

Health and health inequalities in a neo-liberal global world

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Summary

Health inequalities are central to current health policy internationally and in many nations. As health improvements have slowed, the extent and depth of health inequalities in the developed world have become too obvious to ignore. At the same time the profound differences in health between the developed and under-developed world, between obesity for some and starvation for others, has created a moral crisis. Yet, the often proclaimed solution to human problems, neo-liberal free-trade producing economic growth and improved human wellbeing, i.e., market fundamentalism, has proven a failure. The dogmatic application of neo-liberal doctrines perversely increases those social inequalities that are among the basic causes of health inequities. The issue then becomes one of creating conditions that would permit more variegated approaches to improving human wellbeing and reducing inequalities. Ironically, the dynamics of globalization, broadly defined as a view of human beings sharing the same planet and the same fate, has produced opposition to the untrammelled dominance of multinational corporations and the states they influence or control. If we know something about who and what the enemy is, we do not as yet know solutions other than doing something differently and more humanely. There are examples of countries and areas that do better than others at translating economic growth into improvements in human welfare. We can learn from them. Yet the onus remains on us to do whatever is within our capabilities to develop a more just and equal world.

Introduction

The rich live longer, healthier lives than do the poor. In US metropolitan areas, the health differences between high and low socio-economic status areas equal '[t]he combined loss of life from lung cancer, diabetes, motor vehicle crashes, HIV infections, suicide and homicide' (Lynch *et al.* 1998). In the USA, people in the

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very poorest households are four to five times more likely to die in the next ten years than are those in the richest (Kaplan 2000). The differences in longevity between the highest socio-economic status group and the lowest (of five groups) in Britain in 1996 were 9.5 years for men and 6.4 years for women.

Amongst nations there are wide inequalities in health status with the richest and healthiest nations showing almost double the life expectancy of the very poorest. Some nations have mortality rates for children under five that are 30 times higher than that of other nations. Yet it is *not* true that richer countries always show better average health than do poor countries.

The contrast of inequalities within and between countries, and the explanations for these, are a major concern of this chapter.

Health disparities within and between nations are referred to as health *inequalities* and, by many, as health inequities. Generally, health inequities are those differences or inequalities that are considered unjust or that reflect or are the consequences of an underprivileged position.

To understand health inequalities within and between nations best, we need to take a step back from the proximate determinants of health to examine the social structures within which inequalities of all kinds, and not just health inequalities, are produced. Doing so indicates that the class structure of capitalism and in particular a specific version of capitalism, neo-liberalism, produces and exacerbates social and health inequalities within and between nations. But there have been different historical *phases* of capitalism (Ross and Trachte 1990) as well as different contemporaneously existing *types*. Health inequalities, and the broader social and income inequalities with which they are associated, are embedded in different societal forms. Because health cannot be divorced from other aspects of social life, health inequalities are inextricably involved with conflicts over national and international political, social and economic policies and such contentious issues as globalization, economic growth and discussions about 'the good society'.

The modern interest in health inequalities dates from Engels, in 1845, but, more recently, from the Black report (1980) and the Acheson report (1998). These reports are part of a continuing British interest in the relationships between socio-economic status (SES) and health (for example, Shaw *et al.* 1999). Health inequalities are now at the centre of attention of regional (EU) and international organizations. During the UK Presidency of the EU, for example, a number of reports on health inequalities were commissioned (*Health Inequalities: Europe in Profile*, Mackenbach 2005; *Health Inequalities: A Challenge for Europe*, K. Judge *et al.* 2005). In 2005, the WHO established a special Commission on Social Determinants of Health, headed by Sir Michael Marmot. In the same year, the EU founded an Expert Group on Social Determinants and Health Inequalities.

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Why this burgeoning interest?

A major impetus to the increasing concern with inequalities arose because of better documentation of major inequalities in health between socio-economic groups. Even more troubling, the data indicated that, though average levels of health were generally increasing, health inequalities between groups have been getting bigger, not smaller. Health inequalities are not 'going away' but are getting worse. Inequalities are also more noticeable now when improvements in longevity or infant mortality are slowing down than when they were rapidly improving. Even within the less developed nations health inequalities are ubiquitous and the poor in these nations are thus doubly at risk, by nation, and by socio-economic status.

Health inequalities; national and international

Any assessment of inequalities depends on what we compare. Do we contrast absolute or relative inequalities? Some nations, groups or areas within nations may show twice the relative infant mortality (IM) of other nations (or socio-economic groups or areas), but the meaning of such inequalities differs depending on the absolute levels of infant mortality involved. An infant mortality rate of 6 deaths per 1000 live births is twice that of 3 deaths/1000 but a rate of 80/1000 is twice that of 40 per thousand. Assuming an ethical stance that one life at birth is worth the same as another it would seem that the inequalities revealed above, similar to many differences within high and low health nations, imply that world inter-nation differences and the inequalities within the less developed nations are currently the most significant. The great attention paid to inequalities within the developed world is laudable and necessary. We have to act where we can. However, in doing so we must not lose sight of massive global health inequalities and millions of potentially relatively easily preventable deaths in the less developed world.

