Health Capital: New Health Risks and Personal Investments in the Body in the Context of Changing Nordic Welfare States
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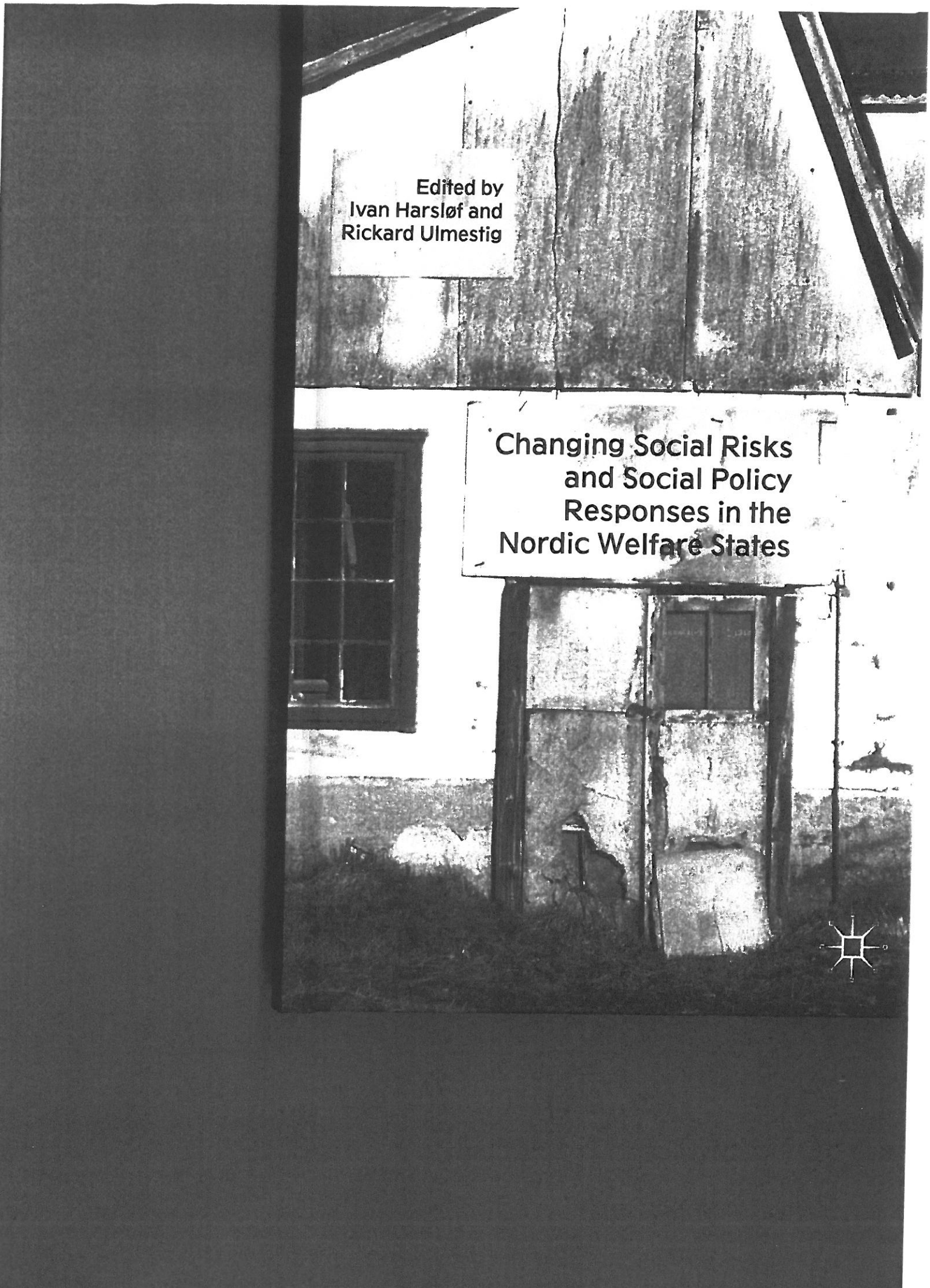

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Health Capital: New Health Risks and Personal Investments in the Body in the Context of Changing Nordic Welfare States[1]

Kristian Larsen, Malcolm P. Cutchin and Ivan Harsløf

Introduction

Throughout the Western world, patterns of diseases and disabilities have changed as new forms have emerged (OECD 2010). While many old social risks affecting people's health, such as inadequate nutrition and hard, physical labour, were related to scarcity, today we are witnessing health risks such as obesity, type II-diabetes, hypertension, cardiovascular disease, certain forms of cancer and so on that in intricate ways may be associated with abundance. Similarly, old social health risks, including dangerous work environments and poor housing conditions, were related to outward physical threats and are as such still present as risk factors, while new health risks appear to be more intangible and seemingly lifestyle related, sometimes even self-inflicted, like eating disorders (e.g. bulimia, anorexia) and deliberate self-harm. And in contrast to the old health risks, often manifested in conspicuous handicaps, the new health risks are less visible, and hence often labelled as 'diffuse' – for example, fibromyalgia, chronic fatigue syndrome, clinical depression and anxiety (cf. Øverbye 2005).

Paradoxically, new health risks are peaking in the face of a growing interest in health and the promotion of individual healthiness through training, nutrition and extensive monitoring of the body. This circumstance has given rise to the fear of an increased polarization, where

some social groups embrace these health trends while others continue an existence of physical passivity and poor diet (Buck & Frosini 2012).

