Introduction: Toward an Integrated Political, Economic, and Cultural Understanding of Health Inequalities

Vicente Navarro and Carles Muntaner

Since the early 1970s, the *International Journal of Health Services* has established an exceptional record of innovation in public health and its associated social sciences (sociology, economics, law, history, anthropology, political science) with regard to understanding the social determinants of health and well-being. To give just a few notable examples, the *IJHS* published some pioneering articles by Nancy Krieger and by Richard Cooper on racism, and by Vicente Navarro on social class, that preceded the growth of such studies in the 1990s (see 1 for a review of these studies). Many leading authors in contemporary social epidemiology, health disparities, and social inequalities in health have been published in the *IJHS,* including, among many others, John Cassel, Peter Draper, Elmer Struening, Thomas Langner, Victor Sidel, Lester Breslow, Howard Waitzkin, Nancy Krieger, George Davey Smith, Richard David, Joseph Eyer, David Williams, Steve Wing, George Kaplan, Mervyn Susser, Milton Roemer, John Lynch, Giovanni Berlinguer, Howard Berliner, Greg Duncan, Karen Messing, Phil Brown, Marsha Lillie-Blanton, Elsie Pamuk, Charlene Harrington, Thomas LaVeist, Sara Arber, Timothy Smeeding, Erik Olin Wright, Dean Baker, Clyde Hertzman, Charles Levenstein, Meredith Minkler, Richard Levins, Irene Yen, Richard Wilkinson, David Himmelstein, Steffie Woolhandler, John McKinlay, and Vicente Navarro. Given the number and current relevance of recent *IJHS* articles on social inequalities in health, we thought that putting together a selection of these articles in book form would increase their diffusion and make them more readily available for multiple academic uses.

This volume builds upon the earlier studies mentioned above, and more specifically upon a previous volume, *The Political Economy of Social Inequalities: Consequences for Health and Quality of Life,* edited by Vicente Navarro in

2002 (2). The current volume covers a more recent period, approximately 2000-2003, and continues the overarching theme of the political and economic determinants of population health. The book is organized into seven parts, each beginning with a summary overview of the individual chapters. We hope this will help to emphasize the main point of each contribution and convey the vibrant state of our developing and growing field of study. The remainder of this introduction covers some salient issues in the ongoing debate over social inequalities in health that set the stage for the content of the various chapters.

The field of social inequalities in health grew rapidly in the 1990s, but it remains a contested terrain (3). For example, epidemiologists and public health scholars are still debating over their discipline's status as a social science. Yet, epidemiology is social by definition. The death of an organism is a biological fact, but dying from drinking contaminated water or from a gunshot wound is also a social fact, making the study of population health a social (and biological) science. The problem does not lie, then, in the suitability of social (economic, political, cultural) explanations in epidemiology. Rather, what is amazing is the intermittent skepticism about social determinants. But the growth in knowledge, expansion of academic departments, and increase in the number of researchers devoted to these studies have all contributed to the growing acceptance of social epidemiology and health disparities research. We could draw a parallel here with psychology. "Mind" had been an intrinsic part of psychology since its origins (e.g., Weber, Fechner, James), but not until the 1960s did "cognitive psychology" blossom as a distinctive subspecialty within psychology, following the efforts of psychologists and nonpsychologists alike (e.g., Simon, Newell, Tversky, Neisser, Chomsky).

In addition to these internal determinants of growth within the discipline, we need to consider external political factors to understand the varied fortunes of research on social determinants of health inequalities. For example, public health is a public good, and in societies dominated by private economic interests there is little incentive to promote it. On the other hand, applied biology (i.e., medicine) is easily marketable (insurance, medical technology, hospital industry, pharmaceutical companies). Social rewards increase with ties to biomedicine. Who needs to get into messy and controversial topics such as the health effects of poverty, income inequality, discrimination, violence, immigration, anti-union activity, and patriarchy? Not surprisingly, some prominent epidemiologists would like to leave the study of the social determinants of health to other disciplines (3).

Another obstacle is that population health research that ignores social determinants fails to identify mechanisms (4). Researchers are often encouraged to use just a few indicators (income, education, race) without further justification. The continuing use of "race" as an implicit biological category, and the commonsense belief that social inequalities in health would be eliminated if everyone had "education," are just two examples of a pragmatic approach that reveals strong theoretical and ideological commitments. These assumptions are common, for example, in studies of drug use among minorities, welfare recipients, and

homeless people. Rather than looking into the social mechanisms underlying the associations with "race" and "education," some epidemiologists persist in the pragmatic use of indicators that reinforce lay myths (that race is a biological category; that those who cannot make ends meet have some intrinsic deficiency such as "low intelligence" or "laziness"). An MD would not be allowed to display similar ethics toward a patient. But in a few areas of public health, we still promote research with poorly conceptualized indicators that either justify health inequalities or promote the removal of health benefits in oppressed populations (such as welfare recipients). With some notable exceptions (5), public health philosophers seem to care only about interpersonal micro ethics of interest to clinicians, such as clinical trials, euthanasia, and genetic counseling, while macro-ethical issues such as the health effects of racism, class, or collective responsibility are absent. Some of the criticisms directed at social determinants of health research might be accurate—such as the etiological claims that often accompany findings based on psychosocial constructs measured with self-reports (6). However, rather than throwing out the baby with the bathwater, a positive heuristic would recognize the numerous contributions of this research and would promote its development.

