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# Health inequalities virtual issue introduction

Understanding health inequalities and exploring effective approaches to their reduction have been central concerns of *Critical Public Health* since its inception. The journal has engaged in the key conceptual and policy debates around inequalities in health. What are the respective roles of material and psychosocial factors in generating and sustaining health inequalities? How should public health professionals seek to influence the policy response to inequalities in a world where dominant ideologies privilege 'wealth creation' over tackling poverty? What are the methodological challenges for public health researchers in an inevitably politicised field of inquiry? At least one article in virtually every issue (and often more) has directly addressed questions of inequalities in health. One special issue (volume 10, number 2, June 2000) was wholly devoted to the topic. Thus this virtual issue is potentially huge, and we have exercised some judgement in prioritising those articles which most explicitly address the causes of, and effective policy responses to, inequalities in health.

Over the last twenty five years there has been a huge growth in the international research literature demonstrating the existence of inequalities in health, and the centrality of poverty in their causality. Davey Smith and colleagues at the University of Bristol, UK have been important contributors to generating this evidence. In a response to the Acheson report on health inequalities in the UK, Davey Smith (1999) not only review the data showing the increase in health inequalities, but argue the simplicity of the solution to this widening gap: 'Any child can tell you how this can be achieved: the poor have too little money so the solution to ending their poverty is to give them more money. Poverty reduction really is something that can be achieved by "throwing money at the problem"'.

In a further commentary on the Acheson Report Labonte (1999) similarly argues the need to go beyond the analysis of health inequalities to grapple with policy options. Labonte notes that reports such as Acheson do not in and of themselves bring about change. But reports become legitimizing tools for those committed to change. This legitimization is essentially ideological, and, Labonte argues, ideology is much more important than the evidence base in the determination of policy. If Acheson provides the basis for continuing debate on inequalities within government, then it will have done much. But Labonte also cautions that despite linking social and health inequalities, Acheson fails to do as well in linking economic practices to social inequalities, and fails to ask the fundamental questions of why poverty exists.

Raphael (2000) makes comparable points in his review of health inequalities in Canada, current discourses and implications for public health action. He notes that despite the health effects of economic inequality and poverty being well known to public health professionals, public health responses are usually limited to the delivery of ameliorative programmes to those living in poverty.

A very similar question is asked by Stewart-Brown (2000): 'what causes social inequality?', who then goes on to ask why this question appears to be taboo in the literature.

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In answering these questions, Stewart-Brown pursues a very different analysis from the materialist and political perspectives of Davey Smith et al., Labonte and Raphael. She draws on conflict management and psychotherapeutic theory to suggest that the development of emotional literacy amongst all income groups, but particularly the wealthy, has the potential to solve the problem of social inequalities in health.

By contrast, Carlisle (2001) explicitly makes the point that the research field of health inequalities is unavoidably politicized. She presents an overview of three different contested explanations (poverty/deprivation; psychosocial stress; individual deficit) and adopts a discourse analysis to conceptualise the links between such explanations and potential policy solutions. Carlisle concludes that uncertainty surrounding competing explanations enables political manoeuvring at the policy making level, with the UK government both claiming leadership in tackling the issue whilst simultaneously assigning responsibility for action to the community and individual level.

Inequalities in health are usually conceptualised in terms of socioeconomic status, but of course they may also have gender, ethnic, geographical or other dimensions. An important review on the UK epidemiological evidence on ethnic inequalities in health is reported by Davey Smith, Chaturvedi, Harding, Nazroo and Williams (2000). They demonstrate that, despite somewhat patchy evidence, important ethnic differentials in health status exist. Different categories of explanation are then explored including artefact, migration, socioeconomic factors, culture, belief and behaviour, racism and biology. Davey Smith and colleagues conclude that influences under each of these explanatory categories will all make some contribution to the production of ethnic differentials in health, but to be more definitive will require the development of more sensitive indicators of socioeconomic position.

An important recent thread of debate on inequalities in health has focused on the role of psychosocial factors relative to material, structural and economic determinants of health. Bolam, Hodgetts, Chamberlain, Murphy and Gleeson (2003) seek to advance this debate by developing a more complex and fully socialized theorization through the examination of a key component in psychosocial explanations, namely, the sense of control over health. This article explores these issues through an analysis of interviews with 30 lower socioeconomic status participants drawn from two qualitative studies of health inequalities. Key findings concern the rhetorical construction and interweaving of two contrasting positions regarding control over health: fatalism and positive thought.

The debate between material and psychosocial explanatory frameworks for health inequalities has important policy implications, in particular for the relative emphasis given to macro-economic policy and health service interventions. In the UK one key service intervention intended to reduce health inequalities has been the implementation of a nationwide programme of smoking cessation services. Woods, Lake and Springett (2003) consider the implementation of smoking cessation in one of the early implementing health action zones. They argue that despite government rhetoric of supporting local, community-driven programmes, smoking cessation has been strongly centrally steered. Thus while the cessation initiative is likely to lead to a general population-level reduction in smoking, perversely it may lead to greater health inequality than is currently the case.

