

Scaling up: the politics of health and place

Abstract

Research into the role of place in shaping inequalities in health has focused largely on examining individual and/or localised drivers, often using a context-composition framing. Whilst this body of work has advanced considerably our understanding of the effects of local environments on health, and re-established an awareness of the importance of place for health, it has done so at the expense of marginalising and minimising the influences of macro political and economic structures on *both* place and health. In this paper, we argue that: (i) we need to *scale up* our analysis, moving beyond merely analysing local horizontal drivers to take wider, vertical structural factors into account; and (ii) if we are serious about reducing place-based health inequalities, such analysis needs be overtly linked to appropriate policy levers. Drawing on three case studies (the US mortality disadvantage, Scotland's excess mortality, and regional health divides in England and Germany) we outline the theoretical and empirical value of taking a more *political economy* approach to understanding geographical inequalities in health. We conclude by outlining the implications for future research and efforts to influence policy from 'scaling up' geographical research into health inequalities.

191 words

Key words

health, inequality, place, geography, politics

Introduction

In recent years, researchers concerned with the connections between health and place have drawn on a wide array of methodological and theoretical innovations to examine how health and illness is socially and physically shaped in place and by place (Elliott, 2018). An international body of theoretically informed research drawing on perspectives such as non-representational theory, socio-ecological frameworks, life course models, amongst many others have contributed significantly to our understanding of the role of place in affecting health and illness, wellbeing and healthcare. However, to date, the development of such theoretically-informed and methodologically-innovative empirical work has had limited traction in the large interdisciplinary field concerned with *inequalities* in health. This is an important area of work when today: Americans live three years less than their counterparts in France or Sweden; Scottish men live over two years less than English men; and there is a 2-year gap in life expectancy between the North and South of England (Bambra, 2016). Research into geographical inequalities in health such as these, continues to draw on a rather narrow conceptualisation of place that we argue has significantly restricted – and probably undervalued – the importance of political processes in shaping health inequalities. In particular, most work on geographical inequalities in health has tended to, explicitly or implicitly, arbitrate between proximal ‘compositional’ and ‘contextual’ explanations (and their inter-relationship) for the stark geographical inequalities in health identified in many countries (Cummins et al, 2007). Whilst the context-composition framing has been important in advancing understanding of some of the drivers of geographical inequalities in health, we argue that the pervasiveness of this approach in the literature has resulted in an incomplete account for why health is increasingly uneven across neighbourhoods, cities, regions and countries.

There is a large literature on context-composition accounts for health, including the very significant body on ‘neighbourhood effects’. In brief, the compositional explanation asserts that the health of a given area, such as a town, region or country, is largely a result of the characteristics of the people

who live there (individual-level demographic, behavioural and socio-economic factors). Whereas, the contextual explanation argues that area-level health is also determined by the nature of the place itself in terms of its economic, social, and physical environment – with place thereby having both direct effects (e.g. environmental pollution, traffic) and indirect effects (e.g. access to services, neighbourhood quality etc.) (Macintyre, Ellaway, and Cummins, 2002). Whilst this body of work has considerably advanced our understanding of the effects of *local* neighbourhoods on health, and re-established an awareness of the importance of place for health, it can also be heavily critiqued for providing a limited account for the large health divisions across cities, regions and countries (Bambra, 2016). Further, the likely pathways linking place and health have often been under-theorised and poorly specified, restricting the evidence of causal relationships (Macintyre et al, 2002). In particular, we argue that the focus on context-composition has privileged horizontal influences at the expense of marginalising and minimising the influences of vertical, macro political and economic structures on *both* place and health. Although there are some notable exceptions (e.g. the work of Walsh et al, 2016 or Niedzwiedz et al, 2015), the general lack of attention amongst health geographers to structural drivers has resulted in conceptualisations that underrepresent the complex multi-scalar and interdependent processes operating at the systems level, often over many decades, to shape geographical inequalities in health. Importantly, the absence of vertical explanations from much of the health geography literature ensures that policy development remains closely wedded to hyper-localised or individualised framings of health. This imbalance has important implications, not just in terms of understanding the causes of geographical inequalities in health but also for theorising and implementing appropriate, robust and sustainable policy solutions.