Empirical inconsistencies, some of them due to the intrinsic difficulty of the subject matter, mixed with theoretical models having strong political implications, are partly responsible for the embattlement of our field. Income inequality, income, education, occupational stratification, social cohesion, social capital, health behaviors, access to health care, cultural barriers, social policy, "SES," social class, race, gender, age, ethnicity, sexual orientation, working conditions, material standards, psychosocial factors, and even political variables—all seem now to intersect, now to diverge, in a myriad studies. These studies range from individuals to nations as units of analysis, and they encompass the fields and subfields of public health, epidemiology, social medicine, sociology of health, health psychology, medical anthropology, health policy, demography, geography, and health economics, among others. In addition, the rapid change in social systems makes it even more difficult to find models that can be applied across settings and periods. For example, for-profit hospitals might be associated with worse patient outcomes in a wealthy country, but not in a very poor country where the public health infrastructure has been destroyed. Thus prediction across time and place often requires careful consideration of multiple social factors and levels of analysis (such as international relations in the above example). As these factors are unlikely to be understood or measured, ambitious generalizations are often risky (7).

What these studies have in common is that they focus on the social rather than on the behavioral or biological determinants of health inequalities (8). That is, given a certain physical environment and more than one person, the economic, political, and cultural relations in which these person engage will determine the observed health inequalities among them. Despite the diversity of topics covered

by these studies, they can be subsumed under sociology (Figure 1). Studies of the social determinants of population health thus include any combination of *economic, political,* and *cultural* relations. Sometimes, economic determinants seem to drive inequality as an effect of absolute poverty (9); at other times, cultural (e.g., ideological, technical, religious, scientific) determinants seem to carry important weight (10). In most instances, all three social subsystems are involved, as in the relation between social class and health (11). Thus nonsupervisory workers might have worse health outcomes than managers because workers are simultaneously paid less, dominated within the labor process, and exposed to an ideology that devalues them. A simultaneous consideration of political, cultural, and economic factors is rare even in sociology, let alone in public health.

The absence of political factors in social inequalities in health has been a major cause of concern (12, 13). Fortunately, there now seems to be a growing interest in political processes as determinants of population health. Several of the chapters in this volume testify to this trend. Table 1 presents the various topic areas (as part titles) into which the book is organized; the checkmarks show what we consider to be the main types of social relations dealt with by each area of study. These areas represent not the field of public health as a whole but the topics covered by articles published in the *IJHS* in recent years. We would like to think they approximately represent the areas of concentration among students of social determinants of health, although we do not have data to confirm this. Areas include social and health policy, health care, occupational health, social epidemiology (globalization, class, gender, and race), and philosophy (i.e., the relation between ideology, theory, and research policy). Topics revolving around politics seem to dominate. If one is willing to include in the "political" the political implications of ideology, then all of them have a political content. Also of interest

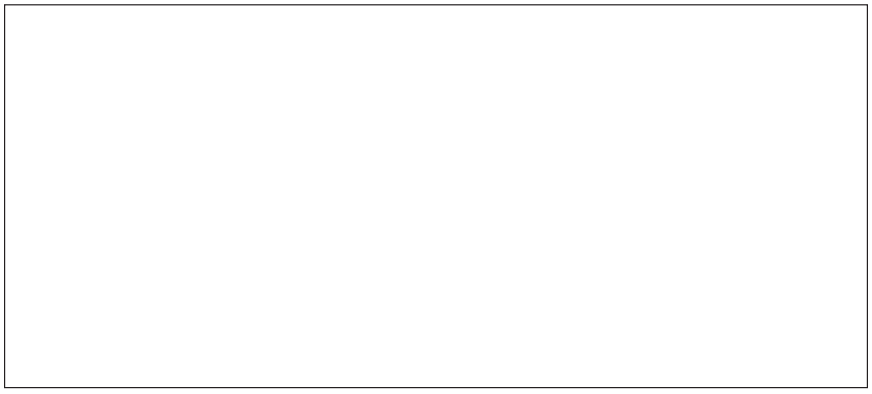

Figure 1. Model for social determinants of population health.

Table 1

Research areas covered in this book, with their main associated social science subdisciplines

Part	Tital	Politics	Economics	Culture
I	Social Policy	X		
II	Globalization	X	X	
III	Health Policy	X		
IV	Health Care	X	X	
V	Occupational Health and Labor Unions	X	X	
VI	Social Capital versus Class, Gender, and Race	X	X	X
VII	Ideology, Theory, and Research Policy			X

is the presence of culture understand as knowledge, values and norms (e.g., in the social capital–social class debate and in the chapters dealing with the concept of race). Thus the chapters have the applied research/technological flavor of epidemiology and public health. In some disciplines, such as demography, this is not necessary; in public health it is essential.

We hope that this collection of *IJHS* articles conveys the exciting nature—in terms of both added knowledge and the intensity and importance of the debates—of the field of social inequalities in health.

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