A related theoretical debate has been on the value of the concept of ‘social capital’ in understanding and taking action on health inequalities. In a thought provoking article, Muntaner, Lynch and Davey Smith (2000) challenge both the theoretical depth and the evidence base for social capital as a determinant of health. They argue that social capital is also used in public health as an alternative to both state-centred economic redistribution and party politics, and, as such, are doubtful of its practical utility in tackling inequalities

in health. By contrast, Morrow (2000) uses the concept of social capital to explore young people's accounts of community and neighbourhood, and the implications for health inequalities. Although recognising some limitations to the social capital framework, Morrow argues that it does enable an articulation of young people's views of their social environment.

Ostry et al. (2000) explore the relationship between unemployment, technological change and psychosocial work conditions in restructured work places in British Columbian sawmills. Downsizing reduced the number of workers by 60% and the number of job titles by 25%. They found that although psychosocial conditions of work (assessed using 'expert' raters) improved after restructuring, these better work conditions were available to fewer workers. A number of lessons were learnt including the need for long term follow up of downsized workers.

Equitable access to health care is a basic value in most developed countries' health care systems, but the reality is probably furthest from this principle in the case of the USA. Whiteis (2000) addresses public health and access to health care for the urban poor in the context of US urban, economic and industrial policy. He argues that the pathogenic deterioration of 'inner city' neighbourhoods is a direct result of political and economic strategies to facilitate capital accumulation. The deleterious public health effects include reduced access to health care; medical indigence; and the spread of social epidemics such as AIDS, violence and substance misuse. Mamo and Mueller (2003) take up the issue of AIDS in the USA in their review of the literature on access to health care for people with HIV/AIDS. They demonstrate that a high percentage (upwards of 66%) of people with HIV/AIDS in the USA are not receiving life prolonging therapy or adequate health care. They argue that despite the existence of social programmes designed to ensure the availability of AIDS-related medical services, social and structural barriers including poverty, race and gender impede patient access to these programmes and services. Using very different methods, Soobader and Leclere (2000) arrive at similar conclusions with regard to the impact of US income inequality on both children's health and their access to health insurance.

Much debate in *Critical Public Health* has focused on the growing health gap between rich and poor in industrialised countries, but there has also been consideration of inequalities in developing countries. Low and Ithindi (2003) consider the impact of a community health workers' programme on equity of access to primary health care in Namibia. They conclude that community health worker programmes do have a legitimate and important role to play in the delivery of primary health care in developing countries and that they can reduce inequalities in access to and utilisation of formal health care by deprived communities. In their example, however, they also demonstrate a number of problems limiting effectiveness, in particular, a lack of effective community participation in the programme. A contrasting example of inappropriate professional development is given in Maupome's (2000) account of human health resource planning in dentistry in Mexico, which he argues has failed to deliver needed community health workers and intermediate-level health professionals. Maupome describes a dental system inappropriately modelled on North American restorative dentistry which fails to meet the dental health needs of the mass of the population.

Globalization is an increasing influence on social policy in all countries, rich or poor. O'Keefe (2000) examines the implications of globalization for inequalities in health. She argues that decisions affecting inequalities in health are being made by undemocratic trans-national regulatory organizations, including the World Trade Organization, pursuing a market based project. The solution, she suggests, is to place deliberative democracy at

the heart of trans-national decision making bodies, and this in turn depends on the strength of a world-wide grass roots movement to challenge unfair social structures operating at a global level.

A small number of articles in *Critical Public Health* consider the methodological challenges of evaluating policy interventions to reduce inequalities in health. Shito and Keskimaki (2000) describe the long term Finnish policy goal of reducing inequalities in health, and reflect upon the challenge of assessment. They conclude by outlining reasons why such policy programmes do not always lead to successful outcomes in improving equity. Evans and Killoran (2000) report on a 'realistic evaluation' of five UK demonstration projects designed to test five different models of partnership working in tackling inequalities in health. Six key themes were identified: shared strategic vision, leadership and management; relations and local ownership; accountability; organizational readiness and responsiveness to a changing environment.

The articles within this virtual issue of *Critical Public Health* on health inequalities are diverse in their theoretical underpinnings, methodological approaches, specific topics and conclusions. Inevitably some of our contributors take up differing positions on some key theoretical and political questions. But they all share a belief in the centrality of understanding and tackling health inequalities to a critical public health perspective, and to improving the health of the poor and disadvantaged. Despite the rhetorical commitment to tackling inequalities in health within many states and international organizations, these issues are as live today as they were when *Critical Public Health* first began to raise them.

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