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FROM a cerebro-vascular, genito-urinary, gastro-intestinal, psycho-therapeutic or mortuary point of view, the rich and famous have never had it so good. Yes, their children are more prone to acne and allergies. Nevertheless, during the last half of the 20th century, people in the developed world with an elevated social status have been producing health, well-being and longevity at a faster rate than those with lower social standing.

Physical and mental health run parallel to social rank. In England, commoners die sooner than aristocrats. In the military, sergeants have more heart attacks than generals. Blue-collar workers — and not only those working in mines, construction sites and chemical plants — have more respiratory infections and hacking coughs than white-collar workers. Office clerks are more anxious and depressed than office managers. Lower-middle-class Americans are more mortal, morbid, symptomatic and disabled than upper-middle-class Americans. With each little step down on the educational, occupational and income ladders comes an increased risk of headaches, varicose veins, hypertension, sleepless nights, emotional distress, heart disease, schizophrenia and an early visit to the grave.

The funny thing is, no one knows why.

Of course, people who are socially well placed have not always been spared the ravages of disease. Mythic images of wounded elites come to mind: gout-endamaged royalty, wan and hysterical Victorian ladies, ascetic malnourished Brahman widows, Mandarins eating vitamin-deficient polished rice and bearing beriberi. In the 1920's and 30's, coronary heart disease was apparently a mark of social distinction among men in England. In the 1940's and 50's, the polio virus crippled those at the top in the United States. And even today there are a few afflictions, like breast cancer and malignant melanomas, that seem to prevail among citizens of high station.

On the whole, though, the upper- crust neuroses and illnesses have all but disappeared from Europe and the United States. During the last 50 years, Western men and women of higher status have lived longer and have been healthier and saner than the people they outclass.

The study of "social inequalities in health" is today one of the hottest areas in epidemiology, medical sociology and health psychology. Only last December, the John D. and Catherine T. MacArthur Foundation established a research network on socioeconomic status and health, under the direction of Nancy Adler, a psychologist at the University of California, San Francisco.

Much of the excitement dates from the 1980 publication of the "Black Report," when Sir Douglas Black (a former president of the Royal College of Physicians) and his medical, social science and public policy associates showed the statistical association between illness and social class in England and Wales. The Conservative Government detested the Black Report, viewing it as a trespass of social medicine into politics, an ideological tract produced by welfare-state advocates longing to redistribute wealth and level the social class system. Liberal egalitarians, just as predictably, took the study as proof that social hierarchy is a public health problem.

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Politics aside, no one knows precisely why people with high status are more healthy and less crazy.

It is not primarily because they have better access to health care. Socioeconomic differences exist for diseases that are not amenable to treatment. In fact, since the advent of the British National Health Service in 1948, the gap in health between occupational statuses in England has widened. (Perhaps this confirms the dismal economic principle that publicly financed institutions — hospitals, schools, highways and courts — always benefit the well-to-do most.)

The health gap cannot be blamed mostly on hazardous work or living conditions, either. Social status differences in health persist even when members of different social classes are exposed to similar levels of pollutants and carcinogens in their environment.

Nor is poverty itself the prime reason. Consider, for example, the famous "Whitehall Studies," an investigation of the tidy, hierarchically graded world of relatively well-off white-collar British civil servants, conducted by the epidemiologist Michael Marmot and his public health colleagues at University College, London.

The Whitehall study showed that with each tiny descent in civil service rank, from senior executive officer down to executive officer, comes more angina, more diabetes and more rough cough with phlegm. In this securely employed population, the mortality gap between senior administrators and clerical workers is even greater than the health divide in the general population. Moreover, as comparisons between richer and poorer countries in Europe have shown time and again, greater national wealth does not readily translate into greater national health. A 45-year-old Greek male can expect to live longer than his English peer.

The health gap cannot be blamed primarily on life style differences, either. It's true that clean living (no smoking, alcohol or fatty foods and lots of exercise) is a high-status religious activity (though professional women probably drink more liquor than working-class women). Nevertheless, it turns out that most of the social inequality in coronary heart disease remains even after such life-style differences are taken into account.

Could the health gap exist because unhealthy people are downwardly mobile or because healthy women marry up? Those things do happen. Some people rise in status because they are vigorous and others are "selected" for demotion because they are disabled or out of their minds. But social migration isn't enough of a stampede to explain all the health effects.

Neo-conservatives believe that both health and high social rank are jointly produced and justly earned by hard-working, intelligent people who avoid reckless risks, educate themselves and take a long view of life. And liberal-minded egalitarians believe that health is a common good that ought to be provided and regulated by the government (just like highways, schools, courts and national defense). But neither side has explained how the health divide is actually produced.

Perhaps it is karma. Perhaps it is in the genes. Perhaps it is all of the reasons above. Perhaps it is a statistical artifact. Perhaps the safest thing one can say is that the socioeconomic health gradient is a "multiple complex synergistic non-linear incremental cumulative threshold-bound lag effect." Social scientists like to talk like that when they think they are looking at something important but don't really know what is going on.

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