Sociology of Health and Illness : Essay
The politics of health inequalities

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To begin our work about the politics of health inequalities we give thought and context to our reflection by using the usual trio polity, policies and politics and briefly review the problematic arising form them.

Through the prism of polity the question revolves around how the institutional system is building a framework for political action adapted to tackle health inequalities? Western countries context lead to a prevalent focus on liberal democracies that can be be classified according their own perception of the Welfare State - [2]. However, looking at totally different situations such as Cuba's regime where, for the past 50 years, the government has focused on developing a health system that would be accessible to all at no cost in order to address health inequalities. This could mean that the politics of health inequalities are worth exploring in various political systems (Geloso et al., 2020).

From the prism of policies, the problematic investigates the political solutions found to reduce health inequalities; Various solutions have been tested - often unsuccessfully when trying to reduce inequalities, let it be tobacco taxes, strengthening occupational health services or reducing inequalities in health behaviors (see essay 1).

From the prism of politics, problematic now revolves around how political views interact and deal with health inequalities? How relevant are health inequalities on the political agenda?

Simply looking at the US for instance, it is often acknowledged that health is a partisan issue. Furthermore, being caught up in a pandemic that has spotlighted distressful health inequalities and simultaneously watching our governments resorting to a wealth of measures, it seems rather obvious that our last question is answered and that health inequalities is a huge political matter.
However, it remains difficult to draw a causality link between opinions on health to a genuine voting behavior. Paper [1] uses the pandemic situation as a great opportunity to study this interplay and quantify the impact of health issues on voting behaviour. The authors design a survey experiment in which treatment groups are exposed to key facts about the pandemic, followed by questions intended to control for confounders. Unexpectedly, the survey came back with null findings suggesting that politicians are unlikely to be punished or rewarded for their failures or successes in managing COVID-19 in the next election. This conclusion raises a lot of questions: if public health is politically inconsequential this also raises concerns about the impact of political institutions on health outcomes. However, questions - let it be sample effects from Mturk, choice of countries or even type of pandemics - around the external validity of the study [1] remain open. Furthermore, recalling the work from Brown et al. (2020) investigating the relationship between voting and health which holds that people with worse health tend to be less likely to engage in voting seems to yield nothing more than a status quo regarding voters behaviors.

The problem might be that focusing the analysis on votes may not be the best approach to understand how health inequalities affect politics but it could also be that the problem might be more complex than just method. Pandemic aside, would any of us perceive health as a subject of upmost importance when considering politics? Reviewing paper [1], the new question seems to be: is health politically irrelevant?

Health being politically irrelevant might be extreme. Indeed, it does seem that politics and more generally political beliefs affect certain health indicators at the very least.
Navarro et al. (2006) hold that policies aimed at reducing social inequalities, such as welfare state and labour

market policies, do seem to have a salutary effect on selected health indicators such as infant mortality and life expectancy at birth. The work of Navarro et al. (2006) pushes us to have a look towards social inequalities and looking back at the 20th century, there are great examples of how social and health inequalities were understood as being highly related. In the late the 70s, in the United Kingdom, the "Black report" spotlighted that poverty and health inequalities remained at a high level and called for increased spending on social matters. On the verge of the new millennium, the Acheson report linked the matter of health inequalities to socioeconomic status (SES, see essay 1). Finally, in 1997, Labour's victory was vastly due to strong inequalities crippling the UK society and the Labour's return to politics meant a great deal of change in policies.

In this context, it seems that dismissing health as politically irrelevant might have been a bit too extreme. However, the work of Navarro et al. (2006) and the UK political turmoil at the end of the 20th century, seem, at least in terms of politics, to link health inequalities with social inequalities. Then, is to say that the politics of health inequalities simply are politics of social inequalities?
Health inequalities are the result of a combination of downstream and upstream factors. For the WHO Commission on the Social Determinants of Health (CSDH), the definition of health inequalities invokes social inequality as the driver of health inequalities and recommends redistributive policies to combat these inequalities. As a consequence, government should act to equalize both the upstream and downstream socio-determinants of health and should not simply focus on equalizing access to health care and prevention for individual health behaviors (see essay 1).
However, looking at the situation in Europe it seems that the idea of working on upstream factors has not really caught on and that government have focused more on individuals than on their context, their structure. No European government has successfully reduced health inequalities and social inequalities that underlie them - [4].Thus, what happened in the fight against health inequalities?

To answer this question we study the work of Julia Lynch in paper [5]. The author investigates the "reframing of inequality"-phenomena which transformed socioeconomic inequalities in health inequalities.
In paper [5], Lynch conducted 84 interviews with health policy experts and policy-makers in England, Finland, France, Belgium and at the WHO Regional Office for Europe over a 5-year period. They discussed topics such as history of politics, policy focus on health inequalities and policy-making context among others. The author also reviewed a certain number of policy documents to grasp the policy-makers beliefs on causal theories of health inequalities and their proposed course of actions. The author's main takeout is that framing the problem of social inequality in health terms may be safer for politicians than speaking directly about inequalities in the fundamental causes of health. Indeed, rising political taboos - such as redistribution and taxes in the UK - sparked the need for a workaround. The idea is simple, politicians talk about health inequalities, to avoid talking about socioeconomic inequalities. - [4]. A very famous example of this matter is the example we took earlier on the election of the Labour party in 1997 and their reelections in 2001 and 2005. The voters desire for a more equal society was strong but the redistribution taboo was also gaining ground. Tony Blair - not being able to frame the problem as a gap between rich and poor - reframed the lot in health inequalities and undertook real efforts on various issues such as childcare and access to social services but got very poor results in return. Then, what is wrong with this reframing habit?

In fact, the reframing alters the policy-making arena and ends up transforming a socioeconomic inequality into an admittedly more desirable problem politically but much more complex to solve and which often amounts to implementing complex technocratic tools. What's more, the lack of data documenting health inequalities and the very few evidence of efficient policies implementations are a major obstacle to designing valuable policies [5]. This allows us to come back to our initial question with a new grasp of things: is health politically irrelevant?
In fact the massive reframing habit that spotlighted health inequality as a workaround to political taboos as rigged the political playground and might be one of the reasons for paper [1]'s null findings. For instance, coming back to our UK example, technocratic neoliberal language of medicalized policies has broken the association between the Labor party and the idea of reducing inequality in people's minds. Thus, voters went on looking for differentiation between political parties elsewhere. Also, this reframing led to a blatant failure from the Labour party to produce good results after a decade in office which definitely undermined

the credibility of politics to be relevant in terms of health. This could explain paper [1]'s null findings.

That said, the conclusion relies on a new final question: how should policy researchers frame a problem? For instance, during the pandemic, policy researchers used big guns specialized vocabulary by discussing complex measures such as timing and sequencing of lockdowns and avoided the necessary talk - in Julia Lynch's opinion - about pre-covid public policies in deeply affected environments such as nursing home, poor neighborhood and among precarious workers. Social benefits yielded from adequate policies implemented before the pandemic could have produced helpful results that would have been useful now. Finally, policy-makers should avoid using the reframing workaround - [5] - and implement the essentials to reduce social inequality - such as taxation, redistribution and labor market regulation - even if it means facing a taboo and taking politically difficult decisions this will amount to technically easier decisions - [4].

References

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