Assessing the conflict and consensus approaches

Consensus is a concept of society in which the absence of conflict is seen as the equilibrium state of society based on a general or widespread agreement among all members of a particular society. The consensus ideology proposes that society consists of social institutions which are all dependent of each other and are vital for maintaining social order. The consensus theory highlights harmony, integration and stability. Functionalists argue that the main institutional groupings play a tremendous role in determining the culture of society. These, as example include economic, politics, family and kinship, as well as media. Economic growth plays a role as well because it affects the way certain societies think and how they run their everyday lives.

The functionalist perspective is rooted in the work of Emile Durkheim (1858-1917) and gives the view of society as an organism in which each part functions in a certain way to ensure the stability of the whole. Though society is something which exists on its own it has a structure of parts that maintains it. The parts are institutions like the family or the church, which are “ useful” or “ functional” in some way, but if the institution was no longer functional it would disappear and be replaced like a passing fashion. People involved in these institutions may not be aware of their function, but because the institution exists certain effects follow. Institutions are long lasting so therefore functional.

The foundations of functionalism explain how social inequality is necessary to motivate the more talented members of society to train to fulfil the demands of social positions which are functionally more important than others. They list the rank order of positions as religion, government, wealth and technical knowledge and point out that only a limited number of people

have the talents which can be turned into the skills needed for these positions. This takes training which means social and financial sacrifices are made, so in order to encourage people to undergo this training, and to endure the demands of the future position itself, they are given certain privileges. This may include access to scarce resources such as property, power and prestige. This access to scarce resources produces stratification but also inequality in the amount of resources allocated to different people. This inequality is both functional and inevitable.

Functionalist theories state that education meets the needs of the industrial society as well as the cultural society and has the important role of socialising the individual to fit into, and continue, the social system. Individuals are born into a society that already has an identity of its own and education has the function of passing on shared values and skills.

Where functionalism uses consensus, shared norms and values and concepts such as order, harmony, cohesion and integration, Marxism takes a different view.

Marx argues that that economic inequality is at the heart of all societies. Conflict is a disagreement or clash between opposing ideas, principles, or people-this can be a covert or overt conflict. The conflict perspective is based on many conflict approaches. In spite of their inconsequential differences, they all have a model of society as a whole and they collectively share the view of the structural approach. Additionally, all perspectives, in some form or another, share the notion that sociological groups have different interests. As a result, they propose that conflicts are always

probable since that when different groups advocate their own individual interests, it tends to cause disagreement and in certain situations, resentment. Arguably, the two most prestigious standpoints within the approach are the Marxist and feminist conflict theories. A major difference between functionalism and the conflict perspective is that the conflict approach accentuates the existence of competing groups whilst functionalism views groups as being fully cooperative.

Conflict theorists emphasise conflict and contradiction whereas consensus theorists maintain that society's institutions work within functional unity. The conflict paradigm (particular Marxists), conversely, holds that society has an infrastructure and a superstructure that work independently. The ideology considers value as being the mechanisms for keeping society together. Conflict theorists reject the assertion and claim that values are imposed by the powerful groups in society. Conflict theory, proposes that conflict, struggle and change are more prevailing within society. Marxism sees human history as a class struggle, with oppressor and oppressed wrestling for control. The dominant class controls and owns the means of production or wealth generation, and the working class in therefore controlled by them.

Welfare is a result of the strength of working-class resistance to exploitation, a concession the dominant class must make to maintain social order. Programmes such as welfare and pensions help to legitimise the capitalist system with the working class. Welfare then becomes another vehicle for power and control by the dominant class. Its purpose is to placate rather than empower the poor, and seeks to reduce the individual to a state of dependency on those in power. According to Marxist theory, society has

unfolded in a series of ever-progressing and better structures, as defined by their economic development and modes of production, from the primitive communal to slave-based to feudal to capitalist. The final stage was communism. This was predicted to be the best possible means of governance and structure of society, one that would erase inequalities and allow individuals to achieve their full potential and value within their community.

