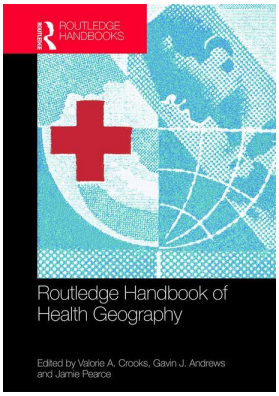

Routledge Handbook of Health Geography

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Introducing the Routledge Handbook of Health Geography

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INTRODUCING THE *ROUTLEDGE HANDBOOK OF HEALTH GEOGRAPHY*

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Health geography is a vibrant, engaged, and methodologically diverse sub-discipline of human geography that explores all aspects of the relationship(s) between health and place. Research by health geographers is not only contributing to wider disciplinary debates in geography, but also proving increasingly influential across other social science and health disciplines and in the development of local, national, and global public-health policy. This edited volume provides the most comprehensive overview to date of contemporary research in the field of health geography. As a collection, it chronicles the diverse ideas, debates, and pressing questions that have driven this sub-discipline forward. The contributed chapters are written by those with recognized expertise in specific domains, which serves as a significant strength of this landmark edited collection. Each chapter offers an overview of the intellectual trajectory of a particular domain, identifies major claims and developments related to this domain in the context of health geography and health research more broadly, discusses the principal contributions of the domain to the sub-discipline, articulates the main criticisms or limitations of this domain of study, and offers ideas regarding future research directions or developments.

Our goal in this chapter is not to provide an exhaustive or detailed overview of health geography and its evolution. There are excellent resources to turn to for such accounts (e.g., Andrews et al., 2012; Elliott, 1999, 2017; Kearns and Gesler, 1998; Kearns and Moon, 2002). Instead, we seek to contextualize this volume by briefly providing insight into the relationship between health and place and the sub-discipline of focus and then introducing the structure and organization of the book. We build on this initial contextualization in our own short chapters that are placed at the start of each of the five sections. These short chapters provide further insight into important facets of health geography and the study of health and place, including syntheses of some of the most significant contemporary debates in the sub-discipline.

The acknowledged relationship between health and place

Space and place affect people's health, well-being, and access to and experiences of health care. The connections between health and place have been recognized as far back as Hippocrates' *Airs, Waters and Places* (written in 400 BC) showing early recognition of the causal influence of place (water, food, climate and seasons) on health and well-being. Similarly, the work of the social reformers of the 19th century in Great Britain, such as Edwin Chadwick, Friedrich Engels and Benjamin Seebohm Rowntree, was significant in making the connections between the rapid industrialization of British cities and the health of people living there (Pearce, 2014). These early reformers not only documented the stark differences in health across urban areas of the country but also identified some of the underlying living conditions that were integral to understanding the

observed inequalities. The same can be said about the importance of the earliest works that described traditional medicines, and the later writings of Florence Nightingale (1859) and other public-health pioneers, in terms of articulating the importance of the local environment in understanding people's opportunities for health and well-being (Barrett, 2000). The interconnection between health and place has thus been acknowledged for centuries, and the sub-discipline of health geography sets at its core the task of uncovering and explicating all of its facets. Indeed, this interconnection is widely recognized, and the relationship between health and place has been researched not only by geographers, but also by those from public health, sociology, epidemiology, biostatistics and other disciplines (see Macintyre, Ellaway and Cummins, 2002).

In 1946, the World Health Organization defined "health" as being composed of our "physical, mental and social well-being, not merely . . . the absence of disease or infirmity" (World Health Organization, 2014, p. 1). Acceptance of this widened definition of "health" prompted a gradual shift away from an exclusively biomedical model of health toward a framework of health that also emphasized its economic, political, social and cultural antecedents not only in the health professions but also among health researchers. This shift also led to wider interest in understanding and acknowledging social influences on health; in doing so, it helped popularize consideration of the role of place (e.g., where we live, where we work, where we access health services) in shaping health. For example, by the time of the World Health Organization's Declaration of Alma Ata in 1978, which was a milestone declaration enforcing the necessity of primary health care in achieving health for all globally, the infusion of heavily geographic concepts such as community, (spatial) equity and (socio-spatial) access into public health vocabulary had become reasonably commonplace (Crooks and Andrews, 2009a, 2009b).