Indeed, such concerns have been expressed in the Nordic countries (e.g. Norwegian Government 2006). Despite strong performance in terms of economic redistribution, comparative studies have found that the Nordic countries hold only a mediocre position among contemporary welfare states when it comes to social inequalities in health (e.g. Mackenbach 2012). This surprisingly low ranking in health equality has been attributed to a relatively strong social stratification of unhealthy life-styles in the Nordic countries (Bambra 2012:157).

This chapter will take as a point of departure that such an inference needs to be qualified. Hence, we aim at critically discussing the notion of lifestyle and discussing how the interaction and relations between individuals exhibiting certain lifestyle traits, on the one hand, and institutions such as the health system, the labour market and the state, on the other hand, may impact the distribution of chances and risks. The purpose of this chapter is thus to discuss health resources as a vector of social stratification in the post-industrial Nordic countries.

We discuss such resources in terms of Pierre Bourdieu's conceptual framework of forms of capital. Bourdieu demonstrated in numerous studies the fruitfulness of grasping processes of social reproduction and stratification by assessing the possession and composition of different forms of resources, or 'capitals', among social positions. Economic status (economic capital), education (cultural capital) and social networks (social capital) are doubtless the most important to explain social differentiation in the Nordic countries (Hjelbrekke et al. 2007). Yet, expanding this framework, in this chapter we ask whether a range of health and body-related activities, from everyday doings, such as eating, exercising and monitoring the body to more extraordinary activities, like marathon running and undergoing plastic surgery, can be seen as strategies that build a particular type of capital that advances one's social position.

So far, the issue of health and health policies has not been covered within the field of research preoccupied with new social risks (Bonoli 2007:501). Yet, such an inquiry is timely and important because society and politics in the Nordic states are undergoing transformation, and risk is increasingly being shifted to the individual as he or she manoeuvres in social fields such as the workplace and educational settings. In this chapter, we point at developments that should prompt researchers to consider health as an indispensable factor when assessing individuals' risk exposure in modern society. Hence, we discuss health

capital as a distinctive type of capital that supports the owner and increasingly concentrates social risks among those who do not invest in it.

In advancing health capital as a concept for the analysis of contemporary social stratification in the Nordic welfare states, we start by briefly introducing Bourdieu's theories, which are drawn upon in the later discussions. We next outline health capital as resources pertaining to the physical body, to objects, and to how bodies and objects are *validated* through their interaction with the surrounding labour market, health and welfare institutions. We bring in the notion of symbolic violence to understand how the welfare state itself may contribute in marginalizing certain social groups and certain bodies. Next, we discuss how the transition towards a post-industrial society may increase the importance of health capital. We draw on some secondary data sources to provide examples of how different social groups have gradually moved apart in terms of health activities and consumption. The final section discusses the importance of the Bourdieuian model and its implications for health care policy in the Nordic countries.

Health capital

An understanding of health capital requires both a conceptual and descriptive analysis and a focus on the fields (social space) where it occurs. In Bourdieuian theory, capital and field constitute each other, and health resources only constitute capital insofar as they are perceived and can be 'traded' on the 'market' for a distinct advantage. The fact that many in society are investing in their body, health and in various artefacts and tokens that signal healthiness calls for a deeper understanding of this process and its relationship to market and welfare state institutions.

The work of Bourdieu is useful due to its sensitivity to the relationships between individuals' *habitus* – their background, aspirations and predispositions – and the societal context. It is an approach that relieves individuals and social groups from the implicit blame and stigma of purely lifestyle-oriented models of explanation – while acknowledging that social outcomes and social reproduction ultimately go through the action and interaction of individuals and groups (or *agents* as he terms them). While claiming universal and trans-historical relevance (cf. Calhoun 1993), Bourdieu simultaneously insists on examining the specific context or field to unravel its order of stratification (Bourdieu & Wacquant 1992:119).

The concept of habitus aims to explain how agents, guided by taken-for-granted sympathies and antipathies, affections and aversions, tastes and dislikes, act in particular ways and create routines and manners for going about that are comfortable and reflective of a person's social group (Bourdieu 2000:50). In this way, habitus 'knows' what to do and how to do it, to move, eat, play, walk, bike or drive, as appropriate for that specific position in the social space (Bourdieu 1984). Habitus guides and structures an agency to apply principles that are adequate for its position in the social space. There is a tendency for people to look for and create relationships with other people (friendships), occupy places (neighbourhoods) and to purchase things (clothes, furniture) that are associated with, and similar to, what habitus 'knows' from earlier experiences (Bourdieu 1984).

The field concept suggests a historical and social development (genesis and structure) of a micro-cosmos that is regulated by a specific inner logic, its own informal rules and structure, where the agents engage in struggles for acknowledgement. This is an unequal struggle as the chances that are offered are unequally based on one's position in the field. Positions in the field have different accumulations and types of resources (capitals) that provide advantages. Agents, so this perspective holds, draw on different dispositions (habituses) to think and act in specific ways, depending on their social experiences. The field integrates structures of dominance, hierarchy and relations between the appointed 'experts' (e.g. priests) and the 'laymen', and it involves the accepted views and convention (orthodoxy), the 'dissents' with challenging views (heterodoxy) and the implicit taken for granted (doxa). These concepts can be used to describe and explain new phenomena in studies about social reproduction and inequality in health.