The analysis of health inequalities, and the determinants of these, are fraught with explanatory and measurement issues. Many social factors have a life long and cumulative influence rather than immediate effects resulting in issues of time lag effects. Some measures, infant mortality, for example, *are* more highly related to current conditions than, for example, factors associated with cardiovascular disease. And what seems to be important is what can be measured. Mortality statistics are relatively widespread and routinely collected. The same cannot be said for data on morbidity or illnesses which do not necessarily lead to immediate death (HIV/AIDS is an exception). Few analyses even touch on the topic of mental illness. Yet it is estimated that 480 million people suffer some form of mental or behavioral problem and there are nearly 900 000 suicides per year. Nevertheless, it is in this situation, with all of these deficiencies, in which decisions have to be made.

At one time it was thought that health inequalities were simply the consequence of unequal access to health care. The assumption was that health would improve and health inequalities would disappear with the advent of universal access to care. Now we know differently. In 1990, Evans and Stoddart equated the provision of medical care with turning up the furnace (or air conditioning) in a house without regard to the adequacy of the insulation. Medical care today is regarded as important in the amelioration of disease and injury, and in easing the burden of disease. However, the onset of disease and injury are now viewed mainly as being due to social causes. Thus, the emphasis on 'the social determinants of health' and on the social determinants of health inequalities. Nevertheless, health care is one of the determinants of health inequalities although it can be claimed that equitable health care systems are themselves the product of some of the same social and class struggles which are associated with lessening social and health inequalities (Korpi 1989; Korpi and Palme 1998). As social products, both health inequalities and unequal access to health care are subject to amelioration by social action and social policies.

The fact that, within nations, the rich live longer and healthier lives than do the poor is not simply due to the fact that unhealthy people, families, or groups 'drift down' from higher to lower socio-economic positions. Most of the evidence indicates that the declining social position of those in poor health does not explain health inequalities or inequities. Moreover, there may be great inter-nation variation in the degree to which ill health actually does produce lowered socio-economic status. Lowered SES may be more closely tied to poorer health in more marketized nations lacking social welfare buffers to such crises as illness.

On the national level, poor average levels of health negatively influence national wealth – the international equivalent of the 'drift down' hypothesis. Much attention is now being directed to the potentially positive economic effects of human capital, particularly better health and education, and reduced levels of poverty, on economic growth. Whereas earlier it had simply been assumed that improved economies would lead to increased human wellbeing, now at least some attention is being paid to the opposite causal pathway, that of health and other human assets on economic growth. We are by now all familiar, via the Russian example, with the opposite situation, that of the effect of economic downturn and social upheaval on life expectancy. Since 1989, for example, the life expectancy of Russian men has declined 13 years, to approximately 60 years, about the same as India (United Nations Human Development Report 2005).

Ranking individuals according to their health status would produce a national (or worldwide) distribution of health. Much of this health ranking would not be considered as inequitable because some part of individual health differences might be viewed as arising from genetic or related characteristics about which we currently cannot do very much, since they are the 'luck of the draw'. Yet, there

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would also be differences by sex, by race or ethnicity, or by socio-economic status reflective of socially patterned health inequalities. Within nations we know that blacks in the United States and native peoples in Canada, Australia and elsewhere in white settler nations, live much shorter lives, by as much as 20 years, than do the white population (Marmot 2005 p. 1100).

Combining various social characteristics, such as race, ethnicity, income, or area, can produce much larger differences in life expectancy or infant mortality than any one of these alone. Much of the literature on health inequalities, however, focuses on socio-economic differences in health. Though some social differences may have additive health effects, many types of group health disparities are a result of social exclusion or the lower socio-economic status of those with particular race, sex or ethnic characteristics – hence the centrality of socio-economic status in many studies of health inequalities. Socio-economic status seems to be a central cause because socio-economic position is related to many different forms of social exclusion or discrimination and to many different types of disease or disability (Phelan *et al.* 2004). Hundreds of studies have examined the SES–health relationship; however, with few exceptions (Muntaner and Lynch 1999; Navarro 1999), there has been an overwhelming tendency to focus on the possible mechanisms through which social factors might be tied to health rather than on the causes of inequality itself. The lack of attention to the possible determinants of social inequalities is doubly interesting given international and national political and economic trends, which one would assume to have implications for our understanding of health inequalities. These trends include the ‘globalization’ of the world economy as well as the rise of New Right political regimes and the ‘decline of the welfare state’.

