The Politics of Research

THE POLITICS OF HEALTH INEQUALITIES RESEARCH IN THE UNITED STATES

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In this article, based on a speech to the European Association of Health Policy, the author discusses the political context in which health inequalities research has historically operated in the United States. The discussion focuses on the limitations of research that uses income, consumption, and status as the primary categories of research practice, and demonstrates these limitations by critically analyzing *The Health of Nations* (by Kawachi and Kennedy). The author concludes that it is essential to use categories of analysis that focus on class relations as well as race and gender relations and their reproduction through the international and national institutions, to study their impact on the health and well-being of populations.

THE LIMITED DIVERSITY OF U.S. SCHOLARSHIP

Thank you very much for inviting me to share with you my thoughts about scientific practice and discourse, on both sides of the Atlantic, in the areas of social science research in health and medicine, areas in which I have been working for more than 40 years. As you may know, I had to leave Spain for political reasons in 1962, going to Sweden first (where I studied at Uppsala University and at the Karolinska Institute in Stockholm), then to Great Britain (studying at the London School of Economics, Oxford University, and Edinburgh University), and finally to the United States, where I have been on the faculty of the School of Public Health of the Johns Hopkins University since 1965. I have also been a visiting professor at other leading U.S. universities, such as Columbia University, the University of California, Los Angeles, Harvard University, and the University of Michigan. Since the death of the Spanish dictator, General Franco, in 1975, I have also spent considerable time in Spain, where, since 1997, I have directed the

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Public and Social Policy Program, jointly sponsored by the Johns Hopkins University and the Pompeu Fabra University, in Barcelona. I have therefore been a member of the U.S. academic community for most of my working life, and have been able to compare and contrast it with the European academic institutions where I have also worked. Thus I do believe that I have enough knowledge about academic life on both sides of the Atlantic to be able to comment on it. But before proceeding with my presentation, I want to clarify that I am going to focus on the areas of health and medicine, leaving out other areas of social science research to which my comments may not be applicable. Health and medicine studies are, after all, very conservative sectors of U.S. academia and have their own specificity that distinguishes them from other areas of social science research.

Let me start by saying that one of the very attractive features of U.S. academic life (at least in the universities where I have taught and in the areas in which I have labored) is the richness of the academic infrastructure and the intensity of its intellectual life. Needless to say, a country of this size has universities of all types and all levels of quality, a reality frequently ignored by some European observers who only know or visit the top academic centers. There are many poor-quality universities in the United States, but the leading universities do have the features—a rich and intense intellectual life—that I have just mentioned.

On the other hand, the main weakness of U.S. academic institutions—and a major one—is the very limited diversity in both their faculty and their academic offerings. And by diversity I don't mean number of courses taught, which tends to be very large indeed, but rather a diversity of perspectives, except critical perspectives based on race and gender. Indeed, there are a great many critical analyses of health and medicine (including public health and health policy research) from feminist and black perspectives, for example, but all these are constructed within certain well-defined boundaries. Analyses of U.S. health care from class perspectives, for example, are very rare indeed. If you look at the journals *Health Affairs, Medical Care, Milbank Quarterly,* and *Journal of Health Policy, Politics and Law,* not to speak of *The New England Journal of Medicine* and *JAMA,* you will rarely find articles that use class analysis in their understanding of the realities of U.S. medicine or public health. The only exception is the *International Journal of Health Services,* which frequently presents such analyses in its pages. Otherwise, class analyses are, for the most part, frowned upon in these forums.

Indeed, contrary to what is usually claimed, the academic environment at U.S. universities is profoundly ideological. Simply using the terms "class struggle," "working class," "imperialism," or the like in academic discourse is enough to provoke an emotional response of dismissal. Whoever uses such terms is likely to be dismissed as doctrinaire, and thus marginalized. You may be surprised to know that I have received letters from senior editors on this topic, including one from *The New England Journal of Medicine,* asking me to change

some terms I used in my article, such as "working class" and "class struggle"; the editor wanted them changed "for being too doctrinaire"—a direct quotation from his letter of conditional acceptance. My refusal to agree to that condition led to the rejection of the article. Cases like this are many. Other colleagues of mine who use similar types of analysis have reported similar experiences.