A number of phenomena together constitute a 'taste for health'. Religion that used to guide people also in terms of health conduct is being dissolved and immersed into a wider field of symbolic manipulation (Bourdieu 1985). Science, and health science in particular, has, over time, supplanted religion in the social space, installing psychologists, psychoanalysts, doctors, sexologists, 'life coaches', body therapists, nature healers/therapists, and instructors as the 'new priesthood' (Bourdieu's phrase). These positions take part in the struggle to provide the 'laity' with advice about how to live via health, healing and spiritual and bodily care. Another feature affecting the taste for health relates to how the ingestion of food and beverages over time, established as a relatively autonomous field of knowledge such as 'eating', becomes 'nutrition'. A third feature relates to how ritual games and festive entertainment – again in a historical perspective – are transformed into 'sport' and, along the way, established as a competitive field (Bourdieu 1981).

In this chapter, we theorize health capital as qualities disposed of and managed by individuals or groups that, following such developments, are increasingly appreciated across disparate social fields, and that can hence be deployed, intentionally or simply as part of an embodied, unconscious practice, to bring about actual effects in the field, advancing the possessors' social position vis-à-vis others. We argue that agents through certain activities and the purchase of objects, treatments and services, can 'invest' in health capital. Health capital is part of social reproduction of class relations and investment in the body is a distinctive activity, as other investments (Bourdieu 1984). Moreover, such investments may contribute to establishing practices (e.g. training), occasions (e.g. a race) or places (e.g. training studies or private hospitals), where those who are unwilling to or incapable of reaching these standards are screened out, so that, as a further gain, exclusive yet legitimized networks with others strong on health capital are formed (cf. Bourdieu 1986:104).[2]

Health capital objectified and institutionalized

By approaching health resources as a species of capital, we can highlight dimensions of health that are not merely of a physical–biological nature. While there are obvious overlaps between physical health constitution and the possession of health capital, paradoxically, aspects that may sustain health capital, say cosmetic surgery, may have no or even adverse health effects in the physical–biological sense. To capture this insight, the following extension and development of Bourdieu in this chapter expands upon Bourdieu's three mutually dependent dimensions of cultural capital (Bourdieu 1977), which are termed embodied, objectified and institutionalized. We conceptualize health capital in a similar way. In addition to the *embodied* state, there is health capital in its *objectified* form as related to physical artefacts such as buildings, health and medical technologies, and treatments and services. We conceptualize health capital in its *institutionalized* form as in health legislation, instructions, health certificates and accreditation, professional certification and titles, and prevailing, authorized 'health theories' as they are presented in textbooks, public brochures, etc.

As a meta-field, the Nordic welfare states have accumulated certain resources that are communal, as they in principle are available to all

citizens. Related to health, this capital has an *objectified* form, as in public infrastructure, hospitals, road and rail network, common distribution of water supply, electricity and so on. It also has its existence in artefacts like medical or pharmaceutical technology or in 'everyday' products like hormones, vitamins and clothing.

Resources related to health also have an *institutionalized* existence in the forms of social, educational and health care laws and statutory instruments stipulating rights and obligations, institutions and professions. For example, all residents in the Nordic countries are entitled to free treatment by a general practitioner and specialist. Moreover, they can get substantial support for medicine, dental treatment and care, physiotherapy, foot therapy, chiropractic care and psychological treatment. The inclusion and exclusion of types of therapists (physician/laymen), therapies (conventional/alternative) and interventions (evidence based/experience based) are objects of struggle in the field.

There is thus an ongoing struggle in the state (the meta-field) and in the health field between accepted views and conventions (orthodoxy) and dissidents and their challenging views (heterodoxy). It is common sense in the implicit, taken for granted way (doxa) that the healthy body has certain normality in terms of serum cholesterol, body mass index and so on. The 'choice' of lifestyle is seen as important, and the authorities who dominate the health field, like the national boards of health, distribute declarations and guidelines about how to monitor and treat the healthy body (Ljungdahl 2011). The power of the meta-field imposes and inculcates fundamental principles of classification also in relation to the healthy body. Individuals' health capital taps into the knowledge accumulated in authorized theories and models about the human body, anatomy/physiology, nurturing/surgery and knowledge about pharmaceutical treatment, and so on. These 'sources' of health capital are mutual products, produced over time and by the 'work' of the social, organized by the meta-field.[3]

The extent to which agents' health attributes, behaviour and activities constitute health capital is dependent upon this objectified support and institutionalized validation. We argue that within the Nordic countries the 'availability' of such support and validation is changing, from a universal and standardized organization, to now being more unequally distributed among and within groups. This change has to do with an overall transformation of Nordic health systems. This is the subject of later sections, but first we review a number of other arguments that have some similarities to ours.

A review of prevailing perspectives on health capital

Shim (2010) defines a comparable concept of cultural health capital, as 'the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal health care relationships' (Shim 2010). This concept was developed in order to account for growing unequal treatment in clinical interactions, with special attention to US health care and the variable relationships between social position and health care interactions. We agree about the emphasis on cultural capital as a precondition for health attributes to translate into improvements in one's social position (field effect).[4] Yet, in contrast, the concept of health capital that we propose aims at linking more deeply this species of capital to other fields, suggesting its wider ramifications beyond the specific health care sector at the 'face to face' level of interaction.

Lindbladh and Lyttkens' (2002) analysis of decision-making in health-related behaviour has also important similarities with our approach. On the basis of 16 thematically structured interviews, the authors examine how differently positioned individuals are able to act on choice. They conclude that 'people in lower social positions are more inclined to rely on habits and are, accordingly, less likely to change their behavior' (Lindbladh & Lyttkens 2002:463). Compared to the approach that we outline in this chapter, their approach places more emphasis on habitus in explaining health behaviour than on the different investment strategies used among social groups – and how these strategies are appreciated by the overarching institutional setting.

