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REVIEW ARTICLE

Desperately seeking reductions in health inequalities in Canada: Polemics and anger mobilization as the way forward?

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Abstract
Progress in reducing health inequalities through public policy action is difficult in nations identified as liberal welfare states. In Canada, as elsewhere, researchers and advocates provide governing authorities with empirical findings on the sources of health inequalities and document the lived experiences of those encountering these adverse health outcomes with the hope of provoking public policy action. However, critical analysis of the societal structures and processes that make improving the sources of health inequalities difficult—the quality and distribution of living and working conditions, that is the social determinants of health—identifies limitations in these approaches. Within this latter critical tradition, we consider—using household food insecurity in Canada as an illustration—how polemics and anger mobilization, usually absent in health inequalities research and advocacy—could force Canadian governing authorities to reduce health inequalities through public policy action. We explore the potential of using high valence terms such as structural violence, social death and social murder, which make explicit the adverse outcomes of health-threatening public policy to force government

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action. We conclude by outlining the potential benefits and threats posed by polemics and anger mobilization as means of promoting health equity.

KEYWORDS
anger arousal, health inequalities, polemics, public policy, research traditions

> "That's why I reckon you should stay there with your sword drawn if you're truly set on it and your anger's big enough, because you got grounds, I agree, but if your anger's a short one best leave right away."
>
> -- Bertolt Brecht (Brecht, 1939/2006)

> "While change and innovation may not be caused by polemic, they are apparently seldom effected in its absence."
>
> -- Jonathon Crewe (Crewe, 2004)

INTRODUCTION

Canadian researchers, advocates and governmental authorities have made important contributions to understanding the source of health inequalities and providing means of reducing them through public policy action (Bryant et al., 2011; Raphael, 2016). These contributions include the specification of how the quality—the experience of health-enhancing versus health-threatening living and working conditions—and the distribution—the public policies that determine these exposures—of the social determinants of health create health inequalities (Mantoura & Morrison, 2016). Despite this reputation, addressing health inequalities is not on the public policy agenda of any federal, provincial or territorial government (Raphael & Bryant, 2020). It should not be surprising then that Canada's public policy profile regarding the quality and distribution of the social determinants of health compares unfavourably with most OECD nations (Bryant & Raphael, 2020). This may be due to the barriers inherent in Canada being a liberal welfare state that is increasingly under the thrall of corporate-friendly approaches to governance and resource distribution (Bryant & Raphael, 2020).

Canadian researchers and advocates take two primary approaches to create impetus for action: providing statistical findings on the extent and sources of health inequalities and documenting the lived experiences of those encountering these adverse health outcomes (Bryant et al., 2019). Using terms such as 'health inequalities' 'health inequities', 'premature mortality', 'excess deaths' and 'inequities in morbidity and mortality between groups', they aim to provoke action by governing authorities on the sources of health inequalities, that is social inequalities, thereby reducing their adverse health effects. Others, however, carry out critical analysis of the structures and processes that make improving the quality of living and working conditions difficult. These researchers dispute the view that providing information to governing authorities by itself will provoke action (Raphael, 2015).

Behind these differing efforts are numerous assumptions about the public policy process which are usually not made explicit but are important for understanding the likelihood of research findings and advocacy effecting change. These assumptions can be categorized as

pluralist, institutionalist and political economy (Bryant, 2016). We argue that the most common approaches, the pluralist—putting arguments to governing authorities by advocates—and institutionalist—shifting established approaches to governance—fail to recognize the structural barriers to health inequalities-reducing public policy in liberal welfare states such as Canada. A political economy approach focused on issues of politics, power and influence in the making of public policy makes it more useful for reducing health inequalities. It is through this latter approach—in the tradition of Engels (1845/2009), Virchow (1848/1985), Scambler (2002) and Navarro (2009)—where use of polemics and anger arousal could mobilize the public to force governmental action to reduce health inequalities. These differing approaches are illustrated through the example of Canadian researchers' and advocates' efforts to provoke government responses to household food insecurity (HFI), an outcome of a variety of social determinants of health and a social determinant of health in itself (Mendly-Zambo & Raphael, 2018).

In this paper therefore, we explore the value of making explicit the adverse health effects of what the World Health Organization (2008) terms 'a toxic combination of poor social policies and programmes' by adding terms such as structural violence, social death and social murder to health inequalities discourse. Such an exploration seems timely as our keyword search through Google Scholar™ of the terms polemic, anger arousal and emotions failed to find any linkages with the terms health or health inequalities.