More recently, it has been acknowledged that the context-composition approaches are not mutually exclusive and that the health of places results from the interaction of people with the wider environment – the *relational* perspective (Cummins et al, 2007). In their seminal paper on the relational nature of health and place, Cummins et al (2007) highlight the importance of vertical place-

based influences on health – stating that researchers should *“incorporate scale into the analysis of contexts relevant for health from the local to the global”* (p.1832). Further, Macintyre, Ellaway, and Cummins (2002) note the importance of incorporating scale into the analysis of contexts. Composition and context should not therefore be seen as separate or competing explanations – but entwined. Both contribute to the complex relationship between health and place – an ecosystem made up of people, systems and structures. As Cummins et al. (2007) argue, *“there is a mutually reinforcing and reciprocal relationship between people and place”* and that a *relational approach* should therefore be taken to understanding how compositional and contextual factors interact to produce geographical inequalities in health (Cummins et al, 2007, p.1826). They argue that the composition and context debate - and the analysis that has ensued - has taken a conventional view of place as static, bounded and fixed (Cummins et al, 2007, p.1826). Drawing on more relational approaches to understanding place, Cummins and colleagues (2007) instead proposed a relational view of health and place in which place is understood as unbounded and dynamic. This informs analysis which integrates individual compositional level factors with horizontal contextual factors and starts to scale up the nature of place so that it also includes the influence of vertical macro political and economic factors. Operationalising relational perspectives on health and place is likely to require a broader range of methods that can capture these complex and dynamic processes operating over various geographical and temporal scales.

The relational perspective has thereby opened up the analytical space in terms of focusing on the effects of factors beyond the individual and the local environment in shaping places and their health outcomes – and also on how the direct and indirect effects of local places are themselves influenced by vertical factors. However, it has still been largely used in the literature to privilege horizontal understandings of place, (over)emphasising the role of lower level, localised, proximal contextual, horizontal effects, at the expense of marginalising and minimising the role played by larger scale vertical contextual influences, particularly macro political and economic factors. While it is true that

some levers for addressing health inequalities do rest at a local level, notably housing (Gibson et al, 2011; Walsh et al, 2016; McNamarra et al, 2017), the potential for local policymakers to use these levers is inevitably constrained by national government fiscal decisions, national frameworks priorities and targets developed by central government, while many more policy levers lie at the national level (Bambra et al, 2010; Scott et al, 2013; Smith and Eltanani, 2015). Yet, policy efforts to tackle health inequalities often involve devolving responsibility for achieving reductions to the local level – particularly in the UK (e.g. Smith et al, 2009). It is time to reassert the value of scaling up our research by outlining a political economy approach to the understanding of health and place.

In this paper we therefore build on the analytical space opened up by Cummins et al (2007) by outlining what such a scaled up *political economy approach* to understanding the relationship between health and place really implies, before outlining how this approach can be applied to three well documented and high profile case studies: the US mortality disadvantage, Scotland's excess mortality, and regional health divides in England and Germany. We further argue that, if the aim is for research on health inequalities – including geographical inequalities in health - to make a contribution to political and policy efforts to reduce these inequalities, then a fundamental dimension of these analyses should be to identify the policy levers with the most potential to reduce health inequalities, at both local *and* national levels.

The Political Economy of Health

There is a need to very firmly assert the importance of scale in understanding the relationship between health and place, particularly in terms of the influence of the macro political and economic, structural factors shaping places and their influence on population health outcomes and inequalities. In the absence of such analysis, it is difficult to defend ourselves against Heath's (2007) charge that we are participating in the creation of a health inequalities 'industry', where affluent researchers 'piggyback' on the distress of the poor as 'a substitute for difficult political effort – *“opium for the intellectual*

