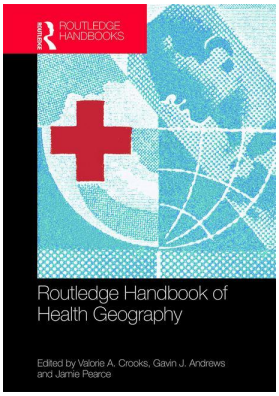

Routledge Handbook of Health Geography

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Introducing Section 2

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INTRODUCING SECTION 2
Theories and concepts

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This section is concerned with the theoretical traditions and concepts that inform and frame research in health geography. Given this focus, it is worth thinking briefly first about the nature of theory. Certainly, theory can seem intimidating for scholars, particularly those just starting out in their careers; much of it appearing complex, often being articulated through dense, technical and sometimes abstract writings. However, it is worth remembering that, fundamentally, theory is nothing more than sets of propositions on, and interpretations of, the empirical realities of the world. These propositions and interpretations constitute a lens: a common way in which researchers look at and understand the world. Indeed, it is a lens through which all inquiry flows, helping researchers determine their empirical priorities, their research questions and the types of methods they employ.

Importantly theory adds value to any discipline or field of study within which it is employed, including health geography. Through building underlying knowledge – or what might be thought of as *surplus information* beyond empirical observations – theory has the potential to facilitate conversations between scholars about the world. As a language, then, theory provides academic direction, informing common ways of practicing, and ultimately building academic identity and cohesion. Having said this, however, no matter how broadly applicable, resilient and open to debate and modification a particular theory might be, there will always be those who disagree fundamentally with it and, in disciplinary contexts where a lot is at stake, ultimately frictions and arguments over which theory should occupy the center ground. Indeed, health geography has had its fair share of these; for three key occasions see these debates: (1) Kearns (1993, 1994a, 1994b) with Mayer and Meade (1994) and Paul (1994); (2) Litva and Eyles (1995) and Eyles and Litva (1996) with Philo (1996) and (3) Andrews, Chen and Myers (2014) and Andrews (2015) with Kearns (2014) and Hanlon (2014).

As is well documented, there are three broad types or levels of theory in any academic discipline; grand or meta theory (i.e., ways of seeing and explaining substantive aspects of the world), mid-range theory (i.e., applicable to more focused, yet still general, situations and scenarios), and specific theory (i.e., focused ideas on quite particular empirical happenings). Concepts, meanwhile, should not be thought of as inferior to theory (i.e., as simplistic-theory, part-theory or sub-theory). Rather, they are important ideas; pieces of a jigsaw that together constitute whole theoretical traditions. Indeed, concepts bring theory to life and, speaking directly to the nature of things, are often used to frame studies. While all three levels of theory are evident in health geography, the chapters in this section tend to focus on the first two, their being more influential to the sub-discipline as a whole and speaking to the broad directions it has taken.

A general observation that seems to hold true is that, over the years, health geography has not been a particularly theoretical sub-discipline, in that it has not produced a particularly large volume of dedicated theory papers. Nor has it led to *cutting-edge* theoretical trends in the parent discipline of human geography (Kearns and Moon, 2002; Parr, 2004). This observation is consistent with a more general narrative that health geography – and particularly the long-standing medical-geography component of it – is rather applied and practical, focused on servicing the needs of health sectors through providing the mapping component of broader health-services research, public-health research and epidemiology. Having said this, however, the idea of health geography as data-rich/theory-poor might well be overstated. Indeed, the chapters in this section illustrate two things: on one hand, that health geography has led to certain theoretical developments in the health sciences more broadly, both in terms of the overall social-science contribution to understanding health and in terms of geographical ideas (space, place, landscape, urbanicity, rurality, settings, etc.); and on the other hand, that health geographers have joined emerging theoretical traditions in human geography quite promptly, the lag time between theoretical developments in the parent discipline and their adoption in health geography being somewhat shorter than it once was.

What this section aims to achieve is an understanding among readers as to how theory motivates and shapes research in health geography and more broadly the nature of the sub-discipline. Moreover, it aims to develop an understanding of some of the main theoretical perspectives; their constituent ideas, interests, range of applications, and internal developments and progress. This sets readers up for a better understanding of many of the empirical topics covered in other sections of the book. The chapters tend to focus on theoretical traditions that have informed and molded the sub-discipline particularly in the last 30 years, many of which have extended histories of use and engagement outside health geography. The section starts with three chapters focused on traditions that have had powerful influences on scholarship in health geography: Neil Hanlon writing on political economy; Benet Reid and Matt Sothern, on humanism; and Sebastian Fleuret, on social constructionism. Indeed, these theoretical traditions in many ways helped kick-start the qualitative, place-sensitive turn in the sub-discipline from the early 1990s onward. The next three chapters focus on some important concepts that have emerged from these traditions: Amber Pearson and Richard Sadler writing on social capital; Jessica Finlay, on therapeutic landscapes; and Meryn Severson and Damian Collins, on well-being. Indeed, these concepts are used to frame and explain much empirical work in health geography since the early 1990s. The final three chapters in this section are more contemporary, in that they map theoretical progress since the early 2000s, providing new perspectives and opportunities for research. Here Josh Evans writes on post-structuralism; Cameron Duff, on post-humanism; and Jennifer Lea, on one style of research emerging from these, non-representational theory. Certainly, there are other ways of dividing the theoretical perspectives that inform health geography, and other theories and concepts could have been prioritized (e.g., theoretical traditions such as positivism/spatial science, ecology, feminism, sense of place and relationality). These have not been missed, as they are discussed throughout the book, both in this and in other sections.

In terms of the future, what the final three chapters in this section clearly show is the emergence of a range of variously interconnected theoretical traditions in health geography that include new materialism, post-humanism, affect theory, complexity theory, relationality, assemblage theory and actor-network theory. Collectively these emerging traditions inform a move away from the traditional twin streams of health geography (mapping health and health care across space versus digging for the meanings of health in place), instead telling us something about the networked, physical, sensory, atmospheric, energetic, performed and moving nature of health and place (Andrews, 2018). Moreover, as health geographer Josh Evans observed at a session at the 2017 International Symposium in Medical Geography, together they also constitute an ontological turn in health geography, this being a move in the sub-discipline away from theory as epistemology (the way we know things) to theory as ontology (what things are). Indeed, this ontological turn involves fundamentally rethinking old ideas in health geography (such as health and place), including what they are and how they emerge. Despite these exciting developments, there is plenty of theoretical work to be done in the

sub-discipline. We need to think more about these emerging traditions and what else they can tell us about the health of/in individuals, groups, communities and places of various forms and scales. Moreover, we need to think more about what they lend to both established and new areas of empirical inquiry and debate and how they can be used in conjunction with other, more established theory. Moreover, relating to other sections in this book, we need to consider what existing methods need to be enhanced, and what new methods need to be developed, so that we might maximize their potential and gain the insights we want from them.

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