Instead, polemic, anger arousal and emotions were linked with concepts from the social movements and political change literature, certainly areas relevant to provoking health inequalities-reducing public policy. Our analysis of how terms such as structural violence, social death and social murder are being applied to the health inequalities area draws upon our own related work (Medvedyuk et al., 2021) as does the illustrative example of HFI in Canada (Mendly-Zambo & Raphael, 2018).

INFLUENCING PUBLIC POLICY THROUGH RESEARCH AND ADVOCACY

Raphael and Bryant (2016) document the profound influence UK research and policy has had on Canadian efforts to reduce health inequalities. One such conceptual tool relevant to Canadian efforts to address health inequalities was Garthwaite et al. (2016) identifying a typology of UK researchers and advocates seeking to reduce health inequalities: policy-focused positivists, empathetic ethnographers and critical materialists. Particularly interesting is how these types map upon John Wilson's three research traditions in sociology: positivism, idealism and realism (Wilson, 1983).

Policy-focused positivists carry out quantitative, statistically oriented research into the extent, sources and responses to health inequalities (Garthwaite et al., 2016). They conform to Wilson's (1983) tenets of *positivism*: commitment to experimental methods, quantitative measurement of observable variables, and a reluctance to engage in normative theorizing of what 'could be' in addition to 'what is'. They believe that since their policy-focused research findings speak for themselves, they will be used by policymakers. In Canada, decades of research endeavours have identified health inequalities, their sources, and means of reducing them through public policy (Bryant et al., 2011; Canadian Institute for Health Information, 2021; National Collaborating Centre on the Determinants of Health, 2021; National Collaborating Centre on Healthy Public Policy, 2021). However, there is a great divide between these research findings and advocacy

efforts—many coming from government-funded researchers and agencies—and government action (Bryant & Raphael, 2020).

Empathetic ethnographers employ qualitative research methods to assess the impact of health inequalities on the day-to-day lives of people (Garthwaite et al., 2016). Conforming to Wilson's *idealism* research tradition, they convey the lived experiences of vulnerable individuals (Wilson, 1983). More so than policy-focused positivists, they engage in advocacy and also believe their research can inform public policy. Both policy-focused positivists and empathetic ethnographers assume policymakers are receptive to their efforts. In Canada, decades of research efforts have articulated the experiences associated with health inequalities with rather little to show for it, as addressing health inequalities is not on the public policy agenda of the federal or any provincial or territorial government and evidence exists that health inequalities are not being reduced but may actually be increasing (Baxter, 2002; Bryant & Raphael, 2020; Ocean, 2005; Reid, 2004; Shahidi et al., 2020; Swift et al., 2010).

Critical materialists expose how powerful elites, by shaping public policies, create the social inequalities that spawn health inequalities (Garthwaite et al., 2016). Like Wilson's adherents to *realism*, they uncover the societal structures and processes behind these processes (Wilson, 1983). Concerned with power relations, they also take on an advocacy role, but unlike the others, they see governing authorities not as potential partners, but as barriers to reducing health inequalities (Scambler, 2012b). Critical materialists question the assumption that providing research findings to governing authorities—and understanding how authorities use information—will lead to public policy that reduces health inequalities (Raphael, 2015). Instead, they consider how social and political movements can be strengthened to disrupt the status quo (Scambler, 2012b). Their efforts—at least in Canada—have also yielded limited results. We suggest therefore that researchers and advocates 'turn up the volume' to mobilize public demands for action.

In the following sections, we examine how the three research approaches identified by Garthwaite et al. (2016) link with models of policy change and the language used in these activities. We then consider the potential value of introducing polemic and anger arousal into the public policy change process as a means of developing new, more effective, means of reducing health inequalities.

PUBLIC POLICY AND PUBLIC POLICY CHANGE

Numerous factors create health inequalities: historical traditions, governing parties' ideologies, and the relative power and influence of the corporate and business sector, organized labour and civil society (Raphael, 2015). What these have in common is their effects are realized through public policy (Bryant, 2016; Coburn, 2004; Graham, 2007; World Health Organization, 2008). Understanding public policy change is therefore key to reducing health inequalities and requires researchers and advocates be explicit about how they believe public policy comes about and how research findings and advocacy can facilitate change.

