo-materialist and psychosocial frameworks of income inequality and health can be viewed as occurring within the context of culture.

IV. The Study of Culture and Its Relation to Income Inequality and Health

Apart from anthropology, much of the attempt to understand components of culture has taken place in cross-cultural psychology, and while it has been recognized that culture is a complex, multidimensional construct, some scholars have purported that the dimension related to the individualism-collectivism spectrum is the most significant distinguishing cultural characteristic of societies globally—with individualism generally understood as the degree of significance placed on the independent individual over other social bonds (C. L. Mansyur, Amick, Franzini, et al., 2009). This construct has been further delineated into vertical and horizontal forms, with verticality signifying a hierarchical orientation in societies with clear ranks among members while horizontality indicates a greater emphasis on equality (C. L. Mansyur, Amick, Franzini, et al., 2009). These cultural orientations are reflected in the political systems of countries; for example social democracies such as Scandinavian nations fall under the horizontal individualist category by promoting individual autonomy but favoring equality while liberal democracies such as the United States and the United Kingdom fall into the vertical individualist category with both a focus on the autonomous individual as well as acceptance of inequality (C. L. Mansyur, Amick, Franzini, et al., 2009). From a historical perspective, many also view the growth of vertical individualism as being connected to industrialization and the rise of capitalism alongside Puritanical Protestantism that emphasized a strong, independent work ethic and believed that personal success was a result of destiny (C. L. Mansyur, Amick, Franzini, et al., 2009).

The cultural value of individualism, and more specifically vertical individualism, seems especially relevant to the topic of income inequality and health and the pathways explaining it. Less reliance on the larger group as a result of individualism could arguably breed a lack of consideration for the welfare of others and less concern about inequality. And it may also lead to the acceptance of income inequality if it is the responsibility of the individual to determine and improve one's position within society. The notion of individualism also corresponds to the concept of social cohesiveness since it relates to beliefs about one's relationship to others. It could therefore be seen as an indicator of social connectedness itself. Individualism could further translate into material mechanisms if a strong emphasis on personal ownership and attainment of resources for one's benefit inhibits the distribution and sharing of these resources amongst members of society. These possibilities logically imply that individualistic values could play a role in the income inequality and health association, and they illustrate the ways in which individualism functioning as habitus governs actions and manifests itself as social practices as Bourdieu's theory argues.

The implications of individualism-collectivism for health have also been considered in the literature. In an early paper by Triandis et al. (1988), the authors illustrated how the individual-level correlates of individualism and collectivism—idiocentrism and allocentrism, respectively—associate with social support, with idiocentric individuals reporting lower levels and quality of social support. This association between culture and social support was

consequently hypothesized to influence one's ability to cope with stressors, leading to poor physical and mental health outcomes. This pathway was demonstrated in relation to differences in heart attack rates between various communities, and results indicated that rates were higher in vertical individualist communities. Thus, their hypothesis links culture to health through a psychosocial pathway. On a societal level, Triandis et al. (1988) also claim that while health outcomes differ by countries' income status, if all were equivalent, collectivist societies should have less illness than individualist societies; and they further discuss how individualism has been linked to several other social problems.

Eckersley (2006) also implicates the cultural values of individualism and materialism in a lack of social cohesiveness and growing isolation and provides evidence for their association with crime and a number of negative psychological outcomes including suicide and anxiety. This is further linked to other health-related consequences including drug use and depression. Additionally, given depression's association with heart disease, he also argues that these cultural values are associated with physical health outcomes.