From a health economics perspective, health resources may be regarded a component of human capital (Becker 2007). This perspective assumes that individuals inherit an initial stock of health that decreases over time, and that can be increased by investment. This way of conceptualizing health capital is developed to measure how investment in the stock of health capital includes 'own time', medical care, diet, housing and other goods as well (Grossman 1972). The production of health capital also depends on certain environmental variables, and the most important factor is the level of education of the producer. This health economics perspective is also articulated by Wadsworth, Montgomery and Bartley (1999) in which health capital was operationalized and empirically measured by calculating an individual's Body Mass Index (BMI), physical training/exercise and intake of fruit. Using this measurement, long-term unemployed were found to possess less

'health capital'. Since the 1990s, there has been a growing literature dealing with the impact of health on labour market participation, earnings and wages. In such models, a higher stock of health capital is expected to increase earnings and wages because it allows workers to increase the number of hours worked and also because higher health capital involves higher productivity.

From another social philosophical angle inspired by the work of Michel Foucault, Rose (2009) writes about the phenomenon in modern society in which people increasingly take on roles as 'pre-patients', acting on expectations and requesting to be examined for possible illnesses or disabilities on a molecular or even genetic material level. By monitoring their bodies, people are trying to better their chances in life. It is no longer destiny that dictates one's future health condition; one can shape the quality and quantity of life oneself. Such individual health behaviour is reinforced by a reconfiguration of the relationship between symptom, sign and illness in modern health systems, where these components are increasingly addressed as predictive factors of future health risks (Armstrong 1995).

Changing Nordic health systems

Initially, the state's purpose was primarily to maintain and optimize its position through the preservation of its territorial boundaries, collecting customs duties and taxes, and ensuring subjects' obedience. Later, to cater to the emerging industry's need for healthy-bodied workers and the army's need for fit soldiers, to contain infectious diseases in the growing cities, and to ensure 'harm control' related to illicit drug use and risky sexual behaviour, it became important to measure, control and intervene at the population level (see, e.g. Johannisson 1991:140). To improve public health, a number of institutions were put in place to provide health services and produce and disseminate knowledge about health, disease and nutrition. In the Nordic countries public health systems providing universal and comprehensive coverage came into existence after the Second World War (Mays 2006). A distinct social democratic model of health care services cannot be identified, but common Nordic features emerging in this period include a high priority of hospitals in the health policies and strong medical professional power (Haave 2006).

A number of developments from the 1970s and onwards challenged the actual universality of such services. Many advanced societies saw a crisis of Etatism, reflected in entrenched bureaucratic structures

and budget deficits (Crook et al. 1992). In the Nordic countries, to ensure cost-containment and efficiency, systems of health finance were reformed, and service provisions were decentralized and deinstitutionalized (Romøren 2001). Simultaneously, the health system proliferated into numerous specialties and subspecialties, accompanied by an accelerating division of work tasks and professional knowledge (Album 2013). Moreover, strong processes of internationalization have meant that, to an increasing extent, the health field cannot be demarcated within national borders. Dominant players in the health care field are operating transnationally. For instance, multinational corporations such as the pharmaceutical industry and its institutional representatives, along with regional and global organizations (e.g. the World Health Organization), constitute dominant positions which are structuring the health field. In particular, the European Union plays an important role in inducing inter-European trade in health services, and in regulating national health systems in general (Byrkjeflot 2011:158).

The principle of equity has remained a strong ethos in Nordic health systems (Calltorp & Larivaara 2009). Yet, it is likely that recent trends and policy reforms in the health field will increase the importance of people's own possession of various resources.

Health care systems have become more productive in treatment and turnover in hospital patients. During the 2000s, the average length of a stay in a hospital was reduced by almost a fourth in Denmark and Norway. In Sweden the trend has been less steep, but along with its Scandinavian counterparts, Sweden is still among the OECD countries with the shortest hospital stays. Finland deviates from the Nordic pattern by having stays at hospitals that are longer than average – and with only a very small declining trend (OECD 2011). By shortening the length of time that patients stay in a hospital setting, arguably, the system has externalized post-treatment health care, making it the responsibility of the primary health care services, but also patients' social network – family and friends, if any. It has also been pointed out how Nordic health systems are increasingly concerned with the coupling of health-related and occupational activities, for example, by increasingly emphasizing measures to facilitate patients' quick return to work (cf. Johansen & Solbjør 2012) and giving priority to the treatment of health conditions that are associated with high rates of absenteeism at work (Vallgårda & Lehto 2009:261).

New public management strategies have made their entry into Nordic health systems in full scale, and the Nordic countries have gone from 'modernizers' to out-and-out 'marketizers', with increased agentification

(e.g. making sub-units accountable through contracts specifying performance targets), and competition (e.g. establishing quasi-markets in terms of free choice of hospital) (Byrkjeflot 2011; Hansen 2011). Among other things, this development has entailed new forms of 'prioritizing' of care in the public health care system. This may result in an increasing marginalization of certain social groups, including older people, because the diseases they are likely to incur are given less priority, either formally or informally (Album 2013). We furthermore note that there has been a concomitant privatization of certain health care services, with for-profit hospitals emerging in all the Nordic countries during the 1990s, even if, with Sweden as the exception, they are still relatively small and specialized (Martinussen & Magnussen 2009).

