The first section provides an overview and interpretation of selected scientific literature (primarily epidemiological studies) to provide evidence for the hypothesis that the risks associated with excess body weight are minimal. In this section, results from studies that demonstrate health risks associated with overweight and obesity are discounted in two main ways. First, a series of criticisms of epidemiological research are presented. These include the well-known facts that these types of studies cannot prove causality and often do not adequately adjust for confounding variables. Second, non-specific terms such as 'average weight' and 'above-average weight' as well as a few well-placed caveats that exclude people 'at the extreme statistical margin' of body weight are used to recast study results. Subsequently, study results are reinterpretated for the reader and presented to show that excess body weight is minimally associated with health risks.

In the second section, which comprises 12 chapters of the book, the detrimental psychological, sociological, economic, and racial implications of obesity in America are examined. Drawing upon a variety of sources, ranging from women’s fashion magazines to television talk shows and a series of personal testimonials by women with weight problems, the pervasiveness of the discussion about weight in America is illustrated. Hidden within this is an interesting discussion about social class, race, and obesity in the US, although much of the message is diminished by the use of inflammatory prose and poorly chosen examples. The message is that, in this era of political correctness, when racial and ethnic discrimination is no longer tolerated, discrimination toward obese people has taken its place and somehow fills a societal need to have a group to ostracize.

The third section of the book aims to discuss how perceptions of appearance negatively influence interpersonal, workplace and even national politics in the US. A series of examples are given, but the logic that guided either their choice or their order of presentation is not apparent. The section opens with a lengthy discourse on how former President Clinton was impeached because he was 'fat', and then segues into a personal rant against ‘infotainment’ reporters. Finally, it ends with a personal narrative about the author’s problems with his weight and how this affected his relationships. Although the aim of the section was potentially interesting, it did not deliver a meaningful or topical discussion.

One strength of the book was the glimpse it gave into how the discussion and focus on the obesity problem has permeated nearly every aspect of life in America. Another is that it provided a reminder that obesity in America is also a marker for many other factors that put people at risk of poor health, such as having a lower level of education, being poor, and being non-white. However, the author’s oversimplification and subsequent reinterpretation of results from scientific studies created a false impression. Although perhaps entertaining, the preponderance of examples given from Hollywood to illustrate the cultural effects of the obesity epidemic detracted from the interesting and important message about social class, race, and obesity. Disappointingly, the last section did not deliver a coherent or logical message about weight and politics. Overall, the book provided an interesting look at how the obesity problem is perceived in America by one non-researcher, but there are better options if one is interested in this topic.

JENNIFER L. BAKER

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This book is written by one of the key researchers, who is an intellectual force, in the field of health inequalities. A professor of Medical Sociology at University College London, Mel Bartley has played a distinguished role in this field for a number of years; this book further adds to his contribution.

The book opens appropriately with a chapter on ‘What is health inequality?’ This has become a ubiquitous term not only in research but also in health and social policy in recent (‘New Labour’) years, but must not go unchallenged. In the UK, the Black Report of 1980 is noted as the definitive report that put health inequalities on the academic and policy agenda of industrialized nations. In that context ‘health inequalities’ refers to ill health and mortality being related to social class but also more generally to the ‘health differences between people in more or less favourable situations with respect to income, prestige (’standing in the community’) and education’ (p. 1).

In this first chapter, as the patterns, magnitude, and changes in health inequality over the twentieth century are explained, so too are key terms and measures (such as standardized mortality rates and age-specific rates), a logical style that will particularly appeal to students. The key examples hail from the UK (this tends to be the case throughout the book although references to USA and to European studies are plentiful). A lot of ground is covered in this first chapter; theoretical explanations for health inequalities are introduced next: genetics (shown to be a non-starter for explaining health inequalities and therefore not covered in depth); the psycho-social model (e.g. control over work); direct and indirect selection; life-course models (which among other things can be used to test theories of indirect selection); and the neo-materialist explanation (emphasizing the importance, for example, of the provision of health and...
The psycho-social model comes next, considering how inequality makes people 'feel'. Bartley sees this kind of explanation as 'one of the most pervasive at the present time', and while some of the concepts here more readily lend themselves to measurement than the 'cultural' factors in the preceding chapter, she points to the particular difficulties with this approach of establishing a causal pathway. At the end of the chapter it is concluded that 'much work would remain to be done to investigate the extent to which the link between social circumstances and health involves the psycho-social pathways' (p. 89) covered here.