However, contrary to these assumptions, individualistic societies have been found to have more social capital in certain studies (Realo & Allik, 2009). For example, some research has shown that countries in which people were more likely to think that others could be trusted were also more individualistic, and a study found that US states that rated higher on individualism also ranked higher on social capital measures such as participation in groups, trust in others, and time interacting with friends; similarly, across countries, a comparable positive relationship was found between individualism and level of social trust and involvement in organizations (Allik & Realo, 2004). The authors suggest that individualism allows people the freedom—and in fact requires of people—to select to engage in social activities beyond the limited groups to which people in collectivist societies remain loyal. So, because collectivist societies center heavily on the family, there is a lack of trust of people outside this circle (Realo & Allik, 2009). Another study demonstrated that the familial focus of collectivism is in fact related to lower social capital while a collective spirit on a societal level is linked to higher social capital (Realo, Allik, & Greenfield, 2008). Because in individualistic societies there is not automatic reliance on pre-determined social groups such as blood relations, people must develop their own social affiliations, which results in wider social networks (Triandis et al., 1988). In other words, individualism ironically leads to a recognition that people are reliant on each other even when they are not obligated to act or think collectively (Realo & Allik, 2009).

Yet, these results could be misleading if one confuses the quantity of social ties with the quality of them, and it is the quality of these ties and the support that they offer that are often more relevant for health outcomes (Schwarzbach, Luppa, Forstmeier, König, & Riedel-Heller, 2014). Triandis et al. (1988) likewise suggest that among individualist groups, there is the semblance of being more social and having a greater number of social connections but that although the number of ties among collectivists is fewer, these ties are stronger. This could imply that the commonly used measures of social capital may not adequately capture the construct and its relationship to individualism in these studies if they do not assess quality, and Mansyur et al. (2008) likewise suggest the need for utilizing more nuanced measures of social capital in analyzing the income inequality-health association.

Moreover, in the Beilmann and Realo (2012) article looking specifically at the relationship between individualism-collectivism and social capital at the level of the individual, results seem to be more consistent with expectations. The study used data from the Estionia Survey on Culture & Personality. Social capital was based on beliefs in the trustworthiness of most people, beliefs in the honesty of most people, and interest in politics. Individualism was subdivided into autonomy, mature self-responsibility, and uniqueness; and collectivism

encompassed familism (relations to members of the family), companionship (relations with friends), and patriotism (relation to society at large). Results showed that all three types of collectivism were positively correlated with social capital but familism was not significant. However, for individualism, autonomy and uniqueness were negatively correlated with social capital while mature self-responsibility was positively correlated. After adjusting for age and education, the correlation with uniqueness lost significance but the direction remained the same. The authors note the patterns were similar for other items related to social capital (volunteering, diversity of social network, and belonging to organizations). These results do support the idea that certain aspects of collectivism—namely, sense of connection to friends and society as a whole—are in fact associated with greater social capital in individuals while the autonomous aspect of individualism is associated with lower social capital.

V. Missed Opportunities for Cultural Analysis on Income Inequality and Health

Though the arguments presented here indicate that the cultural construct of individualism may be an important underlying factor in the income inequality-health correlation, most scholars have not specifically addressed it in their work on the subject. Nonetheless, many of them—from both the psychosocial and neo-materialist camps—allude to the role of culture in some shape or form. For example Kawachi et al. (1997) provide the following caveat to their results: "it should be cautioned that…there may exist unmeasured societal attitudes that underlie both social capital disinvestment and tolerance of income inequality." Mansyur et al. (2008) echo this in their study, saying their inconsistent findings "may be an indication that there are country-specific characteristics related to both income inequality and social capital that could also be associated with health outcomes," and they list cultural factors as one of such characteristics. Likewise, a review on the topic mentions culture as one of many factors that could be confounding the income inequality-health relationship (Babones, 2008), and Wilkinson refers to "cultural processes by which less egalitarian societies develop more aggressive and less supportive social environments" (1999b) and a "culture of inequality" in his writing (2000), though this view assumes mediation.

Moreover, in Coburn's proposal on the neoliberal roots behind the Wilkinson hypothesis, he states that "the political rise of neo-liberalism is freighted with a more individualistic view of society and, perhaps, itself reflects a decline in the notion of 'we are all in the same boat'" (Coburn, 2000). And Lynch's response in support of this article adds that "income inequality is but one, albeit important manifestation of a set of background historical, political, cultural and economic factors" and that "the social and philosophical tenets of neo-liberalism reflect individualist rather than collectivist sentiment" (J. Lynch, 2000). Therefore, although these authors have not directly emphasized "sentiments" and "attitudes" as determinants of income inequality, they acknowledge their role and indirectly lend support to this idea. In their recent review on income inequality and health, Pickett and Wilkinson (2015) also discuss cultural factors as an alternative explanation for the relationship but question its role due to vast cultural differences that may exist across settings that may still have similar profiles for health and inequality. While this may be true, it underlines the importance of considering specific aspects of culture rather than culture as a whole.