To further complicate matters, the degree of knowledge about critical traditions based on class perspective is so limited in the United States that one runs the risk of very easily being labeled a "communist," since, even in scholarly circles, all critical perspectives using class categories are quickly defined as "Marxist," which usually means Marxist-Leninist or "communist." In that respect, it is important to notice that while "mainstream" authors are never labeled with the scholarly traditions to which they belong (such as Weberian or Durkheimian authors), authors who use class perspectives are automatically introduced or referred to as Marxist authors—which, given the very limited diversity and tolerance of academic institutions, may mean academic death for those authors. Indeed, there is an authentic fear about using certain terms derived from the Marxist or even the Weberian tradition in scientific discourse, a fear, as I mentioned before, of being identified as "red," a coloration that may ruin one's academic life.

You may be surprised to hear this observation, since you may think this happened in the United States in the McCarthy era, but no longer. McCarthyism, however, is alive and well in U.S. academia. Actually, it never was defunct. You know, of course, that the existence of classes and class struggle was indeed accepted by the two prominent sociological traditions in the western world during the 20th century: the Weberian and the Marxist traditions. And you also know, of course, that the difference between Marx and Weber was not in their use of class struggle as a category of analysis, but rather in their definition of the roots of that struggle, based on exploitation in the case of Marx (which he considered intrinsic to capitalist relations) and domination in the case of Weber. But otherwise, they both spoke of class struggle. In the United States, however, someone who speaks about class struggle is liable to being defined as Marxist-Leninist. And that is the end of that scholar. I admit that this discrimination may have been less acute in other areas of social science. In sociology, for example, there was a very rich renaissance of class-based studies in the social sciences in the 1970s and 1980s, which continues today (although in diminished form) in some branches of sociology. But in the areas of health and medicine in which I have worked, this has not been the case. It is an extremely conservative environment in the United States; McCarthyism is still alive and well.

The continuing existence of McCarthyism in the area of health and medicine is explained by the system of funding of most U.S. research and the process for granting academic tenure. Most funding comes from either private foundations, such as the McArthur, Johnson and Johnson, Commonwealth, Rockefeller, and

other foundations, or from government agencies, whose peer-review committees tend to be very establishment oriented. Faculty members are under enormous pressure to get significant amounts of funding from these research agencies, since in many centers (such as Hopkins, a top academic health center in the United States), 80 percent of a faculty member's salary (and that of her or his secretary) has to be raised by the faculty member with research funds. Survival in U.S. academia depends not only on the famous dictum "publish or perish" but also on an ability to get research funds, since your salary depends on getting these funds, whether you have tenure or not. So, as you can easily conclude, academic freedom in health and social science research is dramatically reduced (some may even say practically nonexistent) in the United States. Researchers interested in controversial topics (such as the politics of health care) with a class-based outlook, or those who work in disciplines that are not easily funded, such as history or political science, are let go easily. Examples are many: one of the best-known historians of public health in the United States, Professor Elizabeth Fee, was let go from Johns Hopkins School of Public Health (a major U.S. teaching and research public health center) because she could not easily get funds for her research (and thus for her salary). Another example is Professor Jeff Johnson, a leading occupational epidemiologist, who could not get research funds to analyze the negative impact of employers' practices on the health of their workers: he also had to leave. Actually, of the very few critical scholars in health and social science research in the United States, many get their research funding from non-U.S. sources.

Let me clarify that this situation has become much more common since the 1980s than is realized, because of the ending of federal teaching grants that formerly sustained many faculty salaries. President Reagan discontinued these teaching grants and they have never been replaced. This has dramatically reduced the ideological diversity in social science research in health and medicine. As you can see, this system of funding very seriously compromises academic freedom in the United States. The diversity is indeed limited. It resembles the restricted diversity of the American broadcasting industry, where you can find 75 television channels, but not one socialist or even mildly center-left social democrat as a commentator (among 83). In academia, reinforcing this situation is a system of faculty promotion that is clearly skewed against critical perspectives (except race and gender). Exceptions do exist, of course. But they are just that—exceptions.

Academic freedom is indeed dramatically reduced in the United States, to a point that it is practically nonexistent. This is a reality rarely discussed in the United States and rarely presented outside the country. It's as if dirty linen is supposed to be washed at home, but not abroad. But, let me repeat: the main and most obvious characteristic of U.S. academic life is its extremely narrow boundaries and its very limited academic freedom in social science research in health and medicine.