In 1994, Evans, Barer and Marmor spoke to the importance of using a population-based lens for understanding the social determinants of health, outlining a perspective that has become a guiding framework for health and health-promotion policy internationally. A population-health focus considers health outcomes at the group level, including its distribution, and seeks to identify why some populations have better health than others. From a policy perspective, population-level approaches have been increasingly influential, as they seek to identify the policy levers that will have the most wide-ranging and sustainable benefits. A population-health lens also positions health inequities as a central public-health concern and has resulted in a wide-ranging interdisciplinary and international literature on the ubiquitous social gradient in health that has been observed in most countries (Smith, Bambra and Hill, 2015). In recent years, the social determinants of health have come to provide a widely used framework for examining how societal factors and forces, including socioeconomic and political inequalities (e.g., social exclusion, racism, and housing security) shape health status locally and globally. Most of these determinants have explicitly, such as housing and the built environment, or implicitly, such as gender and income distribution, spatial or geographic components, further reinforced a wide acknowledgment of the connections between health and place.

This volume shows that the sub-discipline of health geography is influenced by many conceptualizations of health, particularly those informed by the social model of health proposed by the World Health Organization, as well as the "social determinants of health" framework (see also Elliott, 1999; White, 1981). The first two sections in particular do an excellent job of showcasing this breadth. Health geographers have played a significant role in articulating the role of spatial and place-based factors and forces in shaping health through a social-determinants lens. Examples from the health-geography literature include examining how geographical processes such as local labor market dynamics, urban segregation, neighborhood resources, social capital and networks, housing quality and security, and colonial legacies shape the relationships between place and health outcomes (e.g., Brown et al., 2018; Curtis, 2004). Increasingly, health geographers are giving attention to the role of these determinants in influencing health and well-being among diverse people who are exposed to different structural and social inequalities (Giesbrecht et al., 2014). In particular, work in the sub-discipline has revealed many of the key barriers to, and facilitators of, positive health experiences among some of the most marginalized groups in society. These contexts are particularly well highlighted in

the third section of this book, which explores some of the people and groups that have received significant attention in health-geography research.

Health geographers are interested in understanding and exploring health as it relates to place. As we shall see in this book, place can be a specific location, fixed set of geographic coordinates or politically defined space, or it can be a social and cultural phenomenon, one that is performed, sensed, felt and imbued with meaning and identity (Andrews, 2018; Gatrell and Elliott, 2009). Places are complex in that various elements and facets converge within them to dictate people's overall experiences. Meanwhile place is susceptible to outside influences from officialdom that can facilitate the health of a population, a group, or an individual and can even contribute to exclusion and marginalization. Health geographers widely acknowledge this complexity. Indeed, we expand on the complexity of place as it relates to health in Chapter 32, our introduction to the fourth section of this book. While in this section of the current chapter we have shown that there is wide interest in and acknowledgment of the connection between health and place, it is health geographers' intellectual engagement with place in all its facets that sets this sub-discipline apart from other social-science and health disciplines that are informed by social models of health and social-determinants frameworks.