In fact, any discussion of health inequalities needs to confront the currently prevalent, almost hegemonic, doctrine regarding the relationships between social and economic factors and health. This doctrine, neo-liberalism, or in some versions, neo-conservatism (economic neo-liberalism plus social conservatism) is the dominant paradigm of the day pushed by pre-eminent nations such as the United States and Britain (the Anglo-American countries seem to be the world fountains of neo-liberalism), and by the international organizations which they heavily influence and staff, such as the World Bank, the International Monetary Fund and the World Trade Organization (Dasgupta 1998; Petras and Veltmeyer 2001). There has been recent reconsideration of the pure version of this doctrine due to obvious failures when these policies have been applied internationally. Compare, for example, the World Bank’s recent focus on global poverty and on the economically positive influence of improvements in human capital when juxtaposed to its previous unilateral doctrine of ‘free trade improves human well being’. Nevertheless the major argument is still made that economic growth is dependent on the dismantling of barriers to the flow of investment, goods and services, or

‘economic globalization’. In turn, economic growth produces increasing wealth which may then be used to underwrite social benefits, including access to health-positive resources and to improved and more equal health care. Thus – no problem – all we have to do is to promote free trade between nations and privatization within nations. In this view health inequalities are not considered terribly problematic since either everyone’s health will eventually improve, ‘a high tide will lift all boats’, or it is considered that any inequalities are either temporary, or perhaps unavoidable. In its starkest form this doctrine has a chilling message – that there is a trade-off between economic development eventually benefitting all, and current inequalities: to obtain the former we are unavoidably stuck with the latter.

Though less blatantly advanced now than previously, IMF policies still coerce nations, in exchange for badly needed loans, to ‘open up’ their economies, reduce government supports and subsidies, favour privatization of government programs, eliminate subsidies for basic nutrition and health care, etc. These ‘structural adjustment policies’ may have been renamed but the substance remains (Labonte *et al.* 2005),

We cannot understand health inequalities or health trends without analysis of the social factors that produce and accompany health differences and that determine health status (Graham 2004). How can one have greater equality in health matters in fundamentally unequal societies? In turn we cannot do something about social inequalities without consideration of the prevailing structures of power. Power structures on the national and the international level influence the prevalence of ideas, the development of policy, and the implementation or non-implementation of policy. The idea that some have more power than others implies conflict – and it is in a situation of conflict of ideas, of structures, of policy, that debates about what to do about health inequalities are taking place.

A neo-liberal ‘Washington Consensus’ (Finnegan 2003; Teunissen and Akkerman 2004) has generated increasing resistance. Anti-globalization social movements have made it much more difficult for neo-liberals to pursue their aims when faced with opposition by the very groups or nations that neo-liberals say are supposed to benefit from neo-liberal policies. In both the developed and less developed world have risen neo-governmental organizations struggling against the blindly ideological prescriptions of the true believers in market fundamentalism.

‘Anti-globalization’ is, however, too crude a term. Most protestors are not ‘anti-globalization’, simply against the imposition, through ‘free trade’ of corporate rights over the rights of citizens or nations. Much media discussion of globalization by default actually refers to economic globalization, and to a particular version of economic globalization, that of neo-liberalism. Yet globalization in its broader meaning defines those interactions that indicate that we are all part of a single world, ecologically, socially, politically and economically. The problem with much

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current usage of the concept is that influential corporations, international agencies and key national governments have collapsed the meaning of globalization onto neo-liberal economic policy. This perspective assumes that there is really only one aspect of globalization and one way to globalize – societies must adjust to markets rather than the reverse. This is a fundamental misappropriation of the concept of globalization.

Paradoxically, globalization broadly defined can produce positive orientations towards a ‘world community’, the fact that we are all members of ‘spaceship earth’ – the antithesis of the individualistic competitive world which is at the heart of marketized political and economic prescriptions. Globalization in wider perspective can promote collective human effort to solve mutual problems.

Both global and national processes are important. International forces directly and indirectly shape national policies. However, countries react differently to international pressures depending upon the place of a nation in the international economy and division of labour, and historically developed national institutions, economies, political cultures and class structures. Moreover, nations are not necessarily autonomous actors but are partly defined by their place in the world capitalist system (Moore 2006).

Neo-liberalism: a brief critique

We contend that the neo-liberal or economic globalization orthodoxy is factually incorrect and produces perverse (health) outcomes. The central tenet of neo-liberalism, that free trade uniquely produces economic growth, is simply not true. There are, and have been, many avenues to economic growth and not just one. Moreover there are three additional issues with this paradigm, a policy firmly, almost religiously, held. The first is that the paradigm produces unidimensional thinking in which all problems benefit from the same solution. In Canada, the Fraser Institute, a corporate sponsored right-wing think tank, always knows what the solution is regardless of the problem: poverty, racial discrimination, improved health or education, considered, i.e., more, markets or privatization. In the development field, orthodox thinking seldom strays far from the ‘free-trade/free-enterprise produces prosperity and improves human life’ mantra. No thought or analysis is required, since the solution is always the same.