THE RESPONSE OF THE ESTABLISHMENT TO CRITICAL PERSPECTIVES

Of course, critical scholars do exist in the United States, but they operate under huge difficulties. In our field, one of the most creative periods was in the 1960s and early 1970s, when, as a result of the social uprisings taking place in the United States at that time, there was a broad-based questioning of the conventional wisdom. I have written elsewhere about that period and the different critical scholarship traditions it generated (1). One scholarly tradition in the area of health and medicine that became particularly important was what was referred to as "materialist epidemiology," which had the intent of basing social epidemiology in an understanding of the forces that shape society, in which class relations played a critical role. We studied how class relations appear in morbidity and mortality, and how class relations were (and continue to be) reproduced in the institutions, knowledge, and practice of medicine. That way of analyzing our reality—made possible by the intellectually open and questioning atmosphere in the country at that time—also influenced the appearance of radical perspectives in minority- and gender-based studies. That radical thought triggered and stimulated an important process of questioning of our society.

It is interesting to analyze how the U.S. medical and health care establishments, including the foundations and the federal government, as well as their journals and forums, responded to that critical scholarship. They did it in typical and predictable fashion. First, they ignored the radical critiques. Later, as the critiques became too great to ignore, they funded "mainstream" researchers to recycle the critical studies and the issues raised, cleansing them of any political context, changing the terms of the discourse (marginalizing the radical ones), and putting forward analyses and proposals that would be less threatening to the system. This is, indeed, how the medical and health establishments have always functioned in the United States in order to marginalize perspectives they dismiss as "radical." They take over the issues and their radical analysis and recycle them in a form less threatening to the established order. This is the history of the funding of controversial research in the United States. Needless to say, some ex-radicals have assisted in this recycling process for clearly opportunistic reasons, becoming part of the establishment.

Let me say that this situation has also occurred in the U.S. establishment's funding of research on health and medical studies outside the United States, particularly in Latin America and other developing countries. For example, in Latin America during the 1960s and 1970s (with the willing assistance of the Pan American Health Organization, the main transmitter of hegemonic thought from the United States to Latin America), the U.S.-based foundations supported social democratic positions as alternatives to (and in order to put a stop to)

communism. Then, when communism collapsed, or was perceived as no longer a threat to international power relations, these same funding agencies began supporting neoliberalism to put a stop to social democracy. You may have seen how the U.S. funding agencies (including the foundations) have recently been promoting managed competition all over the world, using the World Health Organization and PAHO as the instruments of promotion (2). I must admit I am intrigued about what they will support next, although I hope that social democracy in the world will not collapse, as communism did.

AN EXAMPLE: THE EVOLUTION OF STUDIES ON INEQUALITIES AND HEALTH

What I have just said applies to the study of social inequalities and their impact on health, as well. Let me elaborate. In the 1960s, 1970s, and 1980s, considerable work was done on how class relations affect the health of our populations and how class relations are reproduced in the public and private health care institutions of the United States. It was some of the most interesting work in health research. This work was silenced, ignored, or marginalized in establishment forums—which does not mean, however, that it did not have an impact. Indeed, the evidence was pretty overwhelming that the United States (as the *Lancet* once pointed out) is not a classless society. For the most part, these studies did not enjoy government or foundation support. But such studies were part of a larger movement that established the International Association of Health Policy, which soon spread worldwide. And in the United States they triggered the establishment of the Socialist Caucus of the American Public Health Association, where all political traditions of the left—socialists, social democrats, anarchists, communists, and others—cooperated and ran some of the most exciting and well-attended sessions in the annual meetings of the APHA.

How did the U.S. establishment respond to this critical scholarship? The answer is remarkably predictable: by funding studies that presented an alternative to the radical tradition. These studies focused not on class or even on power relations (terms seen as too ideological) but rather on income and status, referring to income and status differentials, rather than class differentials. Thus income and status differentials became the new game in town. The political spectrum in social science research in health and medicine was thus redefined, with the left—the "respectable" left—focusing on the importance of income and status differentials as a determinant of the health of populations, while the right dismissed the idea that income differentials had any relevance for people's health. Soon, and as a result of the huge influence of the United States in the modern world, this focus on income and status differentials rather than class relations (including class, as well as race and gender, exploitation) became the focus of the "respectable" left worldwide. Income and status differentials were *in;* the analysis of how class structure, class exploitation, and class struggle appear, reproduce, and affect the

