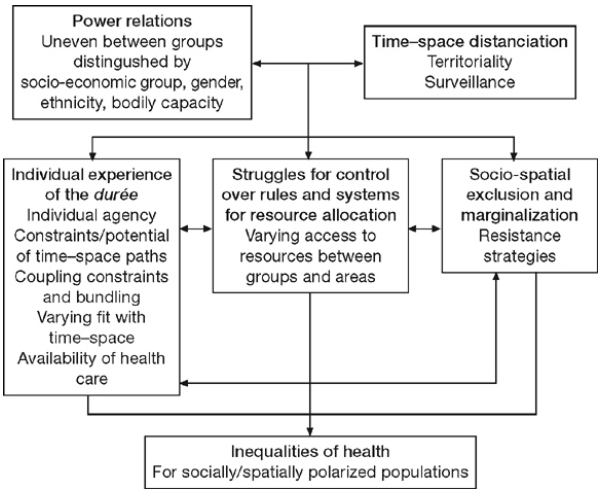
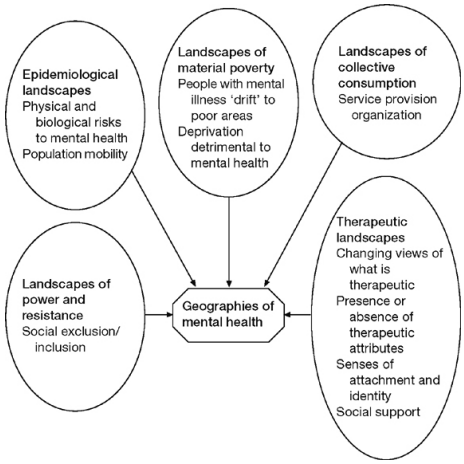
Are geographical inequalities in health just surrogates for other inequalities?

Geographical inequalities in health might be observed as the surrogates of political and cultural inequalities (of income, gender, ethnicity) that produce differing exposures (to health risk) and entitlements (to health resources) between groups within society. There has been a notable stability in the geographical patterning of health inequalities in Britain over the last 150 years such that people living in urban areas and in the north of England experience(d) higher rates of mortality and morbidity when compared with rural dwellers and those living in the south. Rather than static and politically neutral however, these uneven geographies of health - and the general socioeconomic gradient (poorer = unhealthier) that they pertain to - are actively (re)produced through the dynamic social relations and power struggles between actors situated in the political economy. Giddens' (1984) theory of time-space distanciation emerges here as a critical framework to understanding how dominant actors produce uneven "healthscapes", marked by deep social stratification in income, political power, human capital and cultural and social assets (habitus).

Time–space distanciation, writes Giddens (1984) operates through the distribution in space and time of allocative (material) and authoritative (non-material) resources by socio-economic [predominantly state] structures', wherein the allocative pertains to natural environmental resources, goods and technologies (i.e hospitals) and the authoritative to administrative structures of surveillance and territoriality which govern access (i.e social mobility) and the organisation of life chances and opportunities.' The ordering of these allocative and authoritative resources in time–space puts constraints on the life paths and [health experiences] of individual actors, which help to maintain the power relations between dominant and subordinate groups in society. Dorling (2010), suggests that such a marxist framing holds particular relevance for the US and much of western Europe wherein widening socioeconomic inequalities of health are emerging within increasingly unequal societies - 'near the very top of the ladder [in the UK] the gaps between the rungs [grow] by £11 an hour in wage rises' - he writes: 'health inequalities have increased year on year under New Labour['s] health policy of "contextualism" (stressing the importance of place effects (structure) over individualism (bad choice/agency) in health outcomes) and the failure [at the local] of neighbourhood renewal strategies, community development programmes and health action zones.' I explore how the persistence of poor health in these places is 'bound into a more systematic operation of 'health discrimination' - within labour and housing markets - that is fundamental to the structuring and time-space distanciation of society.