Chapter six presents the materialist model, the form of explanation preferred by the authors of the Black Report. It is pointed out that this is the explanatory model which has produced least activity, and the research that exists has mostly been about the relationship between incomes and health; other studies have looked at factors such as poor quality and damp housing, and hazards in the workplace (such as chemicals, fumes, or dust). Interestingly, Bartley aggregates the sum of such findings: 'Adding up the results of the few studies that can be used to try and estimate the size of the effect of this type of material factor on health, it would appear that they are not responsible for more than 25% of all deaths, at the most. . . . Warmer, drier, cleaner homes and workplaces, fewer hours of work and more holidays resulting in less exposure to what hazards there are, seem to be plausible explanations for trends in mortality over time, but they do not seem very important in present-day health inequality' (p. 95). However, it is pointed out the many deaths that may result from the nature of the workplace may not be recorded as industrial accidents—there are social and political processes involved. Bartley also discusses the difficulty of separating out the material from other types of factors, for example, the cost of the bare minimum of survival from the cost of social participation. The chapter closes by (briefly) considering neo-materialist explanations, which refer to the provision of public services and their relation to the health of populations.

Chapter seven considers the more recently developed life-course approach and its advantage over previous explanations, placing a focus on accumulation rather than selection. Studies and analytical techniques useful for this perspective are covered and explained. At the end of this chapter Bartley refers to the ‘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 (p. 115). This is referred to in a few places, but is not developed as an explanatory model in itself; an updated ‘life-course’ version of Doyal’s Political Economy of Health remains to be written.

As with most writings about health inequalities, the bulk of this book seeks to understand inequalities of a socioeconomic dimension. The last three chapters at first glance appear to mop up three dimensions of health inequality that we would expect to see in such a book: social ecology, gender, and ethnicity. However, these three chapters are far more than add-ons, and it is here that the tools acquired in the previous chapters are put to use. The term ‘social ecology’ is a label more often used in the American context; most European readers will recognize this chapter as the ‘Wilkinson debate’ on the effects of income inequality on population health. It is in the chapter on gender, however, where the intertwining of evidence and the assessment of explanatory models works best. The chapter on ethnicity is also absorbing, and again brings the story back to the life-course political economy perspective. The final chapter on social policy once more brings the various explanations into play, and gives policy a more thorough consideration than the usual tag-on paragraphs of so many papers on health inequality.

There is an air of self-development about this book, as the author openly states at the beginning: ‘I have had to change some of my ideas about my own research agenda as a result of writing this book’ (p. 2). It is refreshing to see the usual schema of the Black Report superseded (in fact, Bartley doesn’t even bother to mention the ‘artefactual’ explanation that other texts religiously cover) even though the legacy of that report is rightfully evident throughout the text. Rather than seeing this work as a catalogue of research, or a review of the evidence, it is better to see it as an exercise in how to think about health inequalities; there are few scholars who would make better role models in this respect. The intended audience is much wider than epidemiologists and social scientists, but also includes those with backgrounds in arts and humanities as well as those involved in journalism and policy. In addition it will appeal to those both new and established in the field.

The first chapter ends with Bartley presenting her own ‘hunches’ for the continued existence of health inequalities,
and here she refers all too briefly to the negotiation of personal identity, the difficulties encountered in creating and maintaining relationships, and the effects of social inequality that contribute to that identity. These ideas are not further explored in this book, but we hope will be the topic of Bartley’s next major work. In the meantime, this book should become essential reading for anyone genuinely interested in understanding health inequalities.