Marxism viewed the individual as part of a collective organism, society. Inequalities in society resulted from distinction in classes, not particular individual decisions or behaviours. Conflict was between these classes, and rooted in struggle for power.

Marxism assumes the individual can and will contribute to the greater community as much as they are able, and will be motivated by the common good. When society has evolved or elevated itself to this place, inequalities will be dealt with appropriately The problem with broad application of Marxist theory is that individuals do take advantage.

As Wes Sharrock 1977 puts it: The conflict view is founded upon the assumption that society may provide extraordinarily good lives for some usually only possible because the great majority are oppressed and degraded. Difference of interest are therefore as important to society as agreements upon riles and values, and most societies are so organised that they not only provide greater benefits for some than for others

Social conflict differs from consensus because it is interested in the way unenequal distribution of advantage in a society structures behaviour and is interested in the conflict inherent in such a society.

The Marxist perspective concentrates on the differences between groups and concepts such as control, conflict, power, domination and exploitation. This is the theory based on the work of Karl Marx (1818-1833) Marx felt that social class was the main form of inequality and saw only two significant social classes. He maintained that it was capitalist industrialisation that led to this " two class" society, the bourgeoisie who owned the means of production (e. g. factories) and the proletariat who became the wage labourers (working in the factories).

" What the bourgeoisie, therefore, produces, above all, is its own grave diggers. Its fall and the victory of the proletariat are equally inevitable." (Marx and Engels. 1848)

Is social stratification socially constructed.

Throughout the ages there has always been evidence in stratification and how it is socially moulded into almost everything. It can be seen In families, the workforce, in politics and international from one country to another, male against female, ages from young to the old and from the rich to the poor. It is even seen in the animal kingdom and it appears to be a natural instinctive survival mechanism but one that is unfair. It seems to happen when one or more people having a belief in something which in turn over powers the next therefore creating a layer with a low medium and high for example the class system of the poor and the bourgeoisie It depends on the individuals

definition of social stratification however one may understand it as a form of hierarchy which is displayed almost in everything and everywhere we are only free when we are first born from then on in we belong to a class starting within the family union through to a much bigger ranking within local to international society.

FOUR SECTIONS : RACE GENDER SEX AND AGE

There are two reports which have been commissioned by the government to try and find some evidence of variations in health and illness. These are The Black Report (1980) chaired by Sir Douglas Black and The Independent Inquiry into Inequalities in Health by Sir Donald Acheson (1998).

Firstly, in The Black Report inequalities in human health take a number of distinctive forms. Most attention is given to differences in health as measured over the years between the social (or more strictly occupational) classes. When comparing rates of mortality among men and women in each of the 5 classes. Taking the 2 extremes as a point of comparison it can be seen that for both men and women the risk of death before retirement is two-and-a-half times as great in class 5 (unskilled manua1 workers and their wives), as it is in class 1 (professional men and their wives).

One of the most distinctive features of human health in the advanced societies is the gap in life expectancy between men and women. This phenomenon carries important implications for all spheres of social policy but especially health, since old age is a time when demand for health care is at its greatest and the dominant pattern of premature male mortality has added the exacerbating problem of isolation to the situation of elderly

women who frequently survive their partners by many years. The imbalance in the ratio of males to females in old age is the cumulative product of health inequalities between the sexes during the whole lifetime. These inequalities are found in every occupational class demonstrating that gender and class exert highly significant and different influences on the quality and duration of life in modern society.

Rates of age-specific mortality vary considerably between the regions which make up the United Kingdom. Using mortality as an indicator of health the healthiest part of Britain appears to be the southern belt (below a line drawn across the country from the Wash to the Bristol Channel). This part of the country has not always exhibited the low rates of mortality that are found there today. In the middle of the nineteenth century, the South East of England recorded comparatively high rates of death, while other regions like Wales and the far North had a rather healthier profile. The fluctuation in the distribution of mortality over the years suggests that social (including industrial and occupational) as much as “ natural” factors must be at work in creating the pattern of regional health inequalities.