Primarily, this essay explores geographical inequalities of health as, most fundamentally, a surrogate for inequalities in income. I refer to three explanations, or mechanisms, through which income inequality filters into health inequality and vice versa: (i) the individual income interpretation (aggregate associations between income inequality and health simply reflect the nonlinear (concave) relation between income and health at the individual level); (ii) the psychosocial environment interpretation (perceptions of inequality produce instabilities in social capital - perceived mistrust, lack of social cohesion - that work through behaviours and psychosocial responses to affect health; and (iii) the neo-material interpretation (places with the greatest income inequality are places that also have inequalities in physical and social infrastructure that ultimately





affect health). These causal linkings between inequalities of income and health hold political relevance within national discourses because, as Wilkinson (2004) observes: 'in countries that are relatively egalitarian (Sweden) or have a strong welfare state, income inequality appears to have less of an effect on population health that in countries with large income disparities (US; UK) between individuals.' These "effects" on population health of income inequality are furthermore exacerbated by the presence of other inequalities, constructed around ethnicity and gender. I locate the psychosocial and neo-material interpretations within the structure-agency debate - 'are geographical inequalities in health and illness just a reflection of socio-economic differences among inhabitants (composition; psychosocial) or do places add their own contribution to patterns of health variation (context; neo-material)?' Reiterating Macintyre (1998) however this essay suggests that such a binary is 'more apparent than real', and that features of both - the material infrastructure and collective social functioning - interact to influence health. Williams's (1997) extensive research in the mining towns of South Wales is illuminating in this sense, he postulates:

> 'the world price of steel falls in the context of a strong domestic currency, and thousands of people across Wales lose their jobs in places that have already experienced years of relentless de-industrialisation. While we may say that the health impact of these changes can be explained in structuralist/materialist (contextual) terms, the generational, class and gender (compositional) pathways through which the impacts are felt will be variable and complex' (Williams, 1997).

Geographical inequalities in health thus emerge from the interactions of socio-economic characteristics of the individual (composition) with(in) the levels of poverty and wealth in their residential area (context). Here, Bourdieu's idea of the 'habitus' gains traction, wherein the social processes structured around income distribution 'affect early childhood influences on social and cognitive development', causing social class differentiation and bodies inflected by different health(s) and social mobilities. Such determinism however does not drown out the possibilities of change, or improvement during the lifecourse. Drawing from Nazroo's (1990) extensive research on ethnicity, racialisation and health inequality, I explore how the markers of ill-health traditionally associated with deprived "township-type" areas (context) are actively

resisted and subverted through the collective functioning of individuals in what Nazroo terms the "ethnic density effect".

Wilkinson (1996) suggests that wealthy countries with a very uneven distribution of wealth have poorer overall health than those with more equal wealth distribution. Buck (2012) observes the increased geographical clustering of marginalised people in places of ill-health as a result of income/social mobility dynamics, he writes: 'as inequalities of wealth and income rise it becomes more important where you live [thus] people "who can" migrate from areas of poorer health do. Such spatial sorting over time exacerbates geographical inequalities in health by concentrating poor health in certain places and affecting the psychosocial pathways of the individuals that inhabit them: more people in poorer areas and classes are driven to drink, smoke, overeat and not exercise when there is less to live for. For instance, Ellaway et. al (2001) reported, from a study of individuals in Glasgow, that perceptions of neighbourhood cohesion and neighbourhood problems were significantly associated with a measure of mental health (GHQ12), such that worse mental health was associated with weaker neighbourhood cohesion and perceptions of being relatively 'worse off' than others living in the neighbourhood.

In their study, damaging health behaviours - such as drug addiction and poor diet - were furthermore reproduced by the deprived material and social conditions of the area that 'went against residents' senses of what was "proper" or "socially acceptable". Morris (1991) furthermore suggests how the built environs of Glasgow - the tall, Stalinist playground - pertain to an 'ableist and competition society' that 'demobilise' people with impairments and discriminate against people experiencing chronic and long-term illness by stretching thin resources of healthcare (doctors, hospitals, transport) and human capital (education) in the run-down quarters of the city. In more Foucauldian undertones, Gesler (1998) describes the hospital beds of the city as 'wedded to the early utilitarian vision [of] productivity not sanctuary [...] progress, cleanliness and efficiency over comfort, information and participation.' The inequalities of mobility and thus opportunity afforded to capitalist bodies - dependent on their working or malfunctioning - are implicated in a vision of nationhood founded on fit, able, bodies and a healthy productive workforce, Morris politicises its terms:

> wellbeing hinges around prevention (for the healthy majority) and cure (for the 'sick' minority)...a vision so pre-occupied with the task of 'Securing good health for the whole population' (Wanless 2004), so engaged with the project of 'Choosing health?' (Secretary of State for Health 2004), that living with illness is regarded as an unwelcome, and essentially passing, blot on the epidemiological landscape...a problem to eradicate rather than a way of life to appreciate, a biographical inconvenience rather than a politics of inequality (Morris, 1991).