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Yet, despite these mentions, the authors stop short of critically evaluating the role of cultural factors and thus only scratch the surface. The question then becomes, why have dimensions of culture and ideology such as individualism been neglected in the field of public health and why do they infrequently feature in the public health literature? There is no doubt that they are complex constructs that are not readily observable or easily measured. Nonetheless, several scales have been developed to measure aspects of individualism and collectivism at the individual level. For instance, the 32-item scale by Singelis et al. (1995) includes items corresponding to the four subgroups of individualism-collectivism: vertical collectivism (viewing oneself as a member of a larger group but recognizing inequality), horizontal collectivism (viewing oneself as a member of a larger group but perceiving that everyone is equal), vertical individualism (viewing oneself as independent and tolerating inequality), and horizontal individualism (viewing oneself as independent but believing in equality).

Additionally, Geert Hofstede pioneered the development of measures of national culture originally based on surveys of IBM employees from various countries beginning in the 1960's and later validated among other populations (Hofstede, Hofstede, & Minkov, 2010). The results were reduced to four dimensions of culture for which countries were given a numerical score. These include individualism as well as uncertainty avoidance, power distance (the degree to which a society's lower-level members recognize unequal power distribution), and masculinity (the amount of distinction a society places between the genders in terms of emotions—i.e., aggressive as masculine vs. modest as feminine). Thus, cultural dimensions such as individualism can be measured quantitatively at both the individual and group level.

Limitations in the Assessment of Cultural Dimensions

While some researchers firmly believe in the validity of individualism as a construct, several issues have been raised about its validity and measurement as well (Fiske, 2002; Schimmack, Oishi, & Diener, 2005). For example, there is no clear consensus on what the construct actually captures (Realo & Allik, 2009). While some associate collectivist cultures with reduced competition (Triandis et al., 1988), Hofstede (2010) notes that people often confuse competitiveness with individualism, which is instead more in line with his masculinity dimension. So, although the two concepts may be correlated, some argue that they do not automatically coincide (Realo & Allik, 2009). On the other hand, Eckersley (2006) cautions that autonomy is not synonymous with independence, suggesting that collectivists can still value individual autonomy and choice while emphasizing belonging to a larger community. Thus, clarity and consistency is needed on the definition and relevant aspects of individualism that are being considered before meaningful understandings of its relationship with other factors can emerge. Additional complaints have centered on the overly simplistic treatment of the concept of individualism by psychologists as opposed to an anthropological perspective (Fiske, 2002), as well as measurement issues such as failure to account for differences in the way people respond to scale items across cultures (Schimmack et al., 2005).

It must also be noted that there are problems with considering culture as a national construct since, undoubtedly, culture does not conform to geopolitical boundaries, and this point has been made in critiques of the national measure (Fiske, 2002). In addition, it has also been argued that researchers should instead focus on the various contexts of culture—such as economic systems, family, and institutions—rather than using broad conceptual definitions (Fiske, 2002).

Another important consideration is that culture is not necessarily uniform across members of society but may differ according to who possesses it. For instance, distinctions have been made between mass culture held by the larger

population, elite culture belonging to privileged members of society, and official culture—or the culture of the state—among other categories (LaCapra, 1988). LaCapra (1988) claims that mass culture is the primary driver in Western nations while official culture is more powerful in state-socialist nations. Thus, culture is closely tied to power, social class and structure. Turning again to the theory of practice, Bourdieu likewise recognizes that because of social divisions, people belonging to the same class share a similar habitus, so the habitus exists on a class level (Bourdieu, 1990).

