for critically appraising concepts and taking into consideration their possible underlying ideologies.

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Jonathan Wistow, Tim Blackman, David Byrne and Gerald Wistow: *Studying Health Inequalities: An Applied Approach*
Bristol 2015: Policy Press, 224 pp.

In most developed economies, life expectancy has soared in recent decades. Advancements in public health, and especially in treating 'major killers', such as cardiovascular disease, have raised overall life expectancy, as well as the average quality of life. However, these gains have been unequal among different groups in society. Health inequalities, the gaps in health outcomes between social groups, much like economic inequalities, have persisted and in many cases widened. These gaps are important as a social and moral problem in themselves. However, they are particularly important because they negatively affect overall health outcomes in society. For example, infectious diseases are more likely to be a risk for everyone if there is a group of high carriers. Therefore, understanding the causes and solutions to health inequalities is very important. Unfortunately, health inequalities are not only hard to pinpoint, but owing to their complexity understanding them is particularly problematic. Within the literature, fundamental debates about concepts and measurement continue.

This book gives a very specific and well-argued answer to this predicament. It merges a 'critical and complex realist' theoretical approach with Qualitative Comparative Analysis (QCA) methodology as a solution to understanding the complex reality of health inequalities. The book is structured into three parts. The first part develops the conceptual and theoretical framework, where the authors contrast theoretical approaches and methods that try to isolate effects, to those attempting to understand complex effects. The second part is a historical analysis of health inequality developments in the United Kingdom. The third presents two policy-oriented case studies. One is an analysis of the Health Inequalities National Support Team (HINST) programme, while the other is a QCA analysis of the effectiveness of the Spearhead programme, both of which attempted to tackle health inequalities.

The book begins with a discussion on how to conceptualise health and health inequalities. Following the WHO's definition of health as not merely the absence of disease, but the ability to fully use one's mental and physical capacities, the authors define inequalities in terms of diverging health outcomes for different groups in society. They identify two categories of causes. Risk factors, such as smoking, drinking, or eating red meat, are themselves seen as symptoms of other problems such as education, income, or geographic location. They propose that health inequalities themselves can be understood in two different ways. The first is to view them, as many policymakers do, as a solvable public policy problem, one that has distinct characteristics and possible remedies. The authors argue instead for a view of health inequalities as intractable outcomes of market

economies, much in the same way as some argue about income inequality. They suggest that it can be classified as a 'wicked problem', namely, one that is complex, difficult to define, lacking an immediate solution and itself a symptom of other problems. In this way, they argue that health inequalities are not merely the direct outcome of income or educational inequality, but rather a complex emergent phenomenon in which individual characteristics interact with environment and policies.

The methodological discussion that follows is perhaps the richest and most interesting part of the book. The authors suggest that, because of the complex nature of the phenomenon, more traditional quantitative methods have several limitations. In their view, it is an epistemological and methodological mistake to try to isolate individual factors and variables, as many quantitative methods do. They label this the 'reductionist approach', because it tries to deal with complexity by simplifying it into smaller problems. The problem they have with this approach is that it does not account for fundamental dimensions of complex problems, namely, the importance of context, the emergent properties of systems and interactions between individual components. They argue that health inequalities are the product of such complex systems and interaction.

The authors are particularly critical of randomised control trials (RCTs) and the fact that these are the gold standard in the health literature. They claim that RCTs are not bad in themselves, but that they are inadequate in answering certain types of research questions, such as those relating to the causes and effects of health inequalities. Their proposed solution is a version of 'complexity theory' adapted for health inequalities. This is preferable, in their view, because it allows for non-linear dynamics and takes into account individual agency and context. They also adapt this theoretical framework to set theories and in particular, the QCA methodology as a means of studying health inequalities.

Part two of the book follows developments in health inequalities and health policy in the United Kingdom through the labour governments of the 1990s and 2000s up until the financial crisis. Commenting on several policy reviews, they consider the reasons why the NHS in the UK failed to narrow the gaps in health outcomes. Their argument here is that the NHS was built to function as a 'sickness' service, therefore responding to symptoms and not the underlying problems which cause these divides. Part three of the book discusses case studies. The first is the Health Inequalities National Support Team project that ran in the UK. The authors round up the main lessons and policy implications from the programme. They emphasise a holistic approach to tackling inequalities and particularly stress the role of the community.

The second case study, based on a previous publication [Blackman et al. 2011], uses QCA to determine the reasons why the Spearhead programme was successful at narrowing the gaps in some communities, but not in others. QCA is argued to have several advantages, as a set method. First, it looks at how combinations of causes are associated with particular outcomes. This satisfies their criteria of a method that looks at how conditions can interact to produce the effect. QCA also discerns which causes, or combination of causes, are necessary or sufficient for the outcome. Equifinality, the principle that an outcome can be reached through different pathways altogether, is another reason. This aspect is particularly relevant for health inequalities, which have some causes rooted in geography, others in individual characteristics and yet others in policies. It is therefore likely that there are multiple causal pathways that can lead to the narrowing of inequalities. To run the analysis, the authors use surveys of practitioner opinion to pinpoint the causes of the success or failure of

the programme. Most of these conditions related to bureaucratic practices such as having strategic partnerships or having progress reviews, but also included spending per head on cancers, crime rates, and other structural factors. They find that for cancers, for example, championing—a focus on individual commitment and champions—was a necessary condition. Sufficient combinations included spending on cancer, basic workforce planning, and other organisational factors.