Curtis (2004), drawing health inequalities into a political economy framework, posits how collectivised healthcare systems - such as the British National Health Service, Western European "social insurance", and the Medicare and Medicaid schemes in the USA - might all be interpreted as aiming to mitigate the impact on population health and welfare of capitalist modes of production and thus maintain its viability. Several recent studies on the health geographies of West Europe (Makenbach, 2003) and the US (Singh et. al, 2006)

however suggest that the viability of systems is faltering. Drawing data from six European countries, Makenbach observes increasing inequalities in health along a socioeconomic gradient wherein 'faster proportional decline in mortality from cardiovascular diseases is experienced in higher socioeconomic groups' with a lethargy of response in the lower socioeconomic groups. Mortality in these groups was higher regardless of whether educational level, occupational class or income level were used as indicators.

Affording a type of 'rhythmanalysis' to his research, Makenbach (2003) reasons that this is due to the instrumentalisation of cultural and economic capital, he writes: '[mortality decline] in the higher socioeconomic groups may be due to the faster proportional change in various proximate determinants such as health-related behaviours (smoking, diet, exercise) and healthcare intervention (hypertension detection and treatment). As a caveat, he explores how residual social behaviours - such as a deeply-ingrained culture of smoking - causes lags and even reversals in the mortality declines experienced between the groups in Italy. Singh et. al (2006) - observing the socioeconomic inequalities in US life expectancy between 1980 and 2000 - draw similar conclusions, suggesting that the widening gulf 'may be related to increasing temporal inequalities in the material and social living conditions between area deprivation groups both in absolute and relative terms.' They stress a clear ethnic dimension to health inequalities wherein labour market discrimination and other subtle, institutionalised racisms push minority groups to the margins where material living conditions are poor. Dorling (2013) observes the odd reality that, by in large, in unequal societies the most deprived areas are where the least doctors are to be found. Rather than frame minority groups as passive and structured by the society above it however, Nazroo (1998) explores the populistic, social agencies that often emerge in areas of shared disadvantage, he writes:

> 'associations between ethnic density and health show that increased ethnic density is associated with protective effects on mental health [from a stronger sense of community and belongingness, social cohesion and mutual support] and on some physical health outcomes through the ethnic density effect...which stipulates that as the size of an ethnic minority group increases, their health complications will decrease.'

Platt (2001), furthermore exploring health inequalities through their intergenerational temporalities, suggests that improvements are evident in Britain of increasing social mobility - and thus health(y) profiles - within certain minority groups. Much research into the geographies of health posit the importance of gender inequalities in the distribution of wider inequalities within society. Asthana (1998) explores the relationship between health and the lack of empowerment for women engaged in the sex industry in Madras, India. She suggests that individual practices together with (patriarchal) institutional and structural forces actively shape the nature of the local commercial sex industry and patterns of HIV transmission in the city, such that from the quiet, unassuming streets of Madras emerges 'a complex and geographically dispersed group of commercial sex workers, with little control over their work, or whether or not their clients use condoms, and very poor levels of knowledge about the methods by which the HIV can be transmitted'. Asthana argues that this frenetic organisation and the highly unequal power relations that reproduce it problematises the implementation of community based health education strategies. Courtenay (2000) explores the health

paradox of adopting a masculine role in society that requires the use of high risk spaces and behaviours: 'the need to be different from women (no sissy stuff), to be superior to others (the big wheel), to be independent and self-reliant (the sturdy oak) and to be more powerful than others, through violence if necessary (give 'em hell).' As such, men are more likely to suffer illness or injury due to accidents (road traffic accidents, sports injuries, effects of violence) or risky behaviours (smoking, alcohol and drug misuse) and to not seek healthcare ('wounded pride') when it is required. Geographical inequalities in health might be observed as the surrogates of political and cultural inequalities (of income, gender, ethnicity) that produce differing exposures (to health risk) and entitlements (to health resources) between groups within society.

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