Reference


MARY SHAW

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Vicente Navarro is one the world’s leading authorities on how political economy shapes population health. As the editor of this ambitious volume, he joins the list of distinguished scholars to engage in a series of international and country-based studies of how different political contexts and social policies have shaped public health in Europe. The studies described in this book arise out of a collaborative research group—the International Network on Social Inequalities in Health (INIH), whose goal was to produce reports that were ‘... easily read and understood, that can contribute to the design of specific public interventions to improve the health of populations’ (p. 2).

The book contains 241 pages comprised of an introduction, followed by an international comparative analysis of OECD countries from 1950 to 1998, and then five chapters of country-specific case studies from the UK, Italy, Germany, Spain, and Sweden, and a final chapter of summary and conclusions. The introductory chapter lays out the conceptual model developed by the INIH group that guides the empirical analyses. Essentially, the model suggests that power relations, in the form of electoral behaviour (e.g. voter participation, time in government of different types of political parties) and trade union activity (e.g. density of unions) are the prime movers behind how different societies structure the labour market and social welfare systems for their populations. Labour market structure and welfare provisions in turn determine the extent of social inequality, indexed in this case by income inequality. The extent of social inequality then determines the health of the population. In the empirical analyses presented, population health is measured by the infant mortality rate (IMR) and life expectancy (LE), both considered overall indicators of population health. The great strength of the approach applied in this volume is that the same conceptual model and the attendant variables that correspond to the model inform every empirical analysis.

There is a large amount of data presented in this book that will be of interest to those concerned with associations between social variables and IMR and LE. For instance, in the cross-country comparisons of 17 OECD countries from 1950 to 1998 the authors present both bivariate descriptive associations among a large number of variables, and also model them in a pooled cross-sectional analysis intended to show which factors are the most important in determining levels of population health. The conclusion of this analysis is that lower income inequality, larger proportion voting for left-wing political parties, greater public health expenditures, and larger labour market participation overall and of women in particular, the lower the IMR. However, there was little effect of these factors on LE—a result that was not discussed by the authors.

On one hand it is important to have evidence that aspects of progressive social policy are linked to lower infant mortality. On the other hand, results like these also raise questions for those interested in understanding how broadly defined political and social contexts affect population health. Why are upstream social factors like voting behaviour or income inequality associated with IMR but not LE? What are the mechanisms through which broad social policy may affect some health outcomes and not others? And are cross-sectional analyses even appropriate—i.e. would we expect an instantaneous effect of social policy on population health indicators or should time lags be considered? For instance, even though there is an apparently strong cross-sectional correlation between income inequality and health in the 1990s among US states, long-term trends in income inequality do not match trends in most indicators of population health. Nor is there even a consistent cross-sectional association among US states for each decade from 1949 to 1999. At the US national level, over the last 30 years, all-cause mortality, life expectancy and infant mortality have declined for both blacks and whites, at the same time that trends in voter participation were declining and income inequality increasing. A naïve interpretation of this would be that higher income inequality and lower voter participation are both associated with improvements in population health.

Results of longer-term analyses like the ones mentioned above, present challenges to overly simplistic notions of how broad social factors drive levels of population health. Evidence gained from individual and aggregate cross-sectional studies needs to be examined over time at the population level. The most important determinants of different components of population health should move in some temporally consistent fashion with the changing levels of health in the population, as for instance, do lagged trends in smoking and lung cancer. Of course, it is easier to track the concordance between changes in proximal risk factors and changes in outcomes, when a small number of risk factors account for a large number of cases. The challenge to better understand how social factors affect population health can be informed by documenting trends in the outcome of interest, decomposing those trends into age and relatively homogeneous component causes and documenting what the main proximal risk factors are for those components. Then it may be possible to think more clearly about how so-called ‘upstream’ social factors could be linked and de-linked over time to the main proximal risk factors which determine the bulk of the cases and hence the levels and trends in the population. This approach to ‘triangulating’ individual level knowledge of risk factor–disease associations with population level data is important to better understanding the social determinants of population health.

The points made above are certainly not a criticism of The Political and Social Contexts of Health, rather they are an extension...