masses”. By only focusing on individual characteristics and/or localised neighbourhood effects, research into geographical inequalities in health has been in danger of missing the bigger picture - the ways in which these compositional and contextual determinants of health at the local scale are themselves shaped by larger scale, more macro political and economic factors. The relationship between health and place - and the health inequalities that exist between places - are to a large degree politically determined (Bambra, Fox, and Scott-Samuel, 2005): Place matters for health, but politics matters for place. Indeed, as Slater (2013) has argued in relation to urban geography, we need to think not just about how *where you live effects your life chances* but also *how your life chances affect where you live*, to understand why individuals are living where they are and why that place has the features that it does (Slater, 2013). Indeed, there is a significant body of work by health geographers on health selective migration processes (e.g. Exeter et al, 2011; Tunstall et al, 2016) whereby poor health can lead to downward socio-spatial mobility. Understanding these also require insights from the political economy of health literature.

The political economy approach to health has a long pedigree, arguably dating back to the 19th century, with further influential work conducted in the late 1970s (e.g. Doyal and Pennell, 1979). More recently, it has made a resurgence in social epidemiology and medical sociology, particularly in relation to the examination of cross national differences in health (Navarro and Muntaner, 2004; Schrecker and Bambra, 2015) and within the analysis of inequalities in health between socio-economic groups (Bambra Fox, and Scott-Samuel, 2005; Kreiger, 2003; Diderichsen et al, 2001). Most notably, there is a large and significant body of work that examines the role of different welfare state arrangements in the patterning of population health and health inequalities (for an overview, see Beckfield, 2018) which highlights the importance of how individual and local influences on health and wellbeing relate to the wider social, economic and political conditions operating at national and international scales (see for example, Niedzwiedz et al, 2014; 2015; under review).

In 2014, the Lancet-University of Oslo commission on Global Governance for Health put forward the concept of the 'political determinants of health', insisting that *"construing socially and politically created health inequities as problems of technocratic or medical management depoliticises social and political ills"* (Ottersen et al., 2014, p. 636). The political economy approach argues that the social determinants of health are themselves shaped by macro level structural determinants: politics, the economy, the (welfare) state, the organisation of work, and the structure of the labour market (Barnish, Tørnes, and Nelson-Horne, 2018; Bambra, 2011a, 2011b) and that population health is shaped by the *"social, political and economic structures and relations"* that may be, and often are, outside the control of the individuals they affect (Krieger, 2003; Bambra, Fox, and Scott-Samuel, 2005). Individual and collective social and economic factors such as housing, income, and employment – indeed many of the issues that dominate political life – are key determinants of health and wellbeing (ibid.). Politics is understood here in its broadest terms as *"the process through which the production, distribution and use of scarce resources is determined in all areas of social existence"* (Bambra, Fox, and Scott-Samuel, 2005), not simply the actions of governments or political parties. Public health and health inequalities are thus considered to be politically determined with patterns of disease *"produced, literally and metaphorically, by the structures, values and priorities of political and economic systems... Health inequities are thus posited to arise from whatever is each society's form of social inequality, defined in relation to power, property and privilege"* (Krieger, 2013).

A political economy approach to the understanding of health and place is relational in its nature - albeit privileging the vertical over the horizontal. So, to follow on from Slater (2013), why some places and people are consistently privileged whilst others are consistently marginalised is a political choice – it is about where the power lies and in whose interests that power is exercised. Explanations of health inequalities must therefore consider *"those central engines in society that generate and distribute power, wealth and risks"* (Diderichsen et al, 2001, p. 16). Political choices can thereby be seen as the *causes of the causes of the causes* of geographical inequalities in health (Bambra, 2016).

At the same time, political economy perspectives on health and inequalities have rarely engaged with the geographies of health literature, and tended to overlook the ways in which place and space can mediate the structural drivers of disease, ill health and well-being. Hence, to date, insights from the political economy approach to understanding health has not yet been developed or systematically applied within the health and place literature. This kind of integrated approach is employed in the next section via three case study examples, demonstrating the value to research and policy of scaling up health geography research.