This is usually not done such that mismatches between researchers' and advocates' assumptions about policy change and what actually occurs stall application of research findings and advocacy by governing authorities (Bryant, 2015, 2016). The three primary approaches to understanding how public policy comes about: pluralism, institutionalism and political economy (Bryant, 2016), each have links to the research approaches identified by Garthwaite et al. (2016) and Wilson's (1983) three research traditions. We illustrate these linkages through examples from the Canadian household food insecurity (HFI) research and advocacy scene.

Pluralism

Pluralism considers interest groups and their activities to be the most important unit of analysis in the public policy process (Bryant, 2015). These include societal sectors (corporate and business, organized labour and civil society), agencies concerned with one or more social determinant of health (e.g. housing, food security, early child development and health care) and groups representing a particular constituency (e.g. Indigenous peoples, immigrants, racialized or ethnic groups, women) (Bryant, 2016). The nature of modern democracies is such that citizens are obliged to join groups and associations to influence the public policy process. Society, therefore, consists of a *plurality* of groups competing to influence public policy.

Pluralism usually considers all groups have opportunity—not necessarily equal—to influence policy change such that policy output reflects a rational balancing by governing authorities of costs and benefits. Public policy therefore occurs through a consensus model to meet the needs of most. Governments are viewed as part of problem solution whereby researching and reporting on health inequalities spur government action (Bryant & Raphael, 2015).

This is the primary approach to addressing health-related public policy change in Canada. Both policy-oriented positivists and empathic ethnographers provide governing authorities with reports of statistical analyses, lived experiences and public policy options for reducing health inequalities. The HFI area—a contributor to health inequalities—is one example of research and advocacy that identifies the extent of HFI, documents the experiences of HFI and provides public policy options to reduce it (PROOF, 2016). Despite these efforts, the extent of HFI is increasing and Canada continues to be chastised by the United Nations for not addressing its HFI problem (Mendly-Zambo & Raphael, 2018; PROOF, 2020).

Complicating matters, the presence of food banks and charities creates the illusion that the problem is being managed and 'rather than struggling against capitalism in a transformative way [charity] succeeds only in a struggle that reproduces impoverishment and inequality' (Livingstone, 2013, p. 373). Similar efforts—with similar evidence of lack of progress—take place in the areas of income distribution and poverty, insecure housing and homelessness, precarious employment and working conditions, all of which contribute to health inequalities (Bryant & Raphael, 2020; Raphael, 2016).

Despite these activities by advocacy groups over decades, the specific focus of these public policy failures—health inequalities—is not on the public policy agenda of any Canadian provincial, territorial or the federal government. Not surprisingly, the quality and equitable distribution of the social determinants of health in Canada are worsening and health inequalities are maintained or increasing (Bryant & Raphael, 2020; Shahidi et al., 2020). Clearly, pluralist models of a benevolent state committed to meeting citizen needs have not proven useful in reducing health inequalities in Canada as they neglect the role of power and politics in shaping public policy outcomes.

Institutionalism

In response to such failures, health equity advocates are drawing upon institutionalist models of policy change as means of reducing health inequalities. Institutionalist models see political institutions as structuring public policymaking over time and are resistant to change (Bryant, 2016). These institutions are the formal rules of operation, organizational structures and standard operating procedures of governments. Institutionalism conceives these institutions

as independent forces that promote particular ideologies and restrict the choices available to policymakers. The concept of path dependence, by which authorities continue well-tread policy approaches, is consistent with institutionalist approaches. The literature on framing health inequalities as a means of provoking action also falls within this approach (Blackman et al., 2012; McMahon, 2021).

HFI researchers have analysed how policymakers frame the problem of HFI and suggest advocates take notice of these frameworks (McIntyre, Lukic et al., 2016; McIntyre, Patterson et al., 2016). Since their analysis of Canadian Hansard records revealed ideas about remedying HFI depend on political orientation, they suggest applying a 'nonpolarizing centrist, pragmatist, approach' (McIntyre et al., 2016). Policymakers are seen as potential partners in reducing HFI.

Institutionalist models therefore assume—like pluralism—that governments seek public policy solutions to maximize benefits and limit liabilities (Bryant, 2016). Like efforts to address health inequalities, there is little evidence of these analyses furthering public policy action on HFI in Canada (Martorell, 2017). Institutionalism also tends to depoliticize the public policy process. Concerned with knowledge gathered by experts, it fails to consider how institutions interact with and are themselves shaped by the power and influence of influential players (Aquanno & Bryant, 2021). In practice, it assumes, like pluralism, that provision of expert-driven research findings and advocacy, which take account of institutional histories and structures, will lead to public policy change.