A related trend is the rising importance of private health insurance. Denmark has seen the most dramatic change in this area, with a rise from 50,000 persons covered by private health insurance in 2002 to one million in 2008 (Søgaard et al. 2011). In Norway, the number of persons with private health insurance rose by a factor of 10 in the 2003–2009 period, from 20,000 to 200,000 persons. There has been a similar increase in the number of the private insurance policies in Sweden. In the 2000s, the number grew from 100,000 to almost 250,000 persons (Berge & Hyggen 2010). In Finland, the number grew from 167,000 in 1999 to 462,000 in 2011 (Official Statistics of Finland). With the exception of Finland, this Nordic trend has been driven mainly by an expansion of employers offering insurance to their employees as part of collective agreements. For some of the Nordic countries, for example, Denmark, this trend can be partly associated with deliberate policy changes aimed at individualizing health risks to encourage personal responsibility (cf. Chapter 11 in this volume). Yet, the main impression emerging from the steep expansion of private health insurance seems to be the rising importance attributed to health in working life and among individuals in the Nordic countries.

While privatization and the trend towards private health insurance might amplify social inequalities in health, the public sector remains the prime provider of health care services in the Nordic countries. Yet, inequalities may also be related to the de facto access to these services. An encompassing OECD study revealed that the Nordic countries were fairing rather poorly in ensuring that people in the same 'health risk group' but from different economic strata had the same access to health care services. In Finland and Sweden, high-income groups had more frequent access to both physicians and health specialists than low-income groups. In Norway and Denmark, these inequities

were also found but only concerning access to specialists (Doorslaer et al. 2006). A Norwegian study based on large-scale administrative data, and controlling for the severity of the health problem and other confounding factors, demonstrated that less-educated patients are discriminated against, when it comes to the length of waiting time for treatment. The study, however, did not find discrimination associated with the patients' level of income (Carlsen & Kaarbøe 2010). In another Norwegian study, 17 per cent of the physicians interviewed in a survey endorsed the proposition that 'healthcare priority should depend on the patient's responsibility for the disease' (Bringedal & Feiring 2011). This could imply that their patients' ability to deploy their health capital, for example, by strategically presenting their disease history, may influence whether they are prioritized. Also, social capital in terms of network resources may come into play. Thus, another Norwegian study assessing a number of different personal network resources found that the mundane circumstance of counting a medical doctor among one's friends was associated with better self-reported health, even when a range of other sociodemographic factors were accounted for (Gele & Harsløf 2010).

The state, symbolic violence and health

The previous section argued how developments in Nordic health care systems may have rendered the access to health capital in its objectified form, treatment and services, more unequally distributed, that is, more dependent upon people's social network, their economic situation, their educational level, their employment situation (e.g. having an employer offering private health insurance) and their belonging to a health risk group being prioritized. This section proceeds by arguing how these developments may also have changed how different bodies and different health activities are validated as conforming to prevailing ideals.

Bourdieu suggested a 'model of the emergence of the state', in which the modern state is seen as the culmination of a process involving the concentration of different species of capital: the capital of physical force, or instruments of coercion (army, police), economic capital, cultural capital (or informational capital) and symbolic capital. It is this concentration which constitutes the state as the holder of a sort of meta-capital, granting power over other species of capital and over their holders. The state, as such, is a meta-field that attempts to regulate all other fields by mediating the struggle concerning which principles are to become the dominant principles of legitimation (Bourdieu 1994:4).

But the state is not a monolith; it is stable but under transformation. There is a struggle between groups (cultural and economic elites) that are attempting to dominate the state and impose an understanding of the social world as legitimate. Furthermore, there is a struggle within the state about the state. Bourdieu argues that the state is divided between its welfare and financial functions. One can observe a tension between the welfare functions and their leaders who oppose privatization, and the financial functions of the state, which favour market-based public service reform. The division and struggle is within the state itself, but as we observed above, in the Nordic countries during the last 20 years, the financial side has begun to dominate the welfare side (see also Neumann 2003; Pedersen 2011).

It is a fundamental point that the state as a meta-field has a large effect on the health field through the production of classifications that one spontaneously applies to the social world, including one's own body, its physiognomy, skin, size, weight, etc. Such classifications are translated into cognitive perceptions associated with the body, such as healthy or unhealthy, normal or pathological, nice or disgusting, fit or unfit, etc. The effect of the state's efforts is hardly noticed as the state 'creates a political doxa, that is, an array of official classifications that become practical, taken-for-granted understandings of the social order' (Bourdieu quoted in Swartz 2004:13). Studies have shown that in particular Danish policy documents prepared during the Liberal-Conservative government of the 2000s have enunciated social inequalities in health as rooted in inadequate lifestyle among disadvantaged groups and individuals, whereas in the other Nordic countries, one has been more careful in also acknowledging structural features such as living conditions, work environment, and psychosocial factors like social network and emotional support (Vallgårda & Lehto 2009).

The manner in which the state articulates the health message by defining, advising and communicating about healthy and unhealthy bodies may result in a form of 'symbolic violence' affecting those in lower social positions. Certain forms of articulating the health message may make this group view their own physiognomy as out of proportion, inadequate, and hence marginalized. And the ever stronger articulation of the connection between health and individual lifestyle – and also the emphasis in public health campaigns on the large burdens that people with poor health are assumed to place on public budgets – reinforces this process by associating the marginal social position among those in poor health with bad moral and poor choices. Inferiority is *habituated*, that is, internalized, and growing social inequalities are *legitimized*, also among those bearing the brunt, by reference to differences in health status (cf. Mik-Meyer & Villadsen 2007).