The most substantial contribution of the book lies in its construction of a comprehensive and coherent alternative to the classic quantitative approach to studying health inequalities [see, e.g., Evans et al., 1994]. Despite the flaws elaborated on below, this is an important achievement, and it is sure to ignite very powerful and meaningful debates around issues of conceptualisation, measurement, and methods to study the phenomenon. The book also does a good job at making the case for the adoption of QCA as a standard practice, given the complexity involved in studying health inequalities. Moreover, it makes a very good case as to the usefulness of the analysis. Policy-makers and practitioners are less interested in discussions of the effect sizes of individual factors, but rather want to know which concrete measures to apply in different contexts. The authors also do well in discussing the limitations of QCA. As with quantitative methods, QCA does not directly establish causality. Rather, it establishes association. In keeping with Ragin's advice of checking theory with cases, the book follows up the study with discussions with practitioners [Ragin 2014].

This said, there are several areas that could have been better elaborated in the book. I focus first on issues with the authors' theoretical discussion, followed by the methodological discussion, and, lastly, problems with their application of QCA. The first issue regards the discussion on inequalities themselves. The book leaves the reader with an impression that all of the sources of inequalities are in the end structurally determined and that they, in principle, need to be removed. While this is a plausible and intuitive claim, the authors could have done more to discuss the issue of individual choices, where these are meaningful and less so, as well as the issue of individual responsibility when making choices and trade-offs between health and other goods. The authors could have also tempered their methodological discussion with more nuance. Their claims that quantitative methods do not consider context fail to take into account multi-level modelling, which can do just that by combining different levels of measurement and seeing how, geography for example, can interact with characteristics of individuals. However, their criticism that these models still rely on linearity, and that they might still miss other important emergent properties and interactions, still stands.

Lastly, although the authors make a good argument for the use of QCA, their application of the technique suffers from several problems. A minor issue is that they do not account for pre-existing differences among their regions. One can expect that regions with very high levels of inequality will find it easier to narrow the gaps in some ways than regions that start off with lower levels. This could have been addressed, for example, by including an additional condition containing the pre-existing levels. The more important problem is that the authors are not very clear about how they conduct the analysis. They claim that it was not possible to do a standard 'truth-table' analysis because of 'overlapping and contradictory configurations in the results' (p. 188). It is not clear what kind of analysis they do run in this case. Moreover, contradictory configurations would usually imply that the analysis is problematic in certain respects: either the conditions are not selected well, or they are miscalibrated, or the theory itself is flawed [Schneider and Wage-

mann 2012: 120–123]. In any case, it is not made clear to the reader why this was done.

The problem, then, is that the reader, even one very familiar with QCA, is left helpless in trying to determine for him or herself the validity and implications of the analysis. Added to this is the fact that they do not offer measures of fit. In the case of QCA these are measures of consistency, which checks the certainty with which we can claim that certain conditions or conjunctions are necessary or sufficient, and coverage, which assesses the relevance of those conditions [Schneider and Wagemann 2012: 124–150]. Therefore, it is left unclear to the reader how the conclusions were reached, and how important these conclusions are. Overall, the problem here is one of a lack of transparency, where the authors needed to further justify and explain their particular analysis in order for the reader to be able to evaluate their results independently.

This said, these shortcomings are more technical in nature. They do not in themselves lessen the relevance of the methodological argument as to whether QCA should be applied as a method to study health inequalities. This, and the book's many other theoretical, methodological, and empirical contributions, make it a highly relevant contribution to the literature. Beyond that, the many policy insights it offers from the reviews of programmes attempted in the UK make it a book that will be interesting not only to students and scholars, but also to policy practitioners.

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Kyle McGee: ***Bruno Latour: The Normativity of Networks***
Abingdon and New York 2014: Routledge, 249 pp.

Bruno Latour is undoubtedly one of the most important sociologists in the world today. In the area of law, he has mostly assumed the role of ethnographer, especially in his work *La Fabrique du Droit,* although he also writes from the viewpoint of a legal philosopher in the book's last chapter and in his inquiries into modes of existence, often in collaboration with academic followers. Latour's ideas about law are not confined to just these two areas, but can be traced throughout his writing. Due to its somewhat fragmented nature, the development of Latour's research of law deserves to be studied in a comprehensive manner. This book represents perhaps the first study devoted to legal themes in his prodigious body of work. It should be added that Latour himself approved the book before its publication and that McGee was one of the participants in Latour's AIME project. Despite the initial claim that the book's aim is to introduce Latour primarily to a readership of lawyers and socio-legal theorists, this is not an introductory book. Nor does it explore the historical or bibliographical links between Latour and law. Instead, it is a highly sophisticated and unusual account of socio-legal theory, whose inner logic stands or falls with the mutual