Political economy

Political economy models focus on how politics and economics shape public policy (Bryant, 2016), thereby showing affinities with the critical realism approach to policy change identified by Garthwaite et al. (2016) and Wilson's (1983) research tradition of realism. Societal structures and processes organize the production and distribution of economic and social resources, as well as governing authorities' public policies, and within these structures and processes, elites are seen as skewing these to their own benefit.

One stream of political economy inquiry—the critical materialist—is explicitly concerned with imbalances of influence and power amongst societal sectors and how these imbalances shape public policy (Bryant, 2015). In Canada and other liberal welfare states, the corporate and business sector's influence upon the public policymaking process is implicated as the source of health inequalities (Raphael, 2015). Not surprisingly, critical materialists make political economy their model of choice. Few Canadian health researchers and advocates work within this approach.

This model is rarely applied to the HFI scene in Canada. Riches (2018) and Mendly-Zambo and Raphael (2018) apply a critical materialist analysis to argue that food insecurity results from the skewed distribution of income and other resources. Food insecurity can be reduced by combatting the power of the corporate and business sector and forcing the implementation of public policy in a range of areas—income distribution, employment conditions and benefit programmes—to provide resources for the purchasing of food (Mendly-Zambo & Raphael, 2018).

Critical materialists disdain the dominant public policy models of pluralism and institutionalism by which policymakers are seen as applying research findings for the common good. Instead, they see public policy as resulting from the power and influence of those who control the economic and political systems. In the face of unresponsive governing authorities, moving beyond research and advocacy to mobilizing the public to force government action is required.

In Canada, the critical materialist approach has been applied towards understanding the skewed distribution of income, employment security and working conditions, food security and housing, albeit with rather little effect as the quality and equitable distribution of numerous social determinants of health show little improvement and in many cases (e.g. housing affordability, household food insecurity, income and wealth inequality) are declining (Bryant & Raphael, 2020).

Interestingly, the political economy—and its associated critical realist approach towards public policy change—has a tradition of specifically identifying those who create health inequalities (Engels, 1845/2009; Navarro, 2009; Scambler, 2012a; Virchow, 1848/1985). While there will always be a place for presenting research findings and public policy advocacy within the parameters of pluralist and institutionalist frameworks, it may be that in nations that have historically been resistant to proactive public policy—that is, liberal political economies—the latter approach containing elements of polemic and anger arousal—approaches uncommon to researchers and advocates in Canada and elsewhere—can play an important role in reducing health inequalities. Why might this be the case?

THE LANGUAGE OF RESEARCH AND PUBLIC POLICY ADVOCACY

The identification of those responsible for producing the conditions that create health inequalities, rather than simply describing their presence and calling for their reduction, involves aspects of what communication theory terms valence (Cox & Béland, 2013). Cox and Béland define valence as 'an emotional quality of an idea that can be either positive or negative in its character, or high or low in its intensity' (2013, p. 308). As a result, the valence of an idea can be either (a) negative, high; (b) negative, low; (c) neutral; (d) positive, low; or (e) positive, high. We considered these concepts in relation to the existing health inequalities literature and identified examples of different valence direction and intensity. Table 1 provides these terms differing in valence direction and intensity common to health inequalities discourse. High valence and negative valence terms are expected to evoke greater affective responses. Neutral terms, since they are non-directional, evoke less affective responses.

The language used in health inequalities research studies and advocacy efforts usually consists of neutral and low valence terms. High valence positive terms are less common and high valence negative terms even less so. Overwhelmingly, the terms in health inequality and social determinants domains (e.g. employment security, working conditions, food and housing security, early child development and even social exclusion) appear to us to be of either neutral or low valence intensity.

Cox and Béland (2013) unreservedly argue that the use of positive valence ideas is to be preferred as policymakers are attracted by them and repelled by negative valence ideas. But what if policymakers are not allies but rather barriers to progress in reducing health inequalities; an argument advanced by Scambler (2002), Navarro (2009), and Raphael (2015), since reducing health inequalities involves redistributing income and wealth and reining in the power and influence of those who benefit from the living and working conditions that create health inequalities (i.e. the corporate and business sector)? In this case, the aim is not to influence policymakers but rather to mobilize the victims of problematic public policy and their advocates to confront these same policymakers. And if this is so, then use of negative valence terms of high intensity is to be preferred.