The Political Economy of Health and Place: Three Case Studies at Three Different Scales

This section illustrates the potential of taking a political economy approach to understanding the relationship between health and place. First, taking an international, comparative perspective it examines the US mortality disadvantage (recently the subject of Institute of Medicine report in the United States of America, Woolf and Aron, 2013). Next, we refine our focus to the regional level, examining the contrast between a North-South regional divide in England (the topic of a recent report commissioned by Public Health England - Whitehead et al, 2014) with an East-West regional divide in Germany (Bambra, Barr and Milne, 2014). Finally, we take a local focus, considering the case of excess mortality in Glasgow (the subject of ongoing discussions and highlighted in a recent report by the Glasgow Centre for Population Health, Walsh et al, 2016). For each case study, the conventional horizontal context-composition approach to understanding these issues is outlined and contrasted with a more vertical political economy approach. The intention of this section is to explicate how the integration of a political economy perspective with the traditional terrain of health geography can deepen understanding of the processes leading to the ubiquitous spatial inequalities in health observed in most nation states.

The US Mortality Disadvantage

The US has a significant mortality disadvantage relative to other wealthy countries – with for example, life expectancy rates that are more than three years less than France and Sweden (OECD, 2013) and growing mortality and morbidity rates, particularly amongst middle-aged, low income, whites (Case and Deaton, 2015). Taking a compositional approach, there is evidence that some health behaviours are worse in the US than in some other high-income countries. For example, around 20% of the US health disadvantage is attributable to historical differences in smoking rates (Preston, Gleit and Wilmoth, 2010) and there are significant differences in diet as the US has the highest average calorie intake in the world (Woolf and Aron, 2013). The US has relatively high rates of poverty with over 17% of US citizens experiencing ‘relative poverty’ compared to 11% in the UK and around 7% in Denmark (ibid.). There are also differences between the US and other wealthy countries in terms of contextual factors. For example, the US ranks amongst the lowest of wealthy nations in terms of social cohesion as measured by voting participation rates or levels of trust (OECD, 2011). However, the traditional approach does not explain *why* Americans are more likely to consume more or *why* the US has worse poverty rates than other wealthy countries. This requires a political economy approach (Beckfield et al, 2015).

Perhaps the most obvious (direct) way in which macro level policy decisions in the US help explain the relatively worse health behaviours of the population relate to the limited regulation of unhealthy products, such as tobacco, alcohol and ultra-processed food and drinks, and the industries that produce and market these products (Freudenberg, 2014). The US is one of the least regulated markets among high income countries, and is one of only a small number of high income countries not to have ratified the Framework Convention on Tobacco Control (WHO, 2003). These various political and economic factors interact to shape the health of Americans unevenly, contributing to the country’s extensive health inequalities (Krieger et al, 2014). Geographical work has shown that tobacco, alcohol and ultra-processed foods tend to be highly available in low income urban areas of the US, and that

the products are increasingly targeted at, and available to, low income and minority populations – thereby shaping the local context within which health inequalities arise (Beaulac, Kristjansson, and Cummins, 2009).

Turning to poverty, we can see that the state provision of social welfare is minimal in the US, with modest social insurance benefits which are often regulated via strict entitlement criteria; with recipients often being subject to means-testing and receipt, accordingly, being stigmatised (Bambra, 2016). This is particularly the case in regards to healthcare where the market based system means that around 10% or 33 million Americans remain without health insurance of any kind (Smith and Medalia, 2015). Millions of others remain “under-insured” whereby their health care policies do not cover the full range of health services or their health needs (Woolf and Aron, 2013). The US now provides the lowest level of welfare generosity and the lowest level of health care access of high income democracies (Bambra, 2016). Indeed, the relative underperformance of the US Social Security system has been associated with up to 4 years in reduced life expectancy at the population level (Beckfield and Bambra, 2016).

Collective bargaining and political incorporation have also been associated with national health outcomes. Countries with higher rates of trade union membership have more extensive welfare systems, higher levels of income redistribution - and correspondingly have lower rates of income inequality (Wilkinson and Pickett, 2010). They also have better health and safety regulations. The US has always had the lowest rate of trade union membership amongst wealthy democracies – restricting the representation of working class interests in policy and politics. For example, in 2010 only 12% of the US workforce was a member of a trade union. In contrast, the rates were 26% in the UK and 68% in Sweden (OECD, 2014). Further, the political incorporation of minority groups is also robustly associated with better health among those groups, suggesting a direct connection between political empowerment and health (Krieger et al, 2013). The US was a historical laggard in terms of the

incorporation of minority groups – with equal civil rights for African Americans only achieved in the 1960s (ibid.).