The second issue with the economic orthodoxy is that it neglects the relationships between the economic, the political, the social and health. It ignores the fact that in order to have a particular kind of economy, we also need particular kinds of political and social arrangements. Types of economy have social foundations, moreover they also have social consequences (Esping-Andersen 1999, Korpi and Palme 1998). Thus, neo-liberal economies need neo-liberal forms of societies and neo-liberal

social economies cannot translate economic improvements into improvements in wellbeing, without reinforcing social and health inequalities. When it comes to human wellbeing, the political, social and ideological arrangements that underpin neo-liberalism also produce and exacerbate the social conditions which underlie health inequalities within and amongst nations. For example, economic growth reduces poverty more effectively in nations with high income equality as opposed to nations high in inequality because in the more equal countries a greater share of economic growth accrues to those lower in income than it does in the high inequality countries. Yet neo-liberalism leads to striking income inequalities.

Neo-liberal doctrines are either unconcerned with, or positively endorse, inequalities (as encouraging work motivation, participation in markets, etc.), or, at a minimum, consider it inevitable, necessary or temporary (Coburn 2000). Neo-liberals only reluctantly acceded to welfare state measures and quickly came to oppose these in an era of corporate global power. Any area subject to being taken out of the market during the welfare state era came under unrelenting pressure towards 'recommodification'. Neo-liberal political regimes focus on means testing regarding various income support measures, on reducing entitlements and on undermining the power of unions or progressive groups opposing the strict application of market mechanisms. Nevertheless, various 'types' of welfare state differentially resisted the pressures of economic globalization. As Esping-Andersen (1990; 1999) has indicated, the Social Democratic welfare states, underlain by differing class formations in which working class and progressive movements were more powerful than in other states, were more resistant to neo-liberal pressures than were the Liberal welfare states or even the Familist or Conservative welfare states.

Moreover, neo-liberals are particularly 'individualist' in attacking various forms of collective or state action – insisting that we face markets only as individuals or families – that we 'provide for ourselves'. Neo-liberal doctrines are antithetical to social cohesion or to social 'trust' (now much emphasized by the World Bank (see social capital website at www1.worldbank.org/prem/poverty/scapital/home.htm) and others (Kawachi *et al.* 1999)). The most appropriate relationship is that embodied in contracts reflecting material self-interests. Privatization in fact means the individual ownership of what were once possessions or functions of the state as representative of society, or of those things which were previously the possession of everyone (including natural products, land, fish, etc.). Privatization and the lack of non-contractual connections amongst citizens, imply a generalized increase in scepticism or distrust towards one's fellows. Furthermore, since markets are efficient and just allocators of rewards, then economic or 'social' problems are attributed to individual failings. Recipients of social welfare measures are 'welfare bums'. It is utterly perverse that much is now being made of the notion of social cohesion or social capital as one avenue through which improved health

status might be produced, given the fact that neo-liberal belief systems are postulated almost entirely on an individualist anti-collectivist ethos.

The third problem with the neo-liberal paradigm is related to the second issue, that is, the tendency to confound economic development with improvements in human wellbeing. Discussions about 'standards of living' are not at all focused on human wellbeing but only on macroeconomic indicators. David Coburn lives in Canada, and frequently in Canada's history the Canadian 'standard of living' has been compared unfavourably with that of the United States, particularly by those right-wing groups wishing to emulate US economic and social policies. It is pointed out that the US GNP/capita is higher than the Canadian GNP/capita. The suggestion is, therefore, that Canada should more closely imitate US economic and social policy. Yet, in fact, the United States shows greater income inequality, higher crime and incarceration rates, longer working hours and poorer health and greater health inequalities, than does Canada or almost any other of the OECD nations for that matter. Moreover, comparing income distributions, as opposed to GNP/capita averages, most Canadians are economically better-off than most Americans. The average GNP/capita in the US is brought up by the fact that the United States shows a much higher percentage of extremely wealthy people than does Canada.

We all currently live under various versions of a capitalist mode of production. The capitalism of today, however, is different from the capitalism of Britain in the seventeenth and eighteenth centuries. The capitalism of today in the developed nations is also different from the 'welfare state' capitalism of 1945–1970. We are now in a new *phase* of capitalism, global capitalism, in which business and corporate power has been reasserted in an overwhelming manner.