Why might this be the case? It seems to us that high valence negative terms of social murder, social death and structural violence—terms rarely used in health inequalities discourse—create

TABLE 1 Health inequality-related terms identified by the authors as differing in valence intensity and direction

High valence	Positive	Social justice, human rights
	Negative	Social murder, social death, structural violence
Neutral		Health outcomes, access to care, social determinants of health
Low valence	Positive	Health equity, health promotion, health
	Negative	Health inequalities, health inequities, illness, mortality, morbidity

greater emotional arousal than the high valence positive terms of social justice and human rights and thereby can provoke public policy that reduces health inequalities. As one example, consider the potential reaction to the titles of two volumes concerned with health inequalities: *The Health Gap*: *Challenges of an Unequal World* (Marmot, 2015) versus *The Death Gap*: *How Inequality Kills* (Ansell, 2017). While the Marmot subtitle raises issues of inequality, its valence is clearly not as intense and negative as the Ansell title. An emerging literature on the role that affect—or emotions—play in social and political movements provide evidence in support of this belief (Jasper, 2011; Ost, 2004).

In regard to our example of HFI in Canada, the term hunger has considerably higher and more negative valence than HFI yet is less commonly used by researchers and advocates. More importantly, the identification of those responsible for HFI—those who profit from the inequitable distribution of income, that is the corporate and business sector—is very rare (Mendly-Zambo et al., 2021; Mendly-Zambo & Raphael, 2018).

Statistics Canada reports that First Nations peoples living-off reserve experience moderate or severe food insecurity at a rate three times higher than non-Indigenous people (First Nations Health Authority, 2019) and has led to use of the term 'food crisis'. But without explication of the forces behind the 'crisis', there runs a risk of the term being overused and losing its impact.

THE ROLE OF POLEMICS AND EMOTIONS IN PUBLIC EDUCATION AND MOBILIZATION

Despite increasing scholarship on the role of polemic in academic discourse and public affairs (Badiou, 2006; Gallop, 2012), one has to rely on a dictionary to obtain a precise definition: 'A polemic is a piece of writing or a speech in which a person strongly attacks or defends a particular opinion, person, idea, or set of beliefs' (Cambridge Dictionary, 2021). Our keyword search through Google Scholar™ of the term polemic found no instances of it linked to reducing health inequalities. Considering the consequences for 'keeping body and soul together' (Gordon, 2000, p. 75) of the problematic conditions that create health inequalities, its absence from research and advocacy discourse is puzzling. Indeed, when the term is used in health discourse it usually takes the form of an apology by the writer for injecting emotion into an issue (Asthana & Halliday, 2006; Campbell, 2010). This should not be surprising as guides to academic writing reinforce avoidance of polemic:

> "'Point-of-view (POV) - Academic writing is usually written in third person POV because its focus is to educate on the facts rather than to support an opinion or give advice' (White, 2021).

> 'Impersonal tone. The goal of academic writing is to convey a logical argument from an objective standpoint. Academic writing avoids emotional, inflammatory, or otherwise biased language. Whether you personally agree or disagree with an idea, it must be presented accurately and objectively in your paper' (Valdes, 2019).
>
> 'Scientific writing often contrasts the positions of different researchers. Differences should be presented in a professional, noncombative manner'"
>
> (American Psychological Association, 2010, p. 66)

The resistance to polemic—and the emotions associated with it—stems from a variety of sources. One particularly influential view was put forward by Foucault in an interview near the end of his life (Foucault, 1984/1998). He saw polemics as fundamentally at odds with the primary goal of discovering truth as the opponent is seen as an enemy whose very existence poses a threat.

Crewe (2004) suggests that the aversion to polemic therefore has much to do with the perception of it as: '[U]ltimately and disturbingly inseparable from that of belligerence and violence more broadly' (p. 136). Crewe, however, takes issue with Foucault arguing his categorical rejection of polemics takes no account of the variety of polemics and the useful role it plays in academic discourse:

> "[W]ithout feminist, queer, or postcolonial polemics, some of it ad hominem, there would be no academic fields corresponding to those designations. Without polemic directed at the New Critics and all their works, there would be no institutionalized post-structuralism in the U.S. academy"
>
> (Crewe, 2004, p. 138).