The combination of all of these political and economic factors – acting locally - helps to explain why the US has a mortality disadvantage relative to other countries and why it has become more pronounced since 1980 (when neoliberal economics led to welfare retrenchment, deindustrialisation and deregulation, see Collins et al, 2016 or Schrecker and Bambra, 2015), arguably leading to the increasing mortality and morbidity rates amongst middle-aged, low income, whites that are now being observed (Navarro, 2019). So, to properly understand the US mortality disadvantage, geographical research needs to ‘scale up’ and refocus on upstream political, economic and policy drivers, analysing how macro level factors impact locally. Similarly, political economy approaches to health inequalities can usefully examine the ways in which the structural drivers of health are mediated through socio-spatial processes. For example, in terms of health behaviours, researchers concerned with the commercial determinants need to broaden the existing focus to better capture how these concerns play out at a local level, what the implications are for local health, and what appropriate and integrated policy solutions might be (e.g. greater national regulation alongside local policy interventions). Similarly, political economy work on the relationship between poverty and health would be strengthened by paying attention to the geographical particularities that influence the extent to which risk translates into poorer health outcomes. For instance, local initiatives designed to alleviate poverty such as investment in social housing, transport and other aspects of the local infrastructure, as well as the extent of local ‘disamenities’, including poor air quality, can all enhance resilience to or increase risk of the harmful effects of poverty on population health.

Regional inequalities in health exist across all high income countries. England however has some of the largest regional inequalities in Europe (Bambra et al, 2014b), epitomised by the North South health divide: those in the North of England live on average live two years less than those in the South. The scale of the regional health divide in England is now greater than the gap between the former West Germany and post-communist East Germany (Bambra et al, 2014b). In 1990, the East-West life expectancy gap was almost three years between women and three and a half years between men. This East-West gap has rapidly narrowed in the following decades so that by 2010 it had dwindled to just a few months for women and just over one year for men (Kibele, Kluesener, and Scholz, 2015). So why has the English health divide persisted whilst the German one has closed in a generation?

Firstly, compositional factors such as the living standards of East Germans improved with the economic terms of the reunification whereby the West German Deutsche Mark (a strong internationally traded currency) replaced the East German Mark (considered almost worthless outside of the Eastern bloc) as the official currency - a Mark for a Mark. This meant that salaries and savings were replaced equally, one to one, by the much higher value Deutsche Mark. Substantial investment was also made into the industries of Eastern Germany and transfer payments were made by the West German government to ensure the future funding of social welfare programs in the East. This meant that by as early as 1996, wages in the East rose very rapidly to around 75% of Western levels from being less than 40% in 1990 (Kibele, Kluesener, and Scholz, 2015). This increase in incomes was also experienced by old age pensioners. In 1985, retired households in the East had only 36% of the income of employed households whilst retirees in the West received 65% (Hjonça, Brockmann and Maier, 2000). After reunification, the West German pension system was extended into the East which resulted in huge increases in income for older East Germans: in 1990 the monthly pension of an East German pensioner was only 40% that a Western pensioner, by 1999 it increased to 87% of West German levels (ibid.). This meant that retired people were one of the groups that benefited most from

reunification - particularly East German women as they had, on average, considerably longer working biographies than their West German counterparts (ibid.).