In other words, the effect of state-authorized definitions of body mass index, body proportions, size and weight goes beyond outer physiognomy. Physical shape and size is translated to social power because the authorized definition of the body is incorporated, perceived and active as *the* definition in the health field. Violations of the definition may lead to various forms of symbolically loaded 'sanctions' against those outside the defined norm. And while symbolic violence is mainly a kind of inner domination, such sanctions might be of a more outer nature. For instance, long-term unemployed people or even people on sick leave may be required to participate in physical training as a condition for receiving benefits, as has been the case in Denmark in the 2000s (cf. Chapter 11 of this volume).

Health capital as a mean for positioning oneself in post-industrial working life

Arguably, the dominant view on health investments during the industrial age of Fordism is epitomized in the words of Henry Ford himself: 'Exercise is bunk. If you are healthy, you don't need it; if you are sick, you won't do it' (Ford quoted in Bauman 2000:133). Leaving this mode of production, investments in health capital through exercise and other activities appears to becoming of increasing importance in working life.

Post-industrial production requires not only strong formal credentials but also a multitude of informal skills and competencies (Rodriguez 2003:68; Sennett 1999). This gives employers in a strong interest in gauging the intrinsic work potential of job seekers prior to hiring or promoting them. Workers may in turn find that investments in health capital are necessary to signal their potential capacities for self-discipline, endurance, concentration, creativity, risk taking and risk handling, team work and ability to quickly adapt to the *pivots* performed in management corridors. Under these circumstances, the worker's health capital needs to be constantly maintained and promoted as 'signals of health and vigor may be subject to rapid short-term changes' (Bird & Smith 2005:237).

Another feature of post-industrial production, the blurring of the borders between work and private leisure activities (Hochschild 1997), also intensifies the importance of health capital. A focus on health and on

activities that may enhance employees' health is increasingly gaining a foothold within the work place – with offers to employees of fitness, yoga, sport activities for team-building purposes, healthy food in the canteen and courses in everything from stress coping to life-saving (Alvestad et al. 1998). At the same time, the notion of employment as, in itself, promoting health is gaining ground (see as an example Foss 2012), while one observes a growing 'medicalization' of unemployment, particularly in the Nordic countries (Holmqvist 2009). Likewise, activities in the field of leisure are increasingly appreciated for the value they bestow on peoples' working life, such as when yachting is praised for the leadership education it confers on the yachtsman (*Seilmagasinet* 2003:4), or golf for allowing the golfer to extend and nurture one's network (Horsens Erhvervsråd 2012). Indeed, observers point to how recent trends in sport and training mirror the requirements of post-industrial working life (Willig 2012).[5] A historical study of Danish fitness magazines traces to the early 1990s the perceptional transfer of health promoting exercise from an issue strictly anchored in the training studio and into the arena of working life (Merrild 2012).

Furthermore, while one should expect the transition from manual production work to non-manual service work to imply a relaxation of the requirements for physical constitution, an increased pressure on physical appearance of service workers, especially female workers (Jyrkinen & McKie 2012) and front-line workers (Nickson et al. 2012), and the general heightened focus on the mind and body nexus (see as an example Larssen 2012), might work the other way around. Likewise, the increased intensification of the work pace at Nordic workplaces (cf. Chapter 2) may, in fact, in itself require a better physical constitution. Indeed, as testified by Norwegian time series data from 1980 to 2005, health condition seems to be an increasingly strong predictor of peoples' labour market status (Dahl et al. 2010:36).

Investments in health capital among different educational groups in Denmark

We now discuss examples from Danish data regarding different realms of care for health and body in order to explore how different social groups invest in health capital.[6] By including not only the realm of biomedicine but also alternative medicine (where health effects are contested) and cosmetic surgery (where they might even be adverse) we have the opportunity to highlight the important symbolic dimension

of health capital that pertain to individual and social identity and to objects and institutions.

In Denmark, it appears that the focus on certain indicators of health has generally increased in the population, but different social groups invest in health capital differently, and this difference in investment has changed during recent decades. If we take, as an example, peoples' measurement of their level of cholesterol, we observe that all social groups have made considerably more use of this type of health monitoring. Looking at data from the Danish Database for Health and Diseases,[7] in 1987, we find no difference between low- and high-educated groups when it comes to having one's level of cholesterol measured; for both groups about 15 per cent had taken such a test. In 2005, nearly 20 years later, we find a highly increased test frequency for both groups. However, while the low-educated groups take the test more frequently – 45 per cent report that their cholesterol has been tested, against 34 per cent in the higher educated group, one should take into account that their rate of obesity (Body Mass Index > 30) is almost twice as high (17 against 9 per cent). Hence, given the fact that cholesterol-related health risks are substantially lower for the high-educated due to the low frequency of obesity, their test propensity, indicating health capital investment, is relatively high.

Indeed, the increase since 1987 in those who are overweight has mainly occurred among the less educated (10.2 per cent versus 1.8 per cent among the higher educated). From a more conceptual perspective, we suggest that being overweight is related to social position and more specifically to the presentation of one's body in public. In other words, the advantage gained by presenting a 'state legitimized' healthy body is much greater for the higher-positioned groups than just 25 years ago. The distribution of body physiognomy is getting more unequal. Within the time span of about 20 years, both higher- and lower-positioned groups reduced the use of tobacco and participated more in sports, but there are major differences in the distribution. The percentage of the lower-educated who exercise or are physically active is 56.2 per cent while the corresponding figure for the higher-educated is 77.4 per cent. More specifically, higher-positioned citizens are more likely to engage in at least moderate exercise during leisure time. In 2005, 30.5 per cent of the higher-educated indicated as such while only 12.9 per cent of the lower-educated did. Conversely, 23.4 per cent of the lower-skilled engaged in sedentary/sitting activities during leisure time, while the figure for the higher-educated was 9.2 per cent.