Indeed, Crewe suggests 'While change and innovation may not be caused by polemic, they are apparently seldom effected in its absence' (2004, p. 139). Yet, despite its potential for effecting progress, we should not be surprised by the avoidance of polemic by the research and advocacy communities who clearly adhere to the dictums provided above for academic writing, then generalized to advocacy activity. Essentially, research and advocacy should be stripped of affect or emotion. Indeed, it is striking how little literature exists on the role of emotions in promoting change (Crewe, 2004; Jasper, 2011; Ost, 2004).

Jasper sees emotions, including anger, contributing to social and political movements (Jasper, 2011). Emotions focus attention, radicalize and create collective solidarities that contribute to the building of social movements, thereby effecting change. Certainly, in relation to the health inequalities associated with the inequitable distribution of economic and social resources, the role of emotions, including anger mobilization, appear to be an important area for research and action. In the materialist political economy approach, where class divisions play an important role, emotions could be a key component of class mobilization. Ost (2004) has also written about the role that anger mobilization can play in social and political movements:

> "Anger is central to politics both as a diffuse, untargeted sentiment citizens experience, usually economically, and as the emotion political organizers need to capture and channel, which they do by offering up an 'enemy' they identify as the

> source of the problem. Opposition movements and parties of power alike succeed when they persuade people to accept the enemy they propose"
>
> (Ost, 2004, p. 229).

When Labonté states 'Anger is often the magnet of mobilization; mobilization is often the tool for social transformation that shifts power relations in ways that allow societies to become more inclusive' (Labonte, 2016, p. 424), it is the single example we found explicitly linking emotions with reducing health inequalities.

We certainly see elements of anger in critical realists' discourse concerning the source of health inequalities: 'Greedy Bastards' (Scambler, 2012a, p.137); 'those who are responsible for these inequalities that kill people' (Navarro, 2009, p. 423); 'The plutocracy… did not recognize the Upper Silesians as human beings, but only as tools or, as the expression has it, "hands"'. (Virchow, 1848/1985, p. 309); and the class that 'so hurries them to the grave before their time' (Engels, 1845/2009, p. 107). Increasingly, potentially anger-arousing terms such as social murder (Chernomas & Hudson, 2007, Grover, 2019), social death (Short, 2016) and structural violence (McLean & Panter-Brick, 2018) are appearing in the academic literature, mainstream media and social media in relation to disease and injury resulting from public policy (Chakrabortty, 2017; Hamlett, 2018). It appears then that the role of emotions, including anger mobilization, can be a fruitful area for research and action. In the materialist political economy approach, where class divisions play an important role, emotions could be a key component of class mobilization.

Class mobilization theory refers to the situation where class-based political activity brings about particular societal structures and processes (Korpi, 2018). As one example, Esping-Andersen described how mobilization of the industrial working class in alliance with farmers brought about social democratic dominance of the political process in Scandinavia to create the Nordic welfare state (Esping-Andersen, 1985). Carroll and Sapinski (2018) document how Canada's corporate sector has come to shape public policy in the interests of the 1% rather than an unmobilized Canadian working class, while Scambler (2012a) does so for the UK scene.

In Canada, the greatest health inequalities occur between Indigenous populations and other Canadians (Smylie & Firestone, 2016) with reliable differences also seen between those differing in income, a proxy for social class (Sayani, 2019). To date, research and advocacy have avoided exploring the class dimensions of health inequalities in Canada and the analysis of power and influence as determinants of these health inequalities (Raphael, 2015). Identifying those who profit from health inequalities—the business and corporate sector that keeps wages low, carries out anti-union activities and advocates for retrenchment of the welfare state—and making explicit how their power and influence skews the quality and distribution of the social determinants of health could contribute to election of parties of the left and the strengthening of the labour movement, eventually leading to progressive public policy (Brady, 2019). As argued by Crewe (2004) and supported by research on the role of emotions in social movements, polemic may mobilize those experiencing health inequalities.

INCREASING USE OF POLEMICS: STRUCTURAL VIOLENCE, SOCIAL DEATH AND SOCIAL MURDER

The failure to reduce health inequalities may be leading to an increasing use of high valence negative terms in academic and advocacy discourse. Our review of the health inequalities literature identified three primary instances of such discourse: structural violence, social death and social murder.

