Julia Lynch (2020), *Regimes of Inequality: The Political Economy of Health and Wealth*, Cambridge: Cambridge University Press, £75.00, pp. 294, hbk.
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Julia Lynch tackles a big question in *Regimes of Inequality*: why is economic inequality growing in nearly all European societies? She answers it convincingly by showing how and why British, French, and Finnish policymakers in three different welfare regimes avoided neoliberal taboos against redistribution, spending, and regulation while simultaneously signaling commitment to equity by shifting their attention from income and wealth to health. That is my attempt at a tight compression of the book's highly original and satisfyingly complex argument, which builds on historical-institutionalist political analysis, cultural analysis, and even medical sociology.

While rising economic inequality frames the book, Lynch also explains how and why policymakers doomed to failure their own turn toward health inequalities by avoiding the policy taboos of redistribution, regulation, and spending. That is, many apparently sincere efforts to reduce health inequalities in Europe failed because policy taboos rendered unimaginable and illegitimate the very tools that would have most successfully reduced both health inequalities and income inequalities. Lynch argues that a society's regime of inequality – "the basic underlying logic of inequality in the system as a whole" (p. 47) – accounts for this double failure of center-left European policymaking. This is a very bold argument, with many as-yet-untested empirical implications. Specifically, if Lynch is right about how regimes of inequality work, then we should observe the same long-run political processes playing out regardless of which form of inequality we examine. Income inequalities, health inequalities, educational inequalities, political inequalities, wealth inequalities, family inequalities, and employment inequalities, for instance, should all be interdependent and similarly institutionalized. The distribution of any valued social good should rest on the same political processes.

While that general theoretical argument about regimes of inequality gives the book its title and may also account for a good part of the book's ultimate influence on how social scientists think about the politics of inequality, Lynch takes empirical aim at how and why British, French, and Finnish policymakers chose to frame health inequality as a priority public problem. She first uses a systematic frame analysis of documents and reports to show how an international consensus discourse emerged to define health as primarily socially (not medically, genetically, or behaviorally) caused; to focus policy attention on macroscopic causes like socioeconomic status and social policy; and to charge policymakers with raising health and health equity to an intersectoral priority. She then uses interview and historical evidence to show how the reframing of inequalities developed alongside the deepening of policy taboos in the UK, France, and Finland going back to the 1990s. These four chapters (the third, fourth, fifth and sixth) constitute the book's empirical core, and also develop the central concept of the policy taboo. All are narratively strong, empirically original, substantively important, methodologically rigorous, and ultimately persuasive.

In my view, the analytically richest chapter is the seventh, wherein Lynch explains "how talking about health inequality made the problem harder to solve" (p. 176). She conceptualizes a duality to the Overton window, whereby taboos against redistribution, spending, and regulation alone cannot explain why the Overton window on inequality shifted rightward. Because of welfare-regime politics, that rightward shift also required new options to take their places. In the presence of a strongly pro-equity and normative international consensus on health inequities, those new options became intersectoral policy coordination and other difficult-to-implement policies – unsuccessful choices that took the place of tabooed policies. In other words, neoliberalism alone is insufficient to explain resilient inequality. While this conceptual

development still needs to grapple with the problem of exactly how change in the meaning of options vs. the presence or absence of options entrenched in the middle of the Overton window – e.g. "activation" (p. 178) – might also help to explain some of the policy failures, it remains fruitful and innovative.

Lynch also in this chapter develops the idea of medicalizing inequality. In all three country cases, the power of bio-medicine and the vagueness of some of the policies advanced by the international health inequalities consensus combined to turn a social problem into a medical one. While Peter Conrad, a medical sociologist, is commonly credited with originating the overarching concept of medicalization, Julia Lynch develops this concept in a new direction by showing how the specific process of medicalizing inequality depends on politics. For example, in the early years of the Macron government, French policy focused on "health education, prevention, and access to medical care," as it was "built on the foundations of the territorial, medical-care centric frame that had dominated French policy" before the emergence of the consensus (p. 189). The concept of medicalizing inequality also offers an intellectual pathway toward deepening the gender analysis of resilient inequality, as gender vividly marks some of the interviewees' remarks. It seems that, at least in the Finland case, medicalizing inequality moved it from the masculine domain of economic policy ("the big boy", p. 200) to the feminine domain of health ("the small, soft things", p. 200).

The book concludes on a pessimistic note, offering strong advice – some of it likely to attract controversy – to policymakers and health-equity advocates. Lynch tells policymakers to "eschew the health inequalities problem frame and instead stick to tested, effective remedies for social inequality consisting of taxation, redistribution, and labor market regulation" (p. 224), but does not explain how to reverse the forces that led to the tabooing of these policies in the first place, or whether tabooing redistribution resulted more from the reframing itself or from other forces. Lynch also suggests that health-equity advocates de-emphasize "cross-sectoral work and related efforts to decentralize" health-equity policy (p. 224), but does not explain how this would address the funding shortfalls discussed earlier in the book. Nevertheless, I wholeheartedly agree with the central political conclusion that "if the center-left wishes to regain the support of voters now being drawn away by populist and nationalist parties, it will need to rethink how it talks about inequality" (p. 226). Hear, hear!

JASON BECKFIELD
Harvard University
jbeckfie@wjh.harvard.edu

Mary Daly (2020), *Gender Inequality and Welfare States in Europe*, Cheltenham: Edward Elgar, £25.00, pp. 232, pbk.
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In this monograph, Mary Daly claims to "assess the relationship between gender and social policy, for the purpose of both taking stock and sketching out a future research agenda". With this, she follows on from a long-standing and ongoing discussion in welfare state analysis, held first and foremost by feminist scholars.

The aim of this book is to "examine both the nature and consequences of policies" and to fill the gap of "a lack of convincing assessments of both progress already made and the significance of a range of social policy approaches in this context". The book begins by presenting a chronology of approaches to gender and social policy. Starting with the early approaches and proceeding with contemporary ones, it puts dominating concepts in welfare state analysis