There are also different *forms* of capitalism in the contemporary world. Within the developed world, that is, countries in Europe, North America and the English-speaking world generally, nations have been categorized as having different types of capitalism according to the way they organize the provision of care for their citizens, that is, their different types of welfare state regime. We show that the onset of global neo-liberalism and the existence of different welfare regime types are important factors – first, regarding social and health inequalities within nations, and second, with respect to health differences amongst the developed nations.

A note on class versus socio-economic status

As used here, class refers to a structural and relational rather than an SES approach. In fact, class is seen as determining and shaping SES and income inequalities. To oversimplify a complex literature, classes are conceived in relation to one another and in relationship to the means of production (concerning class and health, see

Muntaner and Lynch 1999; Scambler and Higgs 1999 or Navarro 1998; Navarro and Shi 2001). Thus, there are business classes (capital) and working or oppositional classes and social movements. In general, the interests of one of these are inversely related to the interests of the other. On the other hand, Socio-economic status simply refers to individuals or families who score higher or lower on various characteristics without any real social relationships between these and without any necessary antagonism between those lower or higher.

Health and inequalities in a global world

Throughout the second half of the twentieth century there were general improvements in life expectancy and infant mortality. Since 1960, life expectancy has increased by about 16 years in developing countries and six in the developed nations and infant mortality has dropped dramatically – there was some convergence. Yet, since 1990 regarding life expectancy ‘the convergence has ground to a halt.’ (United Nations Human Development Report 2005, p. 25) In sub-Saharan Africa and Russia, life expectancy has actually declined. Similarly, there has been a slowdown in the rate of improvement in child deaths and the divergence between rich and poor nations has been increasing. Most recently, a report on food insecurity reports that 820 000 000 people in the developing world were hungry in 2001–2003, only three million less than a decade earlier, despite lofty goals to eliminate world hunger (UN Food and Agricultural Organization 2006).

The health improvements that did occur are not due to economic growth. There is little, if any, correlation between rates of economic growth and health improvements (Deaton 2003; 2004; Milanovic 2003). Even regarding economic growth, Milanovic argues that growth rates were much higher between 1960 and 1980, presumably before the full impact of global neo-liberalism, than between 1980 and 2000, during a time of economic globalization. Problems with the doctrine that neo-liberalism produces economic growth are also indicated by Navarro’s (1998) findings that, in the developed world, the Social Democratic nations showed generally higher growth rates in the post World War II period than did the Liberal (neo-liberal) welfare states.

Examining social or income inequalities, while there have been reductions in the percentage of the world’s population living on less than US \$1 per day, inequalities do not show the same trend. The United Nations reports clear movement towards increased income inequality within countries in the past two decades. Of 73 nations with available data, 53 (with 80% of the world’s population) showed increases in within-nation inequality (United Nations Human Development Report 2005 ch. 2). The result is massive inequality on a world scale. The world Gini index, a measure of equality in which 100 is complete inequality and 0 is

complete equality, is 67, compared with Gini indices in the high income OECD nations of 37 and Sweden's 33. Sub-Saharan Africa, Latin America and the Caribbean and East Asia and the Pacific Areas all show Gini indices above 50. When countries are used as the unit, global income distributions have also widened. If the latter data are weighted by the populations involved, however, the data show somewhat less income inequality than in previous decades, simply because of the huge populations of India and China, both of which saw increased average income.

On the global level, the cross-sectional relationships between levels of national wealth and health (not the same as the correlation between rates of growth in income and health) show a strong but far from universal relationship for nations under about \$5000 US GDP/capita (at purchasing power parity or PPP). Above that level, particularly for the 30 or so nations of the OECD, the correlation between GDP/capita and average health is weak or non-existent. This finding drove some analysts to argue that, in the developed nations, income inequality was more important for health than was the national level of income itself.

This division, of poor from wealthy nations, and the notion of the 'epidemiological transition', the change from communicable diseases (in the poor nations) as the chief causes of death to the non-communicable or chronic disease pattern in the wealthier nations, has led many analysts simply to divide the world up into rich and poor countries. Alternatively, official international agencies tend to view the world geographically – Europe, Latin America, etc. A few analysts have tried to come up with more theoretically meaningful divisions. For example, Gough *et al.* (2004) applied Esping-Andersen's (1990; 1999) division of the developed world into the three welfare state types to the less developed world. Gough *et al.* concluded that there were three meta-types, consisting of welfare state regimes, informal security regimes and insecurity regimes. A major point of these authors was that these regional regimes differed radically on such important matters as state capacities and historically developed policy paths. Finally, 'World System' theorists believe that nations and the global system interact so that nations are shaped not only by their own pre-existing historically developed assets, institutions and class structures but also by their role in the world economy, with consequences for the health and health inequalities in these nations (Moore 2006). World System theorists see the world in terms of core, semi-periphery and periphery based on the structural position of a nation in the world system. China may have only a moderate GNP/capita but in other respects it is powerfully located in the world economy.