Structural violence

The term structural violence was first used by Galtung (1969) in an analysis of the relationship between different forms of violence and peace. He identified dimensions of physical and psychological violence and personal and structural violence with the commonality being 'violence is present when human beings are being influenced so that their actual somatic and mental realizations are below their potential realizations' (p. 168). Structural violence 'is built into the structure and shows up as unequal power and subsequently as unequal life chances' (p. 171). Galtung suggests the primary aspect of structural violence is the uneven distribution of resources, which creates unequal life chances. Farmer popularized the concept and brought it into health equity discourse (Farmer, 1996; Farmer et al., 2004, 2006).

> "'The term "structural violence" is one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically, not those responsible for perpetuating such inequalities)'"
>
> (Farmer et al., 2006, p.1686).

Herrick and Bell (2020) and De Maio and Ansell (2018) provide critical analyses of the value of the term for health equalities research and advocacy. De Maio and Ansell (2018) conclude:

> "Its potential lies in the focus it gives to the deep structural roots of health inequities; in contrast to the more passive term 'social determinants of health', structural violence explicitly identifies social economic, and political systems as the *causes* of poor health. It is also evocative in its framing of health inequities as an act of violence" (p.749).

The term structural violence certainly takes the discussion of health inequalities to a level consistent with a role for polemic and emotions in social movements. De Maio and Ansell (2018) provide evidence of increasing use of the term structural violence in the health literature (MEDLINE hits in the title, abstract or keywords) finding its presence increasing since 1990. The 1990s saw on average one to three articles per year, but by 2012 and through to 2017, the average has risen to 20 per year. This increase illustrates an increasing willingness amongst researchers to apply high valence negative terms to describe the adverse health effects brought on by problematic living and working conditions (Medvedyuk et al., 2021). Yet, as compared to the increase in the term 'social determinants of health', which averaged 1200 per year from 2017 to 2019, the increase is modest (Herrick & Bell, 2020).

Social death

The term social death emerged in reference to the situation of Indigenous peoples. Short (2016) relates the term to Lemkin's (1943) original formulation of the concept of genocide, which only later came to refer to mass murder.

> "Indeed, when Indigenous peoples, who have a physical, cultural and spiritual connection to their land, are forcibly dispossessed and estranged from their lands

> they invariably experience 'social death' and thus genocide. Furthermore, when Indigenous lands are used by extractive industries the inherent corporate preference for externalizing environmental costs can lead to physical, as well as cultural destruction. The tar sands project is a prime example of this"
>
> (Short, 2010, p. 842).

There is a growing use of the term social death referring to the systematic destruction of the traditional activities of Indigenous peoples and the cultural beliefs associated with these activities (Kearney, 2018, Whitt and Clarke, 2019). Huseman and Short (2016) apply the concept to the effects of the Alberta Canada Tar Sands—a major oil project in Northern Alberta—upon the health of Indigenous people.

Social murder

In 1845, Friedrich Engels described how working-class residents in England died prematurely because of their living and working conditions. He did not simply label the occurrence as is usually done today:

> "If all cohort members had experienced the age-specific mortality rates of those in the highest quintile… that [would] amount to an estimated 40,000 fewer deaths per year (25,000 fewer amongst men and 15,000 fewer amongst women)"
>
> (Tjepkema et al., 2013, p. 17).

Instead, Engels indicted those responsible for the deteriorating health and premature deaths of workers:

> "I have now to prove that society in England daily and hourly commits what the working-men's organs, with perfect correctness, characterise as social murder, that it has placed the workers under conditions in which they can neither retain health nor live long; that it undermines the vital force of these workers gradually, little by little, and so hurries them to the grave before their time. I have further to prove that society knows how injurious such conditions are to the health and the life of the workers, and yet does nothing to improve these conditions. That it knows the consequences of its deeds; that its act is, therefore, not mere manslaughter, but murder, I shall have proved, when I cite official documents, reports of Parliament and of the Government, in substantiation of my charge"
>
> (Engels, 1845/2009, p. 107).

Since Engels' coining of the phrase social murder in 1845, there has been little reference to it in the health-related academic literature. Medvedyuk et al. (2021) carried out a review of the use of the term in academic journal articles since 1960. The nineteen-year period from 1960 to 1978 saw only three instances of the term. The period from 1979 saw an increasing use of the concept through to the present such that the 2015–2020 period averages six per year. The first five months of 2021 already sees 18 articles. As an example, Raphael (2021) links the concept to the estimated 40,000 excess deaths a year in Canada associated with income-related health inequalities.