Secondly, from a contextual perspective, access to a variety of foods and consumer goods also increased as West German shops and companies set up in the East. It has been argued that this led to decreases in CVD as a result of better diets (Nolte, et al, 2002). It was not all Keynesianism for the "Ossis" (Easterners) though as unemployment (unheard of in the full employment socialist system) also increased as a result of the rapid privatisation and deindustrialisation of the Eastern economy. Unemployment remains nearly double that of the West today. These economic improvements were funded by a special Solidarity Surcharge. This was levied at a rate of up to 5.5% on income taxes owed across both East and West (e.g. a tax bill of €5000 attracts a solidarity surcharge €275) (Gokhale, Raffelhuschen, and Walliser, 1994). Further, immediately after reunification, considerable financial support was given to modernise the hospitals and health care equipment in the East and the availability of nursing care, screening and pharmaceuticals also increased. This raised standards of health care in the East so that they were comparable to those of the West within just a few years (Nolte et al, 2000, 2002). This had notable impacts on neonatal mortality rates and falling death rates from conditions amenable to primary prevention or medical treatment (ibid.).

Both the economic reforms and the increased investment in health care were the result of the deep and sustained *political* decision to reunify Germany as fully as possible so that "what belongs together will grow together". Germany's lessons for the English divide are therefore two-fold: firstly, even large health divides can be significantly reduced and within a short time period; secondly, the tools to do this are largely economic but – crucially - within the control of politics and politicians. Ultimately, the German experience shows that if there is a sufficient political desire to reduce health divides, it can be done. It shows the primacy of politics and economics, underlying the need for a political dimension to our understanding of health and place. So, this example shows that to *fully* understand regional

health divides – and how to reduce them – an analysis of how vertical, political economy factors shape compositional and contextual determinants at the regional level is required. We need to ‘scale up’ our research to understand how national policy decisions impact on the local context that in turn shapes geographical inequalities in health. For example, in terms of health care policy, geographical research has demonstrated the importance of local access to health care in shaping the place-based opportunity structures (Macintyre, Ellaway, and Cummins, 2002) that influence health inequalities (e.g. the inverse care law, Tudor-Hart 1971; Todd et al, 2014). But there is a need to go further upstream in our analysis and highlight the national drivers of localised systems and inequalities in access. Similarly, national and supra-national economic and political priorities have regional and/or localised implications for population health. For example, national responses to the 2007-08 global financial crisis, including the subsequent austerity measures adopted in many countries, had profound social and economic effects with strong geographical divergence. The effects of these political-driven and spatially-uneven processes include implications for regional labour markets, which in turn can impact upon the physical and mental health of the local populations (Curtis et al, 2018).

Excess mortality in Glasgow

Much of Scotland’s well known relative health disadvantage compared to the other countries and regions of the UK is a result of excess mortality in the Greater Glasgow area (Walsh et al, 2016). Compared to Manchester, Liverpool and Belfast (which have very similar socioeconomic profiles and histories), Glasgow has an excess of 30% for premature mortality and 15% for deaths across all age groups (Walsh et al, 2010; 2016). So if it is not poverty or deindustrialisation alone, what does explain Glasgow’s excess mortality?

Looking at the issue from a compositional perspective, we might quickly focus on the fact around half of Glasgow’s ‘excess’ deaths for those under 65 years of age can be directly related to alcohol and drugs (Walsh et al, 2010). However, for other health-related behaviours, the evidence is less

compelling; comparisons between Liverpool, Manchester and Glasgow suggest it is *“unlikely that smoking contributes in any meaningful way to the high excess level of mortality recorded in Glasgow compared with the English comparator cities”* (Walsh et al, 2016). Very similar conclusions have been drawn for diet, physical activity and obesity (Walsh et al, 2016). Likewise, while there is some evidence that a slightly higher percentage of Glasgow’s population have no educational qualifications, researchers have concluded that this is only likely to account for only a small proportion of the excess mortality (Walsh et al, 2016).

In terms of contextual factors, it has been suggested that Glasgow’s excess mortality may result from the city’s physical environment as it has relatively higher rainfall and lower rates of sunshine (impacting on vitamin D) compared to other UK cities. However, a comprehensive review of the evidence has rejected this hypothesis (Walsh et al, 2016: 103). Dereliction, overcrowding, land contamination and housing quality, have also all also been considered in the literature with both housing and vacant/derelict land considered to be potential contributors to Glasgow’s excess mortality as overcrowding rates and proximity to derelict/vacant land are higher in Glasgow compared to Manchester and Liverpool (Walsh et al, 2016). Once again, though, this then raises further questions about the structural and political factors leading to these circumstances.