Because most data are collected in terms of rich/poor or global 'regions' we simply follow this convention without implying that it is the right analytical approach.

The developed nations

Why is there so much inequality within and between nations in the developed world? The most prominent, but still contentious, hypothesis focuses on income inequality (Wilkinson 1996; Kawachi *et al.* 1999). It is argued that the major determinant of the health of the developed nations (hence, of inequalities between nations) is not GNP/capita but rather the degree of income inequality itself, and its correlate or consequence, lowered social cohesion or trust (which itself contributes to poorer health). Thus, countries, regions or areas showing higher degrees of income inequality also have lowered social cohesion and lower average levels of health. This is because hierarchy (e.g., socio-economic status) is related, through biopsychosocial mechanisms, to lowered self-esteem. This would help to explain SES/GDP– health relationships both within and between nations.

Oponents of the income inequality thesis contend that the relationships found by Wilkinson are artefactual (Ellison 2002) or that income inequality does not have the causal significance that income inequality advocates contend it has (Deaton 2003; Muntaner and Lynch 1999). If the health of the poor is improved more per dollar or euro, etc., than is the health of the rich per dollar or euro, then the postulated relationship between income inequality and health may be purely a function of the shape of the curve relating income to health (Gravelle 1998). This hypothesis would also suggest a focus on the health of the poor. In fact income inequality may have an influence but it does not have the *causal* significance given to it by Wilkinson. Income inequality is really a proxy for many other forms of social inequality that all influence health (Muntaner and Lynch 1999; Navarro 1998; Coburn 2004). Income distributions are simply a measure of the degree to which an area, city or nation takes care of its citizens (Ross *et al.* 2000). Thus, we are not simply talking about national differences in income inequality but different national (welfare) ‘types’.

Income equality form an important part of welfare states because one of the aims of welfare states is to correct or ameliorate market-produced income inequalities, either by providing universally available services (not adequately measured by income) or by compensating citizens during times of individual or social crisis. Hence, income inequality may be more highly correlated with health within more market-oriented societies than within less market-oriented societies. As used here, income inequality is taken to be a proxy for a whole set of measures with which it is correlated and causally related and this would also encompass any emphasis on the relationships between poverty and health.

Finally, a third hypothesis focuses on medical knowledge. A prominent economist, Angus Deaton (2003; 2004) and others (Cutler *et al.* 2006) contend that national differences in health are simply a result of the differential rate of spread of health and medically relevant knowledge. Certainly, within nations those higher in

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status and education seem quicker to adopt healthy lifestyles, and have access to more health-promoting resources, than do those lower in status and education. The exact cause of this quicker adoption by those higher in socio-economic status is not known. Nor does Deaton explicate the social mechanisms through which some nations spread knowledge or practices more quickly and extensively than do others, although the importance of education, public health measures, and government actions regarding these are mentioned as important. Thus latter the again seems to overlap with the 'welfare state' model.

We illustrate the welfare state model through an examination of income inequality (a fairly readily available measure of welfare state 'results') and infant mortality (a health measure with the least 'lag' effect) amongst different types of welfare state, specifically comparing the 'liberal' and 'social democratic' types.

Neo-liberalism, income inequalities and health inequalities within nations: some examples

Prior to the 1970s, the USA and the UK showed declining inequalities. Beginning about 1968 in the USA and 1977/78 in the UK, income inequality, for example, began a steep and rapid rise (Gottschalk and Smeeding 2000). In the USA, the lowest 60% of households actually experienced a *decrease* in after-tax income between 1977 and 1999. During the same period, incomes of the top 5% of households increased by 56% and those of the top 1% mushroomed by 93% (Bernstein, *et al.* 2000). Data also indicate that welfare regimes actually did what they were supposed to do: lessen poverty and inequality. In fact, despite being one of the richest nations on earth, in 1991 the United States had one of the highest rates of *absolute* (as well as relative) poverty amongst the developed nations – of 15 countries only Italy, Ireland, Australia and the UK had higher rates – the latter three all having neo-liberal policies (Kenworthy 1999 p. 1125). And, in general, within the OECD nations the neo-liberal nations showed higher inequality than did the Social Democratic nations.

Infant mortality is an often-used measure of health, and even of social conditions, because unlike some other measures such as longevity, infant mortality rates tend to reflect current social conditions. Moreover, (comparing the Liberal with the Social Democratic nations) amongst the more developed nations, the neo-liberal nations showed poorer average levels of infant mortality for all decades from the 1960s through to the year 2000. Moreover, the liberal welfare regime states, including the USA, the UK and Canada showed worsening relative rankings regarding infant mortality rates relative to 18 OECD nations between 1960 and 2000 than did the Social Democratic nations (Coburn 2004).