These increases were first fuelled by Canadians Chernomas and Hudson's (2007) release of *Social Murder: and Other Shortcomings of Conservative Economics*. But of greater impact were the 2018 UK documentary *Grenfell Tower and Social Murder* (Hamlett, 2018) where deliberate decisions to save money in repairs to a high-rise tower inhabited by low-income immigrant populations in London resulted in a calamitous fire, and the academic article by UK professor Chris Glover (2019) Violent Proletarianisation: Social Murder, the Reserve Army of Labour and Social Security 'Austerity' in Britain. These received wide coverage in the UK mainstream media and encouraged use of the social murder concept in social media in the UK. Indeed, Cornish (2021) in her analysis of post-Grenfell activism asks, 'Grenfell changes everything?' concludes it has stimulated activism, though to date, successes have been minimal, a result of having to battle hostile bureaucracies and lack of funding. Additional instances of high valence, negative direction titles are available (Cooper & Whyte 2017; Stuckler & Basu, 2013; Therborn, 2014).

IMPLICATIONS FOR RESEARCH AND ACTION

There are numerous barriers to addressing health inequalities through public policy action in Canada. Lynch (2020) identifies three taboos that limit the addressing of health inequalities that she links to welfare regimes (liberal: redistribution; conservative: public spending; and social democratic: market regulation). To our mind, all three apply to Canada, suggesting a profound need to raise the volume in research and advocacy.

Since research has not examined reactions of the Canadian public to terms differing in valence intensity and direction, we do not know whether polemic and anger arousal will accelerate placing health inequalities on the public policy agenda in Canada and elsewhere. Considering the failure to have health inequalities placed on any governmental public policy agenda in Canada and the profound increases in social and health inequalities in the UK despite ongoing research and advocacy, there appears to be little to lose and much to gain. In the UK, the application of 'social murder' to the Grenfell fire stimulated its use in the mainstream and social media in reference to the austerity politics of the Conservative government.

Similarly, Grover's (2019) academic article on austerity's contribution to social murder received significant coverage. The use of social murder in a *BMJ* COVID-19-related editorial (Abbasi, 2021) is rather striking and its uptake by the UK mainstream media suggests value in such polemic (Morris, 2021). Norrie's (2018) provocative legal analysis suggesting the gap between legal and social murder may not be that great is also receiving attention. Admittedly, to date, there has been little public policy action by the UK government to address these issues.

In our own work, we are documenting the increasing use of terms such as structural violence, social death and social murder in the academic literature and mainstream and social media (Medvedyuk et al., 2021; Govender et al., 2021). We intend to carry out inquiries into the reactions high and low and positive and negative valence terms concerned with health inequalities elicit from researchers, advocates and students. These inquiries will help determine whether polemics and anger arousal are productive ways of provoking public policy responses to health inequalities or, instead, lead to the dismissal of researchers' and advocates' arguments, thereby creating an additional barrier to reducing health inequalities. Evidence of initial success in Canada would see the placing of health inequalities on the public policy agendas of governing authorities (Bryant & Raphael, 2020). Evidence of success in the UK would see the tabling of many of the austerity-inspired measures being introduced by the Conservative government (Grover, 2019). In both jurisdictions, the ultimate goal is addressing the living and working conditions that first sicken and then kill.

AUTHOR CONTRIBUTIONS

Dennis Raphael: Conceptualization (lead); Data curation (equal); Formal analysis (equal); Investigation (equal); Methodology (equal); Project administration (lead); Writing-original draft (lead); Writing-review & editing (lead). **Toba Bryant:** Conceptualization (supporting); Data curation (supporting); Formal analysis (supporting); Investigation (supporting); Methodology (supporting); Project administration (supporting); Writing-original draft (supporting); Writing-review & editing (supporting). **Piara Govender:** Conceptualization (supporting); Data curation (supporting); Formal analysis (supporting); Investigation (supporting); Writing-original draft (supporting); Writing-review & editing (supporting). **Stella Medvedyuk:** Conceptualization (supporting); Data curation (supporting); Formal analysis (supporting); Investigation (supporting); Methodology (supporting); Project administration (supporting); Writing-original draft (supporting); Writing-review & editing (supporting). **Zsofia Mendly-Zambo:** Conceptualization (supporting); Data curation (supporting); Formal analysis (supporting); Investigation (supporting); Methodology (supporting); Writing-original draft (supporting); Writing-review & editing (supporting).

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