One of the most important dimensions of inequality in contemporary Britain is race. Immigrants to this country from the so-called new Commonwealth, whose ethnic identity is clearly visible in the colour of their skin, are known to experience greater difficulty in finding work and adequate housing (Smith, 1976). Given, for example, these social and economic disabilities it is to be expected that they might also record rather high than average rates of mortality and morbidity.

Class differences in mortality are a constant feature of the entire human lifetime. They are found at birth, during the first year of life, in childhood, adolescence and in adult life. In general they are more marked the start of life and in early adulthood. Average life expectancy provides a useful summary of the cumulative impact of these advantages and disadvantages throughout life. A child born to professional parents, if he or she is not socially mobile, can expect to spend over 5 years more as a living person than a child born to an unskilled manual household.

At birth and during the first month of life the risk of death in class 5 is double the risk in class 1. When the fortunes of babies born to skilled manual fathers are compared with those who enter the world as the offspring of professional workers the risk of mortality is one and half times as great. From the end of the first month to the end of the first year, class differentials in infant mortality reach a peak of disadvantage.

For the death of every one male infant in class 1, we can expect almost 4 deaths in class 5.

In adult life, class differences in mortality are found for many different causes. As in childhood the rate of accidental death and infectious disease forms a steep gradient especially among men; moreover an extraordinary variety of causes of deaths such as cancer, heart and respiratory disease also differentiate between the classes.

The duration of the human lifetime is one of the best means of approximating the lifelong pattern of health of individuals and whole populations. As we have seen, the risk of premature death in Britain today is

systematically related to socioeconomic variables. This association is not new or unusual. Death rates have always been relatively high among the underprivileged and materially deprived sections of communities. Why this should continue to be so in an era characterised by new patterns of disease, increased purchasing power, and state provision of free medical care is more perplexing. In infancy and childhood where the class gradients are steep, the major causes of death are in many ways directly linked to poverty and to environmental risk. In adulthood the relationship between health and class becomes more complex and in old age social and economic deprivation becomes a common experience.

Both Cartwright and O'Brien (1976) and Buchan and Richardson (1973) have studied GP consultations in depth. Both investigations showed that middle class patients tended to have longer consultations than did working class ones. More problems were discussed at consultations with middle class patients than with working class ones. Cartwright and O'Brien also found that middle class patients were, in a sense, able to make better use of the consultation time, as measured by the number of items of information communicated and the number of questions asked. Moreover even though working class patients tended to have been with the same practice for longer, the doctors seemed to have more knowledge of the personal and domestic circumstances of their middle class patients. In an earlier study Cartwright had found that middle class patients were more likely to be visited by their GP when in hospital than were working class patients (Cartwright, 1964). For cultural reasons then, and also because there is a tendency for the ' better' doctors to work in middle class areas, the

suggestion is that middle class patients receive a better service when they do present themselves than do working class patients.

In the case of family planning and maternity services substantial evidence shows that those social groups in greatest need make least use of services and (in the case of antenatal care) are least likely to come early to the notice of the service. Cartwright (1970) found clear class gradients in the proportion of mothers having an antenatal examination, attending a family planning clinic, and discussing birth control with their GP. Unintended pregnancies were more common among working class women. Bone (1973) also found that women from the non-manua1 classes make more use of family planning services than those from the manual classes. This was true both for married and for unmarried women. Similar differences have been found in presentation for post-natal examination (Douglas and Rowntree, 1949) and (by Gordon, 1951) immunisation, ante-natal and post natal supervision and uptake of vitamin foods. The National Child Development Study (1958 birth cohort) found substantial differences in immunisation rates in children aged 7, as well as in attendance at the dentist. Among women, it has been found that those in classes 4 and 5 are much less likely to be screened for cervical cancers even though mortality from this condition is much higher in these classes than in the non-manual classes.