The sub-discipline of health geography

Health geography has evolved considerably since its inception as a sub-discipline of human geography in the mid-20th century. Initially referred to as *medical* geography, this sub-discipline was heavily positivist, focusing on ecological perspectives of disease (e.g., geographical patterns of disease and environmental determinants) and the spatial distribution of health services (e.g., identifying geographical gaps in health-care provision) (Meade and Earickson, 2000). Although these and related questions were important, this narrow focus resulted in a limited and incomplete understanding of how and why place is implicated in understanding health. What is often referred to as the "cultural turn" in human geography greatly informed the trajectory of the sub-discipline, directing it away from a biomedical understanding of health and disease toward a theoretically informed socio-environmental perspective on health. At the same time, developments in the sub-discipline mirrored shifts in other health-related disciplines by adopting population-level perspectives to examine wider determinants of health (see the previous section in this chapter). An outcome of these changes was a transformation in name, from *medical* to *health* geography, but more importantly a diversification in the methods, theories, and approaches that health geographers employed (Kearns, 1995).

It is widely recognized that this important shift in the sub-discipline from medical to health geography was in part inspired by Kearns, who in his landmark 1993 publication called for a *postmedical* or *reformed medical* geography. He suggested it was time for a repositioning of the sub-discipline within social geography and for the incorporation of stronger links to social theories that recognize situated experiences and qualitative research as valid ways of knowing (for a review, see Andrews, 2003; Elliott, 2018). This approach suggested that facets of social theory, together with a place-sensitive approach, were critical to the evolution of the former medical geography. Several of the theories and conceptual approaches now used in health geography are showcased in the second section of this book and have heavily influenced the work covered throughout the volume. This reformed health geography has also seen increasing attention given to other significant concerns in the wider human-geography literature, such as scale and difference (Parr, 2004) and life-course perspectives that recognize the importance of time and the durability of place (Pearce et al., in press), which are also concepts that run throughout the chapters contributed to this collection. Recently another paradigm shift has begun; a *post-human* turn whereby place is conceived as an assemblage – both it and the bodies within it are understood to be networked, material, open, active and performed phenomena. This turn has seen sub-disciplinary attention increasingly paid to such things as the sensory, atmospheric and affective qualities of health and place, all within a broader objective to think about how health emerges and *takes place* (Andrews, 2018; Duff, 2014).

Although we provide here only a snapshot of its evolution, it is evident that the sub-discipline of health geography has grown from its positivist roots to become a more broadly defined, interdisciplinary field of study informed by diverse and dynamic perspectives. Indeed, health geography is known for its pluralism, and its study has come to be informed by diverse methodological and theoretical approaches. Health geographers often draw upon methods, ideas, concepts, and even research questions from other social-science and health-science disciplines to inform understandings of the complex relationship between health and place. This interdisciplinary and collaborative approach is seen throughout this volume, though perhaps most especially in the final section, which examines the practice of health geography. From a theoretical perspective, health geographers draw upon an array of lenses to better understand the connection between health and place, including humanism, social constructionism, post-structuralism, political economy, complexity theory, relational approaches, non-representational theory, idealist theory and political ecology. The methodological diversity and innovation of health geographers is also extensive, having employed creative methods such as autoethnography, storytelling, photovoice, participatory arts-based approaches, and innovative geospatial approaches using GIScience, GPS-informed and smart technologies and spatio-temporal statistical modeling. Although this growing theoretical and methodological pluralism may have created a methodological divide between quantitative and qualitative approaches and the research questions they inform (Rosenberg, 2016), many health geographers view the methodological and theoretical diversity and innovation to be one of the greatest strengths of the sub-discipline. This view of sub-disciplinary diversity as strength is echoed throughout a number of the contributed chapters.

The practice of health geography is ever changing, and in recent years health geographers have increasingly addressed applied health problems in order to provide evidence for policy debates, stimulate media dialogue, or create interventions (Crooks and Winters, 2016). This engagement reflects a greater expectation of academics to demonstrate the broader societal value of their research through affecting public discourse and engaging with important policy needs. Health geographers are particularly well-placed to respond to this challenge and are well attuned to working alongside policy-makers in the production of research and ensuring research findings are disseminated in ways that are tailored for their intended target audience(s) (Shortt et al., 2016). Although this shift toward placing greater value on academic impact through engagement has not been unproblematic, the increased visibility of health-geography research has resulted in a growing recognition among policy-makers, practitioners and the public of the complex relationship between health and place. This can be seen, for example, in the greater attention to place in public-health strategies such as improving community network, reducing inequities and addressing the obesity epidemic. It can also be seen in the growth of nursing geographies as a dedicated area of study by some nurse researchers (e.g., Andrews, 2003; Kyle et al., 2016).

