
In this second edition, Mel Bartley, Professor Emerita at University College London, presents an extremely interesting overview of our knowledge of social inequalities in health, together with a renewed approach to explanatory theories on them and new research issues in the field.

Despite England’s creation of a national health system in 1948 and ambitious policies to reduce poverty in the 2000s, not only has health inequality in that country not been reduced; it has increased. Similar observations may be made for most European countries, although problems of data availability and comparability make it difficult in some cases to track change and assess health policy effectiveness. These findings attest to the need for better understanding of the mechanisms at work in the construction of social inequalities in health and the need to expose the limitations of current policies in order to overcome them.

The first chapters present and discuss the methodological issues involved in defining and measuring inequality, particularly which social position indicators to choose and which social categories to take into account. Bartley then presents the main explanatory theories and models found in the specialized literature, highlighting the diverse range of independent variables they identify. Each theory is given its own chapter, covering hypotheses and the main research studies used to test them. The first theory (Chapter 4) emphasizes behavioural and cultural causes such as personal characteristics (self-control, for example), which are said to explain individuals’ poor social situation as well as their at-risk behaviours (smoking, alcohol consumption, poor eating habits, etc.). These are compounded, according to this theory, by the “culture” of the individual’s community or reference group (religion, family, etc.). The second theory (Chapter 5) highlights the role of psychosocial factors such as stress, social situation, and “job strain” (related to not having autonomy at work), whereas the third, materialist, theory (Chapter 6) hypothesizes that the most important variables are living and working conditions.

Rather than pitting the different theories against each other, Bartley presents their specificities and verifies their usefulness as tools in the work of better understanding social inequalities in health. To do so, she presents different methodological approaches to the question: cross-cutting analysis (across geographical units, for example), life course analysis, and macrosocial analysis. Life course analysis is a means of getting beyond cross-cutting analysis because it is attentive to health and health determinants throughout the life cycle. Macrosocial analysis, meanwhile, is attentive to the role not only of macroeconomic environments, income levels, and unequal income distribution but also that of welfare regimes (Chapter 7). Each approach allows for testing the previously presented theories and hypotheses at different analytic levels. The interpretive grid thus constructed is then applied to health differences across genders and ethnic groups.
Bartley then turns to life course analysis, one of the main innovations in recent research. Researchers in Britain have followed birth cohorts from the years 1946, 1958, 1970, and 2000, thereby collecting ample data for life course analysis. This approach improves our understanding of trends in social inequality over the life cycle and allows for testing the cumulative effects of living conditions while more effectively taking into account selection effects (Chapter 10). The life course perspective is fundamental because it enables us to develop a causal approach that, in turn, makes it possible to test the respective impacts of social and behavioural determinants and their interactions throughout the individual's lifetime.

The issues of health behaviours and the questionable effectiveness of policies for educating the public on healthy practices often arise in debates on health policy success or failure. For example, public policies implemented in different countries have managed to reduce smoking levels but not the social differences characteristic of that addiction. What we need to find out, then, is whether it is more effective to act on health-related behaviours or living conditions. On this point, Bartley cites recent developments in the philosophical and economic literature, one major focus of which is social justice in the life course of individuals. This equity-based approach can then be used to bring to light determinants that public policy might more legitimately target. The idea here is that it would be more useful to act directly on living conditions, particularly those of children, than on health behaviours, especially if this would have a positive impact on those behaviours in adulthood.

The content and educational clarity of this work will guide or enrich the thinking of students, researchers, and a wider readership interested in social inequalities in health. Bartley is to be commended for emphasizing the importance of developing studies and analyses that will help us better understand the mechanisms that generate health inequality and better identify what types of policy levers should be pulled to combat it.

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