In the Acheson report, the findings were much the same as The Black Report. The Acheson Report has also shown that health was improving but more for the higher than lower social classes. Premature mortality, that is death before age 65, is higher among people who are unskilled. If all men in this age group had the same death rates as those in classes I and II, it is

estimated that there would have been over 17, 000 fewer deaths each year from 1991 to 1993. Deaths from accidents and suicide occur at relatively young ages and each contribute nearly as much to overall years of working life lost as coronary heart disease. Death rates from all three causes are higher among those in the lower social classes, and markedly so among those in class V (Office for National Statistics and Blane & Drever 1998).

In adulthood, being overweight is a measure of possible ill health, with obesity a risk factor for many chronic diseases. There is a marked social class gradient in obesity which is greater among women than among men. (Colhoun and Prescott-Clarke, 1996), (Prescott-Clarke and Primatesta 1997), (Prescott-Clarke and Primatesta 1998). In 1996, 25 per cent of women in class V were classified as obese compared to 14 per cent of women in class I.

Another indicator of poor health is raised blood pressure. There is a clear social class differential among women, with those in higher classes being less likely than those in the manual classes to have hypertension. In 1996, 17 per cent of women in class I and 24 per cent in class V had hypertension. There was no such difference for men where the comparable proportions were 20 per cent and 21 per cent respectively (Prescott-Clarke and Primatesta 1997).

Across different ethnic groups, there are very different rates of unemployment. Those from minority ethnic groups have higher rates than the white population. Black men have particularly high unemployment rates as do Pakistani and Bangladeshi women (Office for National Statistics 1998).

Between 1982 and 1992, there was a steep increase in the number of households accepted by Local Authorities as homeless. Since then, there has been a decrease of about a quarter. Of the 166, 000 households classified as homeless in 1997, over 103, 000 were accepted by local authorities to be unintentionally homeless and in priority need. Over half of households accepted by local authorities as homeless had dependent children and a further tenth had a pregnant household member (Department of the Environment, Transport and the Regions 1997 and 1998).

There is a clear social class gradient for both men and women in the proportion who smoke. In 1996, this ranged from 12 per cent of professional men to 41 per cent of men in unskilled manual occupations and from 11 per cent to 36 per cent for women (Office for National Statistics 1998). In spite of the major class differences in dependence on alcohol in men (Meltzer et al 1995), there are very small differences in the reported quantities consumed. This is not the case among women where higher consumption is related to higher social class (Office for National Statistics 1998).

People in lower socioeconomic groups tend to eat less fruit and vegetables, and less food which is rich in dietary fibre. As a consequence, they have lower intakes of anti-oxidant and other vitamins, and some minerals, than those in higher socioeconomic groups (Colhoun and Prescott-Clarke 1996), (Ministry of Agriculture, Fisheries and Food 1996), (Department of Health 1989), (Gregory et al 1990), (Gregory et al 1995).

One aspect of dietary behaviour that affects the health of infants is the incidence of breastfeeding. Six weeks after birth, almost three quarters of

babies in class I households are still breastfed. This declines with class to less than one quarter of babies in class V. The differences between classes in rates of breastfeeding at six weeks has narrowed slightly between 1985 and 1995 (Foster et al 1997).

Class inequalities in health have been accounted for in a number of different ways. The report of the DHSS Inequalities in Health Working Group ‘ The Black Report’ lists four types of explanation. These are inequality as an artefact, inequality as natural selection, inequality as material deprivation and inequality as cultural deprivation.

The artefact explanation argues that inequalities in health are not real but artificial. They are an effect produced in the attempt to measure something which is more complicated than the tools of measurement can appreciate. It is argued that changes in the occupational structure are likely to combine with age to confound any attempt to measure inequality in mortality even at one point in time. It is suggested that the age structure of social class 5 is likely to be biased towards older workers because younger recruits to the labour force will have entered better paid, more skilled occupations, that have expanded since the war. Since the mortality risk increases with the age, this effect is likely to enlarge the rate of social class 5 as a whole. If so, the observed gradient is really caused by the skewed age structure of the unskilled manual class rather than by the poorer health of its members.