health and quality of life of our populations—all this was *out.* In this theoretical scenario, income is the means by which individuals realize themselves in the world of consumption, the key determinant of status; income and consumption, as well as status, differentials are at the center of analytical debate. And in this new discourse, individuals and how they relate among themselves becomes the main focus of social inequalities research, while concepts such as "social cohesion" and "social capital" become the major trademarks of that discourse. Large income differentials were considered, for example, to be bad for a community because they diluted social cohesion. Large income differentials were also bad because they impoverished the individual's social capital—with social capital defined as an individual's network of contacts and support. Indeed, "social capital" and "social cohesion" became the new terms that must be used to get funding, even from the foundations or the U.S. government. And again, given the enormous power and influence of the United States, these terms and concepts started appearing and becoming widely used worldwide, replacing the concepts of class analysis that, in some European and Latin American countries, had been the most important approach in understanding health and medicine. To get funds even from the European Commission, for example, you must use these code words. Indeed, nowhere in these new studies could you find concepts such as class-consciousness and class solidarity, or class power and its relationship to the state, or collective power resources, such as trade unions or left-wing parties. And those who have continued to work in these areas have been ignored or marginalized by the "respectable" left.

Accompanying these changes was the establishment in the United States of new research networks or research institutions working on inequalities (to replace the socialist associations and networks mentioned above, perceived as "too political"). In these new forums, research and discourse were sanitized to exclude any elements or terms that could be threatening to the establishment or to the funding sources. And all appeared very scholarly, looking at methodological issues, dressed on occasion in extensive statistical apparatuses, and excluding any form of ideological contamination—by which I mean concepts, terms, and proposals perceived as unorthodox and not fundable.

Let me clarify that I am not putting down these income and status studies. On several occasions they have added importantly to the existing knowledge in the area of health inequalities research. What I want to stress, however, is that these studies were presented and put forward as an alternative (less threatening to the sources of class as well as race and gender power) to analyses of realities based on an understanding of class power relations in our societies and their reproduction in the areas of health and medicine. The disregard and marginalization of these class analyses by the income- and status-based researchers carried a major cost, however, revealing the insufficiency of this research in understanding our realities.

A REPRESENTATIVE EXAMPLE OF THE PROBLEM: *THE HEALTH OF NATIONS*

Let me focus on one example of this "respectable left": Kawachi and Kennedy's *The Health of Nations: Why Inequality Is Harmful to Your Health* (3). Funded by the McArthur Foundation (the largest funding source for social science research in the United States), this book is authored by two professors from Harvard University. In the advertising brochure, it is presented by Amartya Sen as "the left proposals that the right wing will hate." The first clue about its ideological character (wanting to appear as the respectable left), however, is that none of the researchers who have worked in the areas of health inequalities from a class perspective are mentioned or acknowledged in the book. And the *International Journal of Health Services,* the journal that has published the most work on the issue of social inequalities in health, is cited only once in 235 references. Quite remarkable!

But let me concentrate on the topics covered by *The Health of Nations.* The authors focus on individual income and individual behavior as the point of departure for understanding our societies. At the outset, in the first chapter, they classify countries according to the income and individual consumption of average individuals and average families in each country. Thus they compare the standard of living of countries as diverse as Ethiopia, Mexico, and the United States by comparing the commodities owned by the average family in each country, with photographs of families displaying their possessions—animals, furniture, and other possessions—in front of their houses, following Menzel's well-known photographic work *Material World: A Global Family Portrait.* The countries themselves are ranked by average income per capita, establishing a gradient from the poor to the rich countries. And richness and power are defined by the commodities owned by the average family.

The way the authors of *The Health of Nations* chose to define the countries, however, carries with it a specific understanding of the world, dividing it into high-consuming countries (the rich countries) and low-consuming countries (the poor). The first group of countries, for example, consumes too much food: the people are obese. The second group of countries has the opposite problem: people don't eat enough; they are hungry. Moreover, the problem in the supposedly rich countries is that, besides people consuming too much, they choose a pattern of consumption that is wasteful and even harmful both to themselves and to those in poor countries—they harm the citizens of poor countries because the poor aspire to consume as much as the citizens of rich countries do, using the consumption model of the developed countries as their model and reproducing in the developing countries the patterns of consumption in the developed ones. According to this argument, then, the root of the problem is that the poor in developing countries want to achieve the same pattern of consumption as people in the rich countries. When they cannot achieve that, the poor get frustrated and generate a lot of tension

in the world. In a similar fashion, so *The Health of Nations* continues, the major health problem in the United States is that people always want more, to the point that they are working themselves sick, working too many extra hours.