The various forms of culture also suggest that imposed political structures could possibly be at odds with more general societal culture if state culture differs. As a result, it is likely that the proposed relationship between cultural values such as individualism, income inequality, and health may not always follow predicted patterns. This may be particularly relevant for transitioning countries that in analyses do not appear to conform to hypothesized relationships, such as historically Communist countries undergoing dramatic political transformation that may be culturally collectivist yet have growing income inequality due to political structures. For instance, in the Mansyur et al. (2008) study on income inequality, social capital, and health across countries, Russia was found to be an outlier in their model because of its unusually low health status; and inequality and social capital measures had a different relationship with self-rated health in the former Communist countries compared to other countries. Additionally, China also stood out as an outlier in the inverse relationship observed between individualism and social capital demonstrated by Realo and Allik (2009) and instead had both the lowest score on individualism but one of the highest levels of trust. Moreover, in their study on cultural factors, inequality, and health, Mansyur, Amick, Harrist et al. (2009) found that the relationship between the cultural dimension of masculinity with health was opposite in individualist and collectivist countries with a vertical structure such that the two variables were positively associated in the vertical collectivist nations but negatively associated in the vertical individualist ones. Therefore, more nuance in the individualism-collectivism dichotomy that considers these differing structures may be needed to account for departures from observed patterns.

Despite limitations, the analysis of individualism and other cultural factors still has the potential to contribute to our understanding of the determinants of health outcomes and should not be ignored, however crude these measures may be. And some researchers have begun to approach similar issues. For example, Singh-Manoux and Marmot (2005) discuss the process by which different social classes are socialized and how this socialization functions as the pathway through which social class differences translate into health inequalities, also drawing on Bourdieu's notion of the habitus. In other words, they suggest that the different cultures associated with the classes within society socialize members of each class to behave a certain way and thus create class disparities in health outcomes. However, the focus appears to be more on the intervening mechanism between class and health inequality and the health of individuals within segments of society rather than the experience of inequality in society as a whole and how differences in ideology on a population level influence inequality and health. Additionally, Eckersley (2006) reviews literature linking culture and health and concludes that:

> A culture of individualism and materialism could also produce those attributes of a culture of inequality. In other words, these developments in thinking about inequality in essentially cultural terms invite a broader consideration of cultural factors as determinants of health.

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But while the article succeeds at illustrating how these factors affect health and provides several concrete examples, it does not focus on demonstrating their effects on inequality *per se*.

Perhaps the work of Mansyur, Amick, Harrist et al. (2009) comes closest to examining cultural traits and their effects on health inequalities. While the authors did not look directly at population-level income inequality (i.e., through Gini coefficients) or population health measures, they did use multilevel modeling to demonstrate that the cultural dimensions of uncertainty avoidance and power distance measured at the country level were negatively associated with individual self-rated health. Moreover, these factors along with GNP modified the effect of individual income on health. Thus, this work is beginning to head in the direction of empirically investigating the effect of societal cultural factors on inequality and health status, though it appears that little research in this area has followed since then.

VI. Recommendations and Future Directions

To further investigate and clarify the role of culture in income inequality and health, several next steps are needed. These include:

An Ecologic Approach That Considers Multiple Levels of Society

Methodologically, continued multilevel analyses will be helpful in parsing out the relative contributions of individual and contextual-level factors and in dealing with the problems associated with ecological studies. For instance, because culture operates on both an individual and group level, the cultural orientations at each level may not necessarily coincide. An allocentric person—or a collectivist at the individual level—may live in an individualistic society while an idiocentric person who is individualistic at the individual level could live in a predominantly collectivist society. Analyses should aim to discern the importance of each level and how they interact to affect personal health.

Research That Examines Changes over Time

Much of the work on income inequality and health and its mechanisms has been based on cross-sectional data. In order to more fully understand the causal pathways between income inequality and poor health, longitudinal analyses are especially needed. For example, studies of communities undergoing change could be particularly useful in examining whether changes in individual or group values or cultural attitudes are associated with changes in inequality, social capital and health status over time. Thus, one might expect that a decline in the proportion of a population indicating that most people can be trusted would result in corresponding increases in poor health outcomes, for example.