Most relevant for this analysis, different welfare regimes and rising inequalities of various kinds have important implications for health inequalities within nations, since social inequalities of many kinds are related to health status

differences. Thus, despite 'expanding economies', health inequalities have increased. A recent study showed inequalities in mortality for all causes between low and high socio-economic status areas to have increased amongst adults in the USA by 50% and 58% (for males and females respectively) from 1969 to 1998 (Singh and Siahpush 2002). A commentator on Britain, a nation that experienced a prolonged period of neo-liberal politics, noted that: 'The inequalities in health between social classes are now the greatest yet recorded in British history,' (Yamey 1999; see also Dorling 1997). Another British study shows an increasing ratio 'between social classes I (high) and V (low) (which) widened from 2.1 in 1970–72 ... to 3.3 in 1991–3,' (Blane and Drever 1998).

More neo-liberal states show greater inequality, greater poverty and poorer overall health status. Yet some tentative data seem to indicate that the level of health inequalities between manual and non-manual workers at least, may be as high in Sweden, for example, as it is in England. It might be that Sweden has more vulnerable disadvantaged populations generally, because it simply keeps more people alive to productive ages (see Coburn 2004), or that some health inequalities in the developed nations reflect differences in education or information flows, as Deaton contends. Other evidence shows that during a time of severe Nordic economic crisis and recession in Finland and Sweden, inequalities in health remained largely unchanged (Lahelma *et al.* 2002). The argument was that the institutions of the welfare state buffered against widening health inequalities in that period. In any event, because Sweden has much better overall health levels than England, the absolute differences in Sweden between socio-economic classes are much smaller than they are in England.

It does seem that there can be a 'virtuous circle' in which economic growth is actually translated, through social policy, into lowered inequalities of many kinds, and (perhaps partially because of lowered inequalities), higher average levels of health.

The less-developed world

The main health problems in the world today lie in the underdeveloped nations and stark global health inequalities. In some nations, obesity is a major health issue, while in other parts of the world millions die or are stunted by starvation and hundreds of millions more have little opportunity to develop their human capacities. We are not living in a world of scarcity but in a world in which resources are radically maldistributed relative to need. This international picture directly contradicts the claim of neo-liberals that free markets can best meet human needs (Labonte *et al.* 2005; Labonte and Torgerson 2005) – in fact, within such a system on the global level the wants of the wealthy supersede the needs of the poor.

The case of health care research, and pharmaceutical research specifically, is instructive. The development of drugs and pharmaceuticals is characterized by the

term 90/10. That is, 90% of the research and resources is focused on the issues affecting the 10% of world health problems in the affluent nations. Why? Because in the developed nations there is a 'market' for such products as blood pressure or cholesterol lowering medications while there is little market for much more acute serious conditions in the less developed world (Labonte *et al.* 2005). It is no accident that the World Health Report (2003) notes that: 'Of the 4.1 million people in sub-Saharan Africa in urgent need of antiretroviral drugs, fewer than 2% have access to them.'

The distribution of health in the world in the early twenty-first century is shocking. While the healthiest nations have overall longevity rates ranging around 80 years, the unhealthiest nations show rates of half that – around 40–45 years. Life expectancy at birth in 2002 ranged from 78 years for women in developed countries to less than 46 years for men in sub-Saharan Africa. The WHO uses a measure of longevity that indicates the equivalent number of years in full health (health adjusted life expectancy or HALE) that a newborn can expect, based on current mortality rates. Japan has the highest HALE longevity in the world at 73.6 years (with Sweden close behind). Angola showed 28.7 years. And this is comparing averages, not contrasting, for example, the poorest health levels in Angola with the highest health levels in Japan or Sweden, which would show even greater disparities (United Nations Human Development Report 2005 chs 1 and 2).

Regarding child mortality, a child in Swaziland is 30 times more likely to die before the age of 5 than a child born in Sweden; a child in Cambodia is 17 times more likely to die than a child in Canada. Some of these differences are increasing, particularly in sub-Saharan Africa. In 1980, child death rates in sub-Saharan Africa were 13 times higher than in rich countries; 25 years later they were 29 times higher (United Nations Human Development Report 2005 ch. 1).

Average national health levels also ignore inequalities within countries. Within a group of 22 low or middle income nations over a three to six year period in the late 1990s, 13 showed an (not necessarily statistically significant) increase in inequality by income for survival rates under age five, while nine showed improvement (Wagstaff 2000). Moreover, this study showed no relationship between overall national levels of improvement in health and health inequalities, suggesting that policies to reduce inequalities need to be aimed specifically at the poor (Gwatkin 2000; Moser *et al.* 2005).