The most persuasive attempt to explain health inequalities as the outcome of a process natural selection, has been put forward by the statistician, Jon Stern. He argues that those people with better health move up the social

class ladder and those with poorer health move down the social class ladder (Stern 1983). Stern defines health as a fixed or genetic property of individuals largely independent of their immediate social and economic environment. His argument rests on the assumption that health itself increases the probability of social mobility and that the class structure permits movement up and down. This means that no matter how deprived the social background, a genetic potentiality for good health will enable a person to overcome material disadvantage and climb out of poverty.

Material deprivation means a shortage of the material resources on which healthy human existence depends. This means that health is directly affected by the material circumstances in which people live. In less developed societies (poor housing) its effects may appear in very high death rates from diseases primarily caused by malnutrition and exposure. People in poverty may not be able to afford or access healthy foods to stay healthy or they may become ill more often because of poorly heated homes.

Health inequality as cultural deprivation means that the poor have a self destructive culture which leads them to become ill because of the lifestyles and personal habits in which they engage, for example, smoking, alcohol, poor diet and lack of exercise, but these poor health behaviours are also a strategy to cope with the persistent material deprivation they experience.

The psycho social explanation suggests that long term chronic stresses are unevenly distributed in society, basically in line with class position (structural inequalities). The impact of stresses depends on how individuals view them, subjectively, and deal with them. This, in turn, depends on the buffering

resources we have in terms of personality, social background, location in the social structure, education, financial resources, and the supportiveness of the social environment.

The social environment and the social location can generate self efficacy which is a feeling of personal control, mastery over one’s life, instrumentalism (opposite concept to fatalism, powerlessness, learned helplessness). Self efficacy is the extent to which individuals see themselves in control of the forces which have a significant influence on their lives.

Self efficacy is linked to self esteem, self concept, social support and individuals coping style. In other words, the psycho-social approach forges a link between class position and vulnerability to social stresses.

Wilkinson et al (1990) discuss a social cohesion approach and argue that social and power inequalities (i. e. authoritarian hierarchies and non democratic social organisations, and potential status inequalities such as gender and ethnicity) will affect the quality of social relationships. Where inequalities produce anger, frustration, fear insecurity and negative emotion, social relations will suffer.

Better health is linked to better social relations, through trust, more security, more social support, more self esteem, self respect, a sense of belonging and less financial and material disadvantage. Thus democratic and participatory styles of social organisation – from the family to political organisations – have a health enhancing effect.

A life course theory regards health as reflecting the patterns of social, psychological and biological advantages and disadvantages experienced by the individual over time. A life course theory of health inequality regards these patterns as being profoundly affected by the position of individuals and families in social and economic structures and hierarchies of status. However, these links themselves depend on the political and cultural environment, which means that there is a need for a life course political economy of health, which examines the ways in which economic and social policies influence the accumulation of material and psycho social risk. The ways in which advantages and disadvantages combine over the life course influence both how long each individual may spend in good health, and also what form of illness they may acquire.

In conclusion, there are many inequalities in health and all the findings from The Black Report in 1980 are still around today, which was shown in The Acheson Report.

The table below shows the standardised mortality rates (SMRs) for ten equal-sized geographical areas in terms of population (or deciles). SMRs which are greater than 100 indicate higher chances of mortality, all relative to the national average. The table demonstrates a continuing polarisation in mortality rates. People living in the best areas have an improving life expectancy, whilst those in the worst areas face a decline, to such an extent that by 1998, those in the worst areas were twice as likely to die by the age of 65 as those in the best areasgraph showing Standardised mortality ratios for deaths under 65 in Britain by deciles of population, 1950-1998

graph showing Health inequalities in infant mortality (by social class for sole registrations)