The solution to this situation is for people in the United States and in the developing countries to lower their expectations and change their level and type of consumption by changing their values; they should learn to value friendliness, togetherness, and time spent with friends and family, for example, more than individual competition and consumption. The authors, in their analysis of the predominant health problems in the United States, thus assume that whatever happens in the United States is a result of (*a*) individuals' choice of the type and level of their consumption and (*b*) individuals' political decisions and their effect on the body politic. Indeed, the authors consider that unrestrained individual consumption also leads to the incomplete democracy of the United States, due to the strong influence of money in the country's political system. Although critical of this U.S. political system, still the book concludes that U.S. society is what people have chosen it to be—rather flattering, incidentally, to the U.S. power structures: they are at the top because this is what most people want.

Regarding the developing countries, the authors of *The Health of Nations* conclude that what is imperative is to reduce income disparities in order to prevent envy, frustration, and rancor, and to stimulate better health among their people. The authors also claim that the solution in the developing countries will be achieved through a change in people's values. How? No more is said. End of book.

THE PROBLEMS WITH THIS ANALYSIS

The problems with the analysis in *The Health of Nations* are many. To start with, individual consumption is a bad place to begin if you wish to understand a society. One society could have lower individual consumption than another yet still have a better standard of living, because it has more collective consumption. To classify countries or families based on the level of individual consumption is to eliminate one of the most important elements that explain a country's quality of life and well-being: its collective consumption, which includes that country's welfare state (public services and social transfers) and infrastructure. So, rather than looking at individual commodities, the book should have included the quality and availability of public schools, public hospitals, public pensions, public childcare and home care services, public transport, and many other aspects of collective consumption (not to mention the nature of work and the public protection of the health and well-being of workers, consumers, and the environment)—all of which largely explain a population's health and quality of life (4; see also 5). Measured in this way, the United States would have looked quite poor, much poorer than other countries with much lower individual consumption.

The authors of *The Health of Nations* are aware that defining rich and poor by looking at per capita income is insufficient, since it does not take into account the

internal distribution of income within the country. But by the same token, they should have realized that measuring the level of development of a country by individual income and by individual consumption is not only insufficient but wrong, because it does not include collective consumption, which is more important than individual consumption in measuring a population's well-being.

A similar problem appears in grouping countries according to patterns of individual consumption. Actually, when we look at the rich countries, we see that the obese are not found among the wealthiest sectors of the population but among the poorest, contradicting the idea of a gradient from very thin to very fat that parallels the gradient from poor to rich. Countries of both North and South have classes, with different patterns of consumption available to them. Contrary to what the authors seem to assume, the dividing line in the world is not between pet lovers who spend millions of dollars on taking care of their pets in the North and hungry children in the South (an image frequently presented in United Nations Development Program reports, such as the *Human Development Report* 2002 (6), as well as in *The Health of Nations,* constantly appealing to the conscience of readers, making then feel guilty). Rather the division is between the dominant economic groups and social classes of the North that impose specific patterns of production and consumption on the majority of their own populations and, in alliance with the dominant classes in the South, on the majority of the populations in the developing countries (see my article "The World Health Situation" on p. 1 of this Journal issue). Thus the problem is rooted not in the envy of the rich by the poor, but rather in the exploitation (a term never used in the book) of the poor by the rich. And to see the problem as poor people and poor countries making inappropriate choices about what they consume, because they are misled by seeing the consumption by richer people and richer nations, is to ignore the reality that most people have very little choice and very limited decision-making power offered to them by an international and national (dis)order based on enormous exploitation.

The evidence of this reality, ignored by the authors of *The Health of Nations,* is plain overwhelming. Exploitation, not choice, is what moves our world. The extreme weakness of the public transport systems in most U.S. cities, for example, is not the outcome of the average person's preference for a private car. Rather, the influence of the auto and energy industries over the political body is what has destroyed or inhibited the development of public transport. Similarly, the pattern of consumption in poor countries is not a result of people's choices; rather, it is a consequence of an overwhelming poverty based on the exploitation of their labor and resources by economic interests of both North and South. Their frustration is a result not of envy but of an awareness of exploitation. Here again, a failure to see issues such as class (as well as gender and race) power rather than people's choice as the root of the problem puts the blame on the victims themselves—they are making the wrong individual choices. Such a view is also highly uncritical of the U.S. distribution of power, which explains

why this view is popular among the social liberals who tend to dominate U.S. funding agencies. But they are wrong.