Yet again, we can see that focusing on compositional and contextual factors alone is inadequate for explaining the health differences in this case study. Rather, there is a need to look at the combination of these horizontal factors and then to ‘scale-up’ and consider the upstream political determinants that help explain why these differences exist. A seminal evidence review concluded that political decisions - particularly around housing and urbanism - are key to explaining the excess mortality in Glasgow (Walsh et al, 2016).

Firstly, local government responses to UK government economic policy in the 1980s differed from Manchester and Liverpool, with decision-makers for Glasgow attaching greater priority to inner-city gentrification and commercial development, which may have exacerbated negative health outcomes for Glasgow's more vulnerable populations (Walsh et al, 2016).

Secondly, looking more historically, Glasgow implemented larger-scale post-war 'slum' clearances and moved residents of these areas to larger-scale, poor quality, peripheral house estates, a greater proportion of which were high-rise developments (Walsh et al, 2016). Accompanying this, local decision makers also decided to make much lower per capita investments in housing repairs and maintenance (Walsh et al, 2016).

Thirdly, around the same time, the Scottish Office pursued the socially selective 'New Town' programme, which involved relocating industry and those sections of the population most able to work to New Towns, away from what were perceived to be 'declining' cities, with policymakers in Glasgow prioritising and extending this policy approach despite being aware of the negative consequences (Walsh et al, 2016).

Finally, the review suggests that a perceived 'democratic deficit' in Scotland during the 1980s in particular, may have increased psychosocial risk factors for poor health in Glasgow (Walsh et al, 2016) and that the neoliberal policies implemented by the post-1979 UK Thatcher-led Conservative governments constitute a "political attack" against the working class (Collins and McCartney, 2011), and that Glasgow and the West of Scotland became a particular target in ways that were perceived as particularly unfair in a context in which the Conservatives had limited popular support (McCrone, 1991).

So, this case study demonstrates that a ‘perfect storm’ of all of these *political* factors helps to explain why Glasgow’s rate of excess mortality became more pronounced since 1980 and why there was an epidemiological shift to causes of death most associated with poverty and despair (e.g. drugs and suicides) (Collins and McCartney, 2011). Political economy factors thereby interacted - relationally - with both the compositional and contextual determinants of health in Glasgow. This demonstrates the need to ‘scale up’ our research into geographical inequalities in health by incorporating an analysis of both *vertical* and *horizontal* influences – not least in terms of how national political and policy drivers play out locally. A geographically-inflected political economy perspective might for example examine the structural factors affecting the migration and mobility flows of Glasgow’s residents over the past 40 years, and then proceed to consider the differential health trajectories of the city’s ‘stayers’ and ‘movers’. Alternatively, political economy approaches might draw on the notion of the ‘lifecourse of place’ to deepen understanding of how the changes in the social and physical infrastructure of Glasgow’s neighbourhoods over the past 50 years can have profound and long-lasting implications for the health of people at different stages of life, with the full repercussions often not apparent until older age (Pearce, 2018).

Conclusion

Taking a political economy approach emphasises the importance of vertical relationships and structural factors in how place influences health. It therefore moves the debate away from an ongoing focus on horizontal or individual factors and encourages researchers and policymakers to think more upstream in terms of the causes of - and therefore the potential solutions to - geographical inequalities in health. It nonetheless maintains the relational perspective in acknowledging that places are unbounded, fluid, and dynamic – impacted by the interaction of local, national and global processes (Cummins et al, 2007). A geographically-nuanced political economy perspective on health inequalities also responds to recent calls for systems-level perspectives on population health and inequalities

which considers the outcomes to emerge from a complex system and for the drivers to be many and interdependent (Rutter et al, 2017). These issues are particularly salient given that the effects of global economic trends (financial crisis and recession) and the impact of government policy responses (austerity) on health and health inequalities between neighbourhoods (Akhter et al, 2018), counties and cities (Loopstra, et al, 2016; Curtis et al, 2018), regions (Bambra and Garthwaite, 2015) and even countries (Antonakakis and Collins, 2015) are increasingly being documented and that the key future challenges - of welfare retrenchment, austerity and privatisation in the UK and Europe (e.g. Beatty and Fothergill, 2014), migration in Europe and the USA, global climate change, and rising income inequalities – will have clear uneven socio-spatial ‘place effects’ with disproportionate implications for health in more deprived areas (Pearce, 2013). These need to be examined by researchers interested in geographical inequalities in health.