An important correlate is that the belief that individual efforts are 'very important' is much higher for the higher-educated group (78.9 per cent) than for the lower-educated (48.9 per cent). One sees a similar pattern (65.7 per cent and 44.7 per cent) relative to whether the two groups are eating a healthy diet to maintain or improve their health. There is a greater tendency for higher-positioned people to eat lettuce or raw vegetables daily or several times a day (23.3 per cent compared to 11.4 per cent). Where smoking is concerned, the proportion of daily smokers among the higher-educated decreased from 35.8 per cent to 25.2 per cent during the 1987–2005 period. During the same time, there was a smaller reduction in smoking rates among low-positioned social groups (from 47.5 per cent to 40.4 per cent).

Using the same data source, we observe that investment in the body through alternative therapy grew between 1987 and 2005. However, among the low-educated, the growth was less than 50 per cent (from 8.7 to 12.8 per cent), while it was 250 per cent, among the high-positioned (from 10.5 to 26.8 per cent). Reflexology/zone therapy is also more frequent among the high-positioned (7.4 per cent) than among the low-positioned (3.7 per cent). The same pattern applies to the use of acupuncture (6.4 per cent compared to 3.6 per cent).

The greatest difference can be seen in relation to the use of massage, osteopathy and other manipulative therapies with 16.5 per cent among the high-positioned compared with 6.2 per cent among the low-positioned. Expenses for most of these forms of therapy are either partly covered or not covered at all by the state – and most likely the different rate at which these groups undergo alternative therapy is partly due to different economic capabilities. While the health effects of alternative treatment are contested, investing in this realm may be seen as buying into the narrative of pursuing a healthy lifestyle.

When it comes to health capital investments, another area of growing importance is plastic surgery, which is expanding as a medical specialty in Denmark (Frich 2006). This branch is getting more 'productive' – on average the number of surgeries rose 14 per cent and fees to surgeons/institutions climbed 23 per cent during the years 2001–2006 (Danish National Board of Health 2007). Assessing data from a recent Danish survey, we observe that one out of six persons would consider undergoing plastic surgery in order to correct the body, women at a rate almost three times higher than men (TNS Gallup 2012). The data do not provide information on socioeconomic background, but Norwegian studies suggest that for women, higher-income groups are more inclined to purchase this treatment (Ramm & Soest 2011).

The behaviours of eating, exercising and smoking are notoriously stable and difficult to change. Yet, we see in Danish society (and others) a significant change in health behaviour during the last few decades – especially in the higher-positioned groups. We argue that the data discussed above are remarkable indicators of the power of habitus among higher-educated groups. The high-positioned groups have the dispositions (habitus) that match the dominant values. They can read and practise the 'healthy game' as they have sufficient capital to make possible – and enter the narrative of – a healthy life. As such, high-positioned groups do not merely 'implement' or 'practice' health advice from the National Board of Health and other dominant positions. Their 'integration' of health messages of better diet, more exercise, and less smoking into their daily habitus is a form of health investment, and the gains that accrue might be harvested in terms of improved positions in the occupational field.

It would appear that the advantages of power that accompany changes in health behaviour have been enough to overcome the sedimented or addictive behaviours typical of both high- and low-educated groups only a few decades ago. Such investments in health capital now pay social dividends and are not just for personal health.

Conclusions

In this chapter, we have suggested that individual investment strategies in health capital are constituted as a response to changes in the state, and to changes in the health system and working life. We have illustrated the importance of shedding light on health resources as a mechanism for social differentiation in terms of risk exposure by identifying growing differences in how low- and high-positioned social groups in Denmark are investing in their bodies. We have further raised questions about the extent to which such investment in the body and in body and health narratives may pay dividends in the post-industrial social order. The differences that one can observe may suggest an emergent polarizing of new health risks.

We conclude with three relatively brief points about this analysis in the context of risk and the changes in the Nordic welfare states. First, we suggest that this type of Bourdieuian analysis is relevant to thinking about current social change. The examples and arguments presented have focused on changes in health behaviour that indicate the formation of a new potential capacity that can be accommodated by the concept of capital as a distinct sub-species, and which is differentially

sought by citizens in post-industrial societies, including the Nordic ones. Health capital is a good that is pursued and then used to distinguish oneself as positioned in a particular part of the social space.

Drawing on cultural and economic capital, people engage in an ongoing process of playing out a habitus in competitive fields. This process is a social practice that changes over time – influencing and influenced by the state, institutions, and by the gradual shifts in relative positions and habitus. The possible emergence of health capital as an important element in this ongoing process of social differentiation and power is thus important to analyse if we are to understand the implications of social change in the Nordic welfare states. While competition over economic, cultural, social, symbolic and other forms of capital will continue to be of relevance for understanding changing social relations in the Nordic states, health capital will most likely continue to emerge as an important part of the larger process of social change and policy responses. As such, there are further implications that relate to risk and the welfare state.