Once critiqued for their overwhelming research focus on the Global North, over the past decade health geographers have increasingly taken up development and global health frameworks that have pushed research into ever-expanding geographic territories. This has also widened the net of policy and practice relevance for research in the sub-discipline and is beginning to bring perspectives from health geography to some of the major challenges in global health, such as global governance, global inequalities, transnational movements, the control of infectious disease, and the rise of non-communicable diseases. As several contributors to this volume point out, particularly in the first section, health geography has much evolving to do to truly engage the world – in terms of both where health geographers are based and the topics and places they study – and to produce evidence that is relevant to global debates and issues concerning health for all.

Overview of the book

We have organized the *Routledge Handbook of Health Geography* into five sections, each of which has nine or ten contributed chapters. These sections are an organizational structure rather than reflecting any dominant classifications of health-geography research, and there is inevitably a certain amount of conceptual overlap

between them. As noted above, each section beings with a short introductory chapter by us that provides important context about the sub-discipline of health geography and offers cross-cutting themes. The lead author of each of these chapters is the editor who took overall responsibility for the tone and content in that particular section of the book.

Section 1 provides an overview of key perspectives and debates in the sub-discipline. Taken together, the chapters in this section outline many of the most significant and enduring issues and questions that health geographers and those involved in geographical research on health focus on. Further, the chapters provide insights into the ways in which health geographers are making vital contributions to many of the most pressing public-health challenges across the globe, including immensely complex issues such as transmission of infectious diseases, global food insecurity and the obesity epidemic, and the continued burden of tobacco-related disease. Several chapters identify the latest thinking on very well-established areas of the sub-discipline, such as environmental health and justice and infectious disease. Other chapters highlight emerging perspectives and debates and emphasize where health geographers should be bringing perspectives that contribute to understanding the importance of place in these rapidly evolving concerns. As we observed above, health geography is interdisciplinary; scholars draw on concepts and ideas from a range of social-science and health disciplines, and they tend to work in highly collaborative teams of researchers with diverse disciplinary and methodological backgrounds. It is increasingly recognized that addressing the major global health challenges of the 21st century will require interdisciplinary approaches, with perspectives from health geography firmly embedded. Section 1 serves to reflect this interdisciplinary nature of health geography.

The second section focuses on theoretical traditions and concepts that inform health-geography research. As we point out in our introductory chapter to this section, health geography is not often regarded as a theoretically rich sub-discipline of human geography when compared to, for example, the theoretical contributions of cultural geography (Kearns and Moon, 2002). There are likely a number of reasons for this, including that much health geography research is tackling applied problems and that the heavily networked nature of much scholarship involves collaborations with health-professional groups in ways that makes the inclusion of theory somewhat prohibitive. However, the chapters in this section show that health geographers are successfully using theories of all types in driving forward research questions, methods and methodology selection, and that some concepts championed by health geographers have been taken up more broadly into health research.

The groups and people of focus in health geography research form the basis of the third section of this collection. Health geography has many foci in this regard, and much of it explores the health and health-service access of the most marginalized and disempowered individuals, and various health- and social-care-provider groups. Health geographers have championed the ways in which place-based and multiscalar experiences shape their experiences and ultimately their health outcomes, identifying the barriers to positive health-related experiences. We introduce this section of the volume in Chapter 22 and in doing so identify several themes that cross-cut the insightful contributed chapters. First, the chapters in this section illustrate health geographers' established interest in showing how recent socioeconomic and political changes at the global scale, such as neoliberal policy agendas (e.g., the shrinking of the welfare state) and transnationalism, are profoundly and negatively affecting the health of the most marginalized and vulnerable groups. Second, these chapters show how the social and structural processes that continue to relegate particular groups to the margins of society and exclusionary places have enduring implications for their health and everyday well-being. Finally, this section illustrates the ways in which health geographers are increasingly employing methods that enable them to work with marginalized people and groups throughout the research process in collaborative, engaged and revealing ways.