The three case studies we have presented in this paper, each of which focuses on a different scale of geographical inequalities in health, demonstrate the analytical and pragmatic gains that can be made from taking a political economy approach. In every case, explanations focusing solely on compositional and/or contextual factors prove inadequate; the depth of understanding required to inform the kinds of changes needed to begin to address inequalities of such scale are only possible from analyses which ‘scale up’ to incorporate assessments of the ways in which upstream policy changes (at international, national and local levels) shape both people and places. Our fundamental argument is that the academic sub-field of health and place would be substantially strengthened if it could normalise the combination of horizontal and vertical analyses evident in these three case studies. At the same time, we have argued that a geographically-nuanced perspective on political economy approaches to health and inequalities would be a welcome development of this literature. It should also be noted that, while the focus of this paper is specifically about ‘scaling up’ the health and place literature, the points made also apply to other, related, research areas concerned with the drivers of population health (such as

public health and epidemiology), where focuses on mid- and down-stream factors still dominate (e.g. Gruer et al, 2017).

That said, we want to acknowledge that developing these more political and critical strands of health geography research is not necessarily straightforward - such work is often, for example, perceived by researchers to be harder to fund (Smith, 2010). There are also empirical challenges in terms of: (i) obtaining comparable data for cross-national studies where different approaches are used to specify outcomes; and (ii) ensuring consistent spatial information between countries when the approach to data collection and the scale of area-level units can vary substantially;. Further, methodological innovation is required to harmonise spatial data across countries (e.g. using automated zoning procedures) and develop techniques for capturing more sophisticated geographical measures at scale (e.g. using social media data, machine learning). Yet, the risks of not doing so seem clear: researchers have now spent over four decades refining their analysis of the causes of health inequalities in the UK to very little substantive effect (Bambra et al, 2011). It is now over a decade since Heath (2007) charged such researchers with participating in the creation of a health inequalities 'industry', developing well-paid careers on the back of others' distress rather than engaging in the more difficult task of advocating for change. It is eight years since Mackenbach (2011) argued that more advocacy would be required to achieve the kind of public mandate policymakers require to act on health inequalities evidence. And it is unclear that much has changed.

The two risks are, therefore, that: First, by avoiding the scaling up of our research, our critique of the policies and political decisions that cause health inequalities remains unhelpfully muted; and second, by failing to adequately connect our analyses of the causes of health inequalities between places to policy levers for change, our research cannot hope to inform political and public debates about potential responses. So, in addition to establishing and documenting the role of political factors in shaping place-based health inequalities, researchers also need to act as advocates for changing

understanding amongst the public and policy makers. This is a significant challenge, but one where health inequalities researchers could draw on the successful tactics of tobacco control researchers by, for example: facilitating and engaging in public dialogue about the causes of, and potential solutions to, health inequalities; working with non-governmental organisations, and/or policymakers to develop and promote evidence-informed policy proposals; and using research to highlight policy influences that worsen health inequalities (Smith et al, 2016). A third risk arises specifically from research focusing on health and place, which is that this work in itself contributes (albeit unintentionally) to the stigma associated with particular places (Smith and Anderson, 2017) and - since the stigma attached to particular places can easily transfer - to particular communities (Bush et al, 2001) with negative implications for the health of local residents (Thompson et al. 2007; Pearce 2012). In other words, as Wacquant (2007) observes, 'certain scholarly discourse' continually reinforces the kind of territorial stigma that residents of affected places often work hard to resist. With this in mind, we suggest researchers focusing on health and place have an ethical obligation to work to connect horizontal analyses to more vertical accounts and, in both cases, to actively identify and advocate for potential policy solutions to key problems.

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