We can only sketch these implications here. One is the extension of our argument that health capital investments are motivated by the desire to maintain or improve social position. Health capital as a form of capital is unique in that it has a tangible connection to new health risks. More specifically to develop one's health capital is not just to present oneself as a member of a group; it is also a strategy to reduce one's risk of morbidity and mortality (even if, as we have emphasized, health capital does not necessarily translate into health improvements). The fact that higher-positioned groups have further distinguished themselves by reducing risk more than lower-positioned groups means that social risk in the Nordic societies has, and is likely to continue to become, more unequally distributed. The implications for the health care system are fairly clear and include additional stresses on the system, its funding schemes, and its policies seeking to address issues of equality and fairness for all citizens.

What, then, are the implications for policy in an era of greater distinction of social classes based on health capital, the health field, and the associated power dynamics that involve the state? The analysis suggests that the state establish health as capital by creating specific classifications and norms that are to be sought in particular ways. This means that without a critical (Bourdieuian) understanding of the establishment of health practices through habitus, capital and evermore competitive relations in the field, one cannot understand how transformations in health and welfare policies influence (by validating and invalidating) health behaviour, thereby producing social distinctions that appear

as outcomes of individually chosen *lifestyles*. The shift towards more individualized health responsibility and the increased privatization of health care has surely influenced the role of health capital in the social sphere. As such, the change in the meta-field and the related change of policies have, in direct and indirect ways, privileged some groups to the detriment of others. The transformation and withdrawal of the welfare states (Bourdieu 1994) shapes the possibility and necessity for investments in health capital. Those who are unable to make such investments, become more prone to new social health risks. These effects go against the grain of the shared values in the Nordic welfare states and should be considered as policy continues to be shaped.

Notes

1. The authors wish to thank Marit Haldar, Espen Dahl, Helle Hansen, Eivind Engebretsen and Tone Alm Andreassen for comments to previous drafts of this chapter.
2. In the same manner as also socializing around perilous consumption can work as a way to screen out unwanted company – like when in the old days the male part of a party after the dinner would withdraw to the study or library to smoke, drink and network.
3. In relation to theories and models about health, we can see the dominant medical-inspired constructions (concepts, classifications and logics) about the body, health and treatment, as well as subordinate positions, which articulate alternative (heterodox) values that challenge dominant constructions. These are often inspired by humanistic, philosophical, religious or 'oriental' philosophies. Still, doxa penetrates and lies beneath the perception that meets the eye at the immediate, un-reflected gaze of a 'fat body' or a 'smoker's body'.
4. A well-trained body has no distinctive value if not associated with 'culture'. Dominant social groups will act and look 'natural' when investing in the body as their values are naturalized, similar to how upper middle class dominate the school and educational system (Bourdieu & Passeron 1977). Some dominated social groups may 'overinvest' in the body through excessive fitness, extreme diet and surgery. The dominant social groups may perceive this as vulgar, 'not appropriate' or as bizarre.
5. A well-trained body has no distinctive value if not associated with 'culture'. Dominant social groups will act and look 'natural' when investing in the body as their values are naturalized, similar to how upper middle class dominate the school and educational system (Bourdieu & Passeron 1977). Some dominated social groups may 'overinvest' in the body through excessive fitness, extreme diet and surgery. The dominant social groups may perceive this as vulgar, 'not appropriate' or as bizarre. Willig e.g. argues how *Crossfit*, a type of fitness based on high intensive and varied exercises using real-life authentic tools rather than machines, is 'designed to the society that needs generalists who are always willing to let go of their acquired knowledge in order to address new unpredictable challenges' (Willig 2012: 5; translation provided).

6. We focus solely on different groups in terms of position in the social hierarchy on the basis of educational status. However, and more in the spirit of Bourdieu's (1984) epistemological break with conventional studies, using the same approach one could just as well have been looking into how people sharing the same educational status were investing in health capital in order to compete within their social class (cf. Börjesson and Broady 2006).
7. We are using data from the cross-sectional surveys carried out among Danish citizens being 16 years of age or older in 1987 (sample = 5,950, response rate = 79.9, $n = 4{,}752$) and 2005 (sample = 21,832, response rate = 66.7, $n = 14{,}556$). In the analyses we have defined the low-educated group as those with primary school as highest achieved level of education, and the higher educated group as the one with an educational level beyond primary school.

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9

Ethnification of New Social Risks: Programmes for Preparing Newly Arrived Immigrants for (Working) Life in Sweden, Denmark and Norway

Ariana Guilherme Fernandes

Introduction

Sweden, Denmark and Norway, to varying degrees, have experienced an accelerating influx of immigrants and refugees during the four recent decades. While offering new opportunities, this influx is also posing new challenges for the welfare state (Brochmann & Hagelund 2005: 9; Djuve & Kavli 2007). Indeed, immigrants' risk of failing to enter the labour market and integrate into society is considered an important new social risk that the Nordic welfare states have to deal with (Timonen 2004: 106). As for labour market integration, this challenge is reflected in the relatively large share of people with immigrant backgrounds among the unemployed and among other groups of working age not participating in the labour force (Statistics Norway 2012; Statistics Denmark 2012; Statistics Sweden 2012). This challenge is not as demanding when it comes to labour migrants[1] as they tend to have high labour participation rates, while immigrants who come in search for protection are more vulnerable to labour market exclusion (see Øverbye 2010).

Successful labour market integration of working age and able-bodied people is essential for financing and maintaining a sustainable welfare state (Kvist et al. 2011: 6; Brochmann & Hagelund 2010; Pedersen 2005; Wadensjö 2001). This is particularly true in the case of the Nordic welfare programmes, which are extensive and costly. Consequently, low labour market participation among immigrants is

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