Given that this is a health-geography collection, obviously themes of place and space run throughout the volume. In the fourth section, however, we give dedicated consideration to some of the places and spaces that health geographers explore most in their work. The chapters in this section show the power of considering both the physical and social understandings of place in order to truly decipher the impact of place on health.

Some authors also offer insight into the ways that place and space contribute to health or health promotion, rather than simply detract from health. This section also sees the most explicit ongoing consideration of health-care and health-service sites and those who work there, both formally and informally. Collectively, these chapters highlight the importance and ongoing nature of the study of the sites of health-care delivery and receipt within health geography, the value of exploring everyday or taken-for-granted spaces (versus exceptional ones) for understanding the role of place in shaping health, and the uptake of the mobilities turn in social-science research into health geography.

The fifth and final section addresses how it is that geographers do what they do and, in part, the challenges that they must navigate in their research. From research-ethics processes and methods to applied collaborations and incorporating diversity approaches into studies, this section details multiple aspects of health-geography practice. As we note in our chapter at the outset of this section, there are three clusters of chapters. The first cluster is focused on the practice of qualitative research in health geography. The second cluster examines aspects of quantitative health geography, including the push toward big-data approaches. The final cluster cross-cuts the first two, exploring issues of practice relevant to all health geographers regardless of the methods they employ.

We think it is important to acknowledge that the chapters contributed to this book do not provide an exhaustive overview of health geography. There are many voices, places, theories, approaches, and practices that we sought to include in this volume but were unable to find contributors for; others we decided against due to space restrictions. Some of the key omissions that we had explicitly sought to include as chapters in this collection are concerned with race, ethnicity and exclusion; feminist theory; gender; affect; critical realism; ecological perspectives; workplaces; the body and embodiment; knowledge translation; public geographies; and health-services research. In our chapters that introduce each section, we reflect on some of these gaps in greater detail and consider some of the reasons it proved impossible to secure chapters on these themes that in some cases point toward important gaps in the literature. Therefore, what is missed in this collection might be important, and we encourage readers to look at the tables of contents of journals such as *Health & Place*, the *International Journal of Health Geographics*, and *Social Science & Medicine* along with recent programs from the biennial *International Medical Geography Symposium* as possible entry points. Meanwhile, we believe that a significant strength of our approach has been to prioritize the inclusion of emerging, cutting-edge aspects of the discipline, such as post-humanism and non-representational theory, in the hope that the contribution of this volume endures.

References

Andrews, G. J. (2003). Locating a geography of nursing: space, place and the progress of geographical thought. *Nursing Philosophy*, 4(3), pp. 231–248.

Andrews, G. J. (2018). *Non-representational theory and health: the health in life in space-time revealing*. London: Routledge.

Andrews, G. J., Evans, J., Dunn, J. R. and Masuda, J. R. (2012). Arguments in health geography: on sub-disciplinary progress, observation, translation. *Geography Compass*, 6(6), pp. 351–383.

Barrett, F. (2000). *Disease and geography: the history of an idea*. Toronto: Becker Associates.

Brown, T., Andrews, G. J., Cummins, S., Greenhough, B., Lewis, D. and Power, A. (2018). *Health geographies: a critical introduction*. Chichester: Wiley-Blackwell.

Crooks, V. A. and Andrews, G. J. (2009a). Community, equity, access: core geographic concepts in primary health care. *Primary Health Care Research & Development*, 10(3), pp. 270–273.

Crooks, V. A. and Andrews, G. J. (2009b). Thinking geographically about primary health care. In: V. A. Crooks and G. J. Andrews, eds., *Primary health care: people, practice, place*. Aldershot: Ashgate, pp. 1–20.