More Nuanced Understandings of Social and Cultural Concepts

Improvement in the operationalization and measurement of constructs such as social capital, individualism, and other cultural dimensions can also improve our knowledge about the role of these factors in health. In particular, expanding the definition of cohesion and social capital beyond trust and group participation to better encompass constructs such as solidarity, for instance, may be necessary to better capture these concepts and how they relate with other factors. Likewise, more specification of the facets of individualism or other related cultural constructs that may be relevant is also needed to fully understand how they affect inequality, social cohesion, political economy, and health. Thus, although there appears to be general acceptance intuitively of the idea that cultural traits such as

individualism are relevant to health and social outcomes, improved definition will assist in analysis and in demonstrating these relationships empirically.

Broader Geographic Perspectives and Units of Analysis

De Maio (2012) urges that we move beyond comparisons within and between nations as geographic entities to view the world as a more fluid and interconnected place. This would entail not just individual-level or cross-country analyses but an approach that also addresses global trade patterns and countries' positioning within the larger global economy. An example he cites is the use of world systems theory to examine how status as a periphery or core nation modifies the effect of income inequality on health. As stated above, culture is likewise not limited to national borders, and such broader perspectives may better recognize the reality of social relations and global patterns of interaction.

Expansion to Other Types of Research Methods

Lastly, while additional analyses will be beneficial in furthering our understanding of the income inequality and health relationship, there will always be limitations in the information that quantitative approaches can provide us. Reducing cultural and social concepts such as individualism and trust to numeric values is inherently challenging and perhaps problematic; and the question remains as to whether these concepts can really be measured and, if so, whether the measures will truly capture their essence. Measurement quality and validity will therefore continue to be debatable. It is here where qualitative approaches can be of particular value. Interviews and other qualitative methods can reveal the thoughts and encounters of groups and individuals as they relate to inequality and its causes and the role of social cohesion and cultural values. These can provide better insight into the lived experience and offer a richer understanding of the relationship between income inequality and health.

In the same vein, De Maio (2012) cautions that we should not be limited by purely positivist approaches to understanding this issue and should rather focus more on theoretical and conceptual understandings from a critical realist perspective. He believes this can be accomplished through greater emphasis on the sources of income inequality rather than the results of it and better theoretical development of the various constructs for analysis. Thus, this also suggests that research should focus on arriving at new conceptual frameworks of income inequality and health.

VII. Conclusions

In summary, using Bourdieu's concept of the habitus to approach health outcomes and their causes from an ideological standpoint further contextualizes health issues. It enhances our appreciation of the complexity of health phenomena in society as well as the difficulties in changing them given the relative stability of cultural beliefs over time. It thus has implications for approaches to health interventions, suggesting that greater attention to societal attitudes may be needed. As Mansyur, Amick, Harrist et al. (2009) note, a cultural framework also helps to explain why findings on the income inequality-health relationship have not been consistent across countries because dimensions of culture may be moderating factors. A better understanding of the role of culture in income inequality and health could also potentially assist in predicting trends in health outcomes over time if one is aware of how and in what direction a given society's culture may be changing as well.

Undoubtedly, cultural values provide an overarching orientation to how societies and individuals view the world and therefore have far-reaching effects on a variety of health and social outcomes. And Bourdieu's theory of

practice provides a framework for understanding how these dispositions are related to social structures and their resulting phenomena, including income inequality and health status. Yet, research on individualism and health may be politically charged because of implications it might have for how societies are structured or how they should or should not change. For example, it may suggest that some cultural traits are healthier or more detrimental than others, which might seem to be an indictment on particular societies. Additionally, it raises the issue of what type of actionable measures or feasible interventions could be developed given the slow change of culture over time. Nevertheless, such an approach can provide a way to synthesize various perspectives on health issues, including psychosocial and neo-materialist perspectives, and put them in a larger context. As Glass (2006) aptly puts it, "culture might become the third leg of the social epidemiological stool."

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