The authors of *The Health of Nations* cite many polls showing that U.S. citizens do not believe in solidarity and prefer lower taxes and individual consumption to higher taxes and collective consumption. But their presentation of the polling data ignores the fact that responses to the polls are determined by how the questions are posed and by the class, race, gender, and age of the respondent (among other characteristics). Ruy Teixeira and Joel Rogers have polled working-class attitudes and have shown that most working people in the United States would favor an expansion and universalization of the very limited welfare state (including development of a universal health care program that guarantees access to health care in time of need as a human right) (7). If people do not get this, the reason lies in the pattern of economic, corporate, and class influences over the U.S. state and over the country's information- and value-generating systems. As my colleagues and I have shown, wherever the working class is strong and the corporate class is weak, you find very strong and highly developed welfare states. Wherever the corporate class is very strong and the working class very weak, you find very weak welfare states—and this is the situation in the United States. *The Health of Nations* barely touches on this key issue, referring to rather outdated studies and ignoring more recent ones that document a relationship between class power and social inequalities and welfare state development (8).

Class power relations also explain why the United States has one of the least democratic political systems in the western world, a situation rooted in the U.S. Constitution, the rules of the democratic process, and the privatization of the electoral process. Given the continued uncritical promotion of U.S. democratic institutions, let me elaborate on each one. And let me start with the U.S. Constitution. The Constitution established that two senators represent each state in the U.S. Senate. One outcome of this is that half the U.S. population (the half that resides in the most populous and progressive parts of the country) is represented by just 18 senators, while the other half (primarily in the least populous and more conservative states) is represented by 82 senators. This situation "makes the U.S. Senate one of the most underrepresented legislative bodies in the world," in the words of Professor Robert Dahl, former president of the American Political Science Association (9).

Second, on the political rules that guide the electoral process, we find that without a proportional system, and with a "winner takes all" type of political regime, the effect (besides disenfranchising those voters who supported the losing candidates) is to make the establishment of new parties practically impossible (third parties usually hurt the major party closest to them). And third, to make matters worse, the overwhelming influence of corporate and economic interests on the electoral process, with a heavy dependency of the two main parties on these private funds, greatly limits the already structurally deficient democracy in the United States. Indeed, the question one needs to ask is, Is the United States

a democracy? The answer is not entirely clear. The answer given by most people in the United States is a strong *no.* Seventy-three percent of U.S. citizens believe the government does not represent them. To present this situation as an outcome of American values and American choice does a serious injustice to the U.S. reality—flattering to those who govem, but profoundly wrong. Here again, we see another victim-blaming situation.

In summary, then, the emphasis of *The Health of Nations* on choice and values rather than on power and exploitation makes its message pretty limited. The message is profoundly apolitical, which leads me back to the point with which I started this presentation.

We need to look for the roots of the problem in the ways that power (class, race, and gender power) is reproduced in the state, in the media, and in the value-generating systems, and to focus on the need to politicize the response by organizing the disorganized, showing them that what they have in common outweighs whatever separates them. In that respect, it is wrong for the authors of *The Health of Nations* to disparage the labor unions. The only time they refer to unions is to note that the head of the city janitors' union of New York draws a salary of $530,000, seventeen times what the average union member makes. While this needs to be denounced, it is profoundly unfair to the U.S. labor movement to present this as representative of the unions. Labor unions have been one of the most consistent forces for change in the United States. A more political analysis would be that public interventions to improve the quality of life of U.S. populations require a set of class mobilizations, with confrontation of rather than adaptation to the U.S. establishment. This is what the authors do not do.

Let me finish these remarks by clarifying, once again, that it is not my intention to castigate research on income inequalities. Income is an important variable, quite handy when other, more important variables are not easy to obtain. But my criticism is directed at those who, ignoring all the work done by critical scholars who for many years have labored in the area of social inequalities from a class perspective, focus instead on income as the dividing line among our citizens, using consumption as the primary area of concern. Consumption is important, but more important are other categories of analysis whose absence, as they are abandoned or discriminated against, weakens and impoverishes the understanding of our realities. In that respect, the whole area of social inequalities research should build upon the very important research work produced from the 1960s through the 1990s that focused on how class power (class, race, and gender power) is reproduced in both political and civil societies and how that reproduction affects the level of health of our populations, in both North and South. Such a focus is not popular in the funding agencies of the North today, but it continues to be the most important.

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