Crooks, V. A. and Winters, M. (2016). 16th International Medical Geography Symposium special collection: a current snapshot of health geography. *Social Science & Medicine*, 168(2016), pp. 198–199.

Curtis, S. E. (2004). *Health and inequality: geographical perspectives*. London: Sage.

Duff, C. (2014). *Assemblages of health: Deleuze's empiricism and the ethology of life*. Dordrecht: Springer.

Elliott, S. J. (1999). And the question shall determine the method. *Professional Geographer*, 51(2), pp. 240–243.

Elliott, S. J. (2018). 50 years of medical health geography(ies) of health and wellbeing. *Social Science & Medicine*, 196, pp. 206–208.

Evans, R., Barer, M. and Marmor, T. R. (1994). *Why are some people healthy and others not? The determinants of health of populations*. New York: Aldine de Gruyter.

Gatrell, A. C. and Elliott, S. J. (2009). *Geographies of health: an introduction*. Chichester: Wiley-Blackwell.

Giesbrecht, M., Cinnamon, J., Fritz, C. and Johnston, R. (2014). Themes in geographies of health and health care research: reflections from the 2012 Canadian Association of Geographers annual meeting. *Canadian Geographer*, 58(2), pp. 160–167.

Kearns, R. (1993). Place and health: towards a reformed medical geography. *The Professional Geographer*, 45(2), pp. 139–147.

Kearns, R. (1995). Medical geography: making space for difference. *Progress in Human Geography*, 19(2), pp. 251–259.

Kearns, R. and Gesler, W. M. (eds.) (1998). *Putting health into place*. Syracuse, NY: Syracuse University Press.

Kearns, R. and Moon, G. (2002). From medical to health geography: novelty, place and theory after a decade of change. *Progress in Human Geography*, 26(5), pp. 605–625.

Kyle, R. G., Atherton, I. M., Kesby, M., Sothern, M. and Andrews, G. (2016). Transfusing our lifeblood: reframing research impact through inter-disciplinary collaboration between health geography and nurse education. *Social Science & Medicine*, 168, pp. 257–264.

Macintyre, S., Ellaway, A. and Cummins, S. (2002). Place effects on health: how can we conceptualise, operationalise and measure them? *Social Science & Medicine*, 55(1), pp. 125–139.

Meade, M. S. and Earickson, R. (2000). *Medical geography*. New York: Guilford Press.

Nightingale, F. (1859). *Notes on nursing: what it is and what it is not*. London: Lippincott.

Parr, H. (2004). Medical geography: critical medical and health geography? *Progress in Human Geography*, 28(2), pp. 246–257.

Pearce, J. (2014). Geographies of health inequality. In: W. C. Cockerham, R. Dingwal and S. R. Quah, eds., *The Wiley-Blackwell encyclopedia of health, illness, behavior, and society*. Chichester: Wiley-Blackwell.

Pearce, J., Cherrie, M., Shortt, N., Deary, I. and Ward-Thompson, C. (in press). Life course of place: a longitudinal study of mental health and place. *Transactions of the Institute of British Geographers*. DOI: 10.1111/tran.12246

Rosenberg, M. (2016). Health geography II: "Dividing" health geography. *Progress in Human Geography*, 40(4), pp. 546–554.

Shortt, N. K., Pearce, J., Mitchell, R. and Smith, K. E. (2016). Taking health geography out of the academy: measuring academic impact. *Social Science & Medicine*, 168, pp. 265–272.

Smith, K. E., Bambra, C. and Hill, S. (eds.) (2015). *Health inequalities: critical perspectives*. Oxford: Oxford University Press.

White, N. (1981). Modern health concepts. In: N. White, ed., *The health conundrum*. Toronto: OECA, pp. 5–18.

World Health Organization. (2014). *Constitution of the World Health Organization: basic documents*. 48th ed. Geneva: World Health Organization.