psychosocial work environment, relative deprivation and social capital, are important for health status but also the extent to which they are important when trying to explain the gradient by class or gender.

The book manages to explore the issues on several levels simultaneously – an impressive achievement. It assesses longitudinal changes in health and inequalities against a background of changes in welfare state institutions; understands health inequalities from a life-course perspective and includes groups not typically examined (the very old and the very young); and covers several health outcomes such as musculoskeletal pain, psychological distress, mobility limitations, self-rated health, psychosomatic complaints, and anxiety. This approach not only highlights the complexity of the issues involved, but also offers a more detailed picture of health as a welfare problem.

The presence of health inequalities in a context such as Sweden may be surprising for some, given its reputation as a society based on equality, and as exemplified by several fairly distinct features of its social democratic welfare state: universalism, commitment to full employment, active labour-market policies, relatively generous benefit policies, high-quality public-care services for children and the elderly, and low poverty rates. Yet, as demonstrated throughout this book, health inequalities have not only persisted from the late 1960s into this new millennium, but are of a substantial magnitude. Does this mean that the Swedish welfare state has been unsuccessful in protecting its citizens' physical and mental health and functioning? The book cannot provide a full answer, but one conclusion regarding the welfare state can be drawn from the analyses presented. The economic crisis of 1990s gave rise to poorer health in general, but mostly, inequalities in health have not increased. This suggests that the welfare state cushioned the immediate impact of the crisis, and the policies seem to be protective for the most vulnerable segments of the society likely to be affected by the economic downturn.

The book takes the middle ground between the psychosocial versus neomaterial explanations for the generation of health inequalities, by arguing that increased command over resources, both material and intangible, is central for health. This has relevance beyond the Swedish context and thus the book makes an important contribution to the discussion on the impact of policies on health.

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The health of populations: general theories and particular realities

Stephen J Kunitz. Oxford: Oxford University Press, 2006, £29.99 (hardback).

As new discoveries in the biomedical sciences make it increasingly possible to identify individuals whose characteristics, whether genetic, psychological, biological or behavioural, put them at risk of diverse health problems, it is important to keep in mind that health is also a function of the broader social context.[1 2] In this captivating new book, Stephen J. Kunitz reminds us of the constant tension between our individual destinies and the communities in which we live.[3]

Part I of the book describes contemporary theories of disease causation. Chapter 1 discusses the emergence of two opposing schools of thought following the Industrial Revolution: the ''New Public Health'', which used ''scientific objectivity'' to highlight individuals' responsibility in promoting their own well-being, and the ''New social medicine'', which laid the ''social environment'' at the roots of disease. As described in Chapter 2, these two conceptualisations of health were later reconciled by the generalised susceptibility paradigm, which posits that an individual's risk of disease is related to an interaction between individual characteristics and environmental risk factors.

Part II reviews evidence on social determinants of health in different settings. The author's main hypothesis is that the health effects of economic or social factors, such as income and social integration, vary across contexts. Chapter 3 argues that the relationship between income levels and health is mediated by the existence of large-scale social programs, and particularly, broad-reaching healthcare. Hence, the policy context matters. The data presented in Chapter 4 show that the health effects of social determinants also depend on the epidemiological context; most health problems are especially frequent among disadvantaged populations, but some show a different pattern; for instance, infectious diseases kill rich and poor alike, leading to weak social gradients in this area. Chapter 5 focuses on the role of community, arguing that it is strongest when surrounding political institutions are weak. Chapter 6 argues that the health effects of globalisation are positive only if increases in wealth are accompanied by policies that limit inequalities and protect the most vulnerable groups. Thus, the health impact of broad social factors is mediated by the political context.

Chapter 7 brings together the issues discussed in preceding chapters through the example of the AIDS epidemic: the causes of the epidemic can be interpreted differently depending on ideology; population risk varies according to levels of inequality and community characteristics; and globalisation influences both the degree of risk and possible responses through its effects on labour markets and political institutions. Stephen Kunitz concludes by warning the reader against oversimplifying generalisations and urges researchers to consider the context of the phenomena that they study.

So where does this leave epidemiologists and other researchers? The historical background on the social, political and economic structures that surround us presented in this book is fascinating. However, how do scientists translate the idea that context matters into testable research hypotheses? Which of the many contexts that surround each one of us matters most? In the introduction, the author discloses his view that government plays a central role with regard to health. However, the data he presents also show that more proximal settings, such as the family or the neighbourhood, also matter. Thus, to understand the determinants of population health, it appears important to conduct research on different levels of social contexts.

The author repeatedly warns about the dangers of broad generalisations, yet, such upstream inferences are necessary to propose theory.[4] For instance, the effects of social isolation may be more or less severe depending on the broader context, but recognising that socially isolated individuals are in poor health across diverse contexts is informative from the perspective of population health research and policy.[5]

Overall, *The health of populations* is a richly-documented, thought-provoking book that forces the reader to reconsider his or her ideas about the role of social factors in health. It is an important read for researchers aiming to understand the determinants of population health.

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CORRECTION

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The following text from the article by Macleod *et al* (Does consideration of either psychological or material disadvantage improve coronary risk prediction? Prospective observational study of Scottish men. *J Epidemiol Community Health* 2007;**61**:833–837) was omitted form the printed article and should have appeared at the end of the results section as the last paragraph before the discussion:

Prediction of coronary heart disease mortality requires a combination of risk factors which can discriminate those individuals at future risk, as investigated above, and calibration to ensure accuracy in the magnitude of risk predicted for those individuals and the cohort as a whole. The standard Framingham risk equation under-predicts the risk in each occupational class in the current cohort, and consequently has high specificity but very low sensitivity (Table 3). Recalibration improves matters, but sensitivity is still unacceptably low. Adding lifetime socio-economic position to the recalibrated equation has little additional influence.