There are similar inequalities in almost every nation. Within India the death rates for children under five in Kerala (a state often mentioned as a jurisdiction having much better health than its wealth would suggest) was 19, as opposed to 123 in Uttar Pradesh. Kerala also showed other positive health data, such as 80% of children receiving vaccination compared with 11% in Behar (United Nations Human Development Report 2005 p. 30). China has shown rapidly increasing

economic growth in the past two decades yet a slowing of improvement in average health and rapidly increasing health inequalities. The death rate for children under five is 8 per 1000 in Shanghai and Beijing compared with 60 in Guizhou the poorest province.

As noted, amongst nations below about US \$5–6000 GNP/capita national wealth is highly correlated with national health. The important point about the correlation between GNP/capita and health status for the poorer nations, however, is that there are still wide disparities in health for nations at similar levels of GNP/capita: 'Life expectancy at birth is about a year longer in Sri Lanka than in Malaysia, even though the latter is more than twice as wealthy as the former. Similarly, life expectancy in Costa Rica is 25 years longer than in Gabon, although both are at a similar economic level.' (NSW health bulletin). For nations at any particular level of GNP/capita a range of health outcomes is possible. Cuba and Mexico both have around \$1000 GNP/capita but 70 more children per 1000 survive to age five in Cuba than in Mexico. Similarly the GNP per capita of Sri Lanka and Indonesia are similar but 60 more children per thousand survive to age five in the former nation than in the latter. There are sometimes startling comparisons even between the developed and the less developed world. The US white infant mortality rate is worse than Malaysia's. The lesson is that, even for the less-developed world, high GNP/capita is neither a sufficient nor a necessary condition for a good average level of health.

And, clearly, it is nations retaining some control over their role in the world economy that seem both able to profit from processes of globalization in terms of economic growth and are better able to translate growth into improved health. One study compared the policies and outcomes of Indonesia, Thailand and Malaysia during the economic crises of the late 1990s. The former two nations followed World Bank prescriptions for adjustment including cutbacks in government spending. Malaysia, on the other hand, pursued its own independent policy. Whereas Indonesia and Thailand had negative health outcomes, the crisis had little impact on Malaysia. The author of this study (Hopkins 2006) noted the: 'importance of social safety nets and the maintenance of government expenditures in minimising the impact of economic shocks on health.'

The major issue is that the current forms of 'development' are based on a neo-liberalism that has impaired health improvements and raised inequalities rather than lessened these. The emphasis simply on economic growth as a cure-all is also misplaced. Deaton (2003) indicates that: 'the cross-country data show almost no relationship between changes in life expectancy and economic growth over 10, 20, or 40 year periods between 1960 and 2000.'

The conclusion to be drawn is that the translation of economic growth into improved health requires appropriate national institutions and public action.

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In the absence of public action, simple market mechanisms tend to produce adverse rather than positive results for health and for health inequalities. There is also a relationship between inequality within nations and the degree to which growth can reduce these. High income inequality, for example, simply means that the poor profit relatively less from economic growth or improvements than the rich, exacerbating inequality. Regarding overall health levels, one crucial factor seems to be high literacy rates and especially women's education. Perhaps because traditionally women are the family caregivers, women's education seems to be the vehicle for direct improvements in health levels. Some types of economic growth, of 'development' are better than others.

What can be done?

Many prescriptions for health policy are simply utopian in that they ignore current regimes of power. Yet, action is already being taken. Viewing health inequalities as part of the product of neo-liberal economic globalization and health and health inequalities as being caused by, and covarying with other forms of inequality, connects health with much broader struggles. Ever since corporations escaped from national controls to become more or less unfettered internationally, there has been opposition to corporate power. Some of this opposition has come from differences in policies amongst states, but most has arisen from social movements in both the North and the South, in the developed and in the less developed world. Every meeting of the World Trade Organization has been a target for civil action but has also been accompanied by meetings of citizen groups from dozens of different nations with a more progressive agenda than that put forward by official international organizations. Events like the World Social Forum seek to take the initiative away from the neo-liberals who dominate official policy-making institutions such as the annual World Economic Forum held in Davos, Switzerland. Pointedly taking place in the developing world – thus far, India or Brazil – the World Social Forum explicitly aims to challenge 'neo-liberalism and . . . domination of the world by capital and any form of imperialism' by democratically debating alternative forms of organization 'centred on the human person' (see: www.wsfindia.org). Globalization has thus shown contradictory trends, towards corporate dominance but also towards the organization of international opposition to such dominance.

A huge variety of groups with disparate specific goals have taken steps to co-operate. As Carroll and Ratner (2005) have noted, in today's global world there is one Goliath – global capital – but there are many Davids. All of these are mobilized against unfettered global capitalism. This organization is visible on many levels. Within the context of North America alone, there are many examples

of the different forms this opposition may take. In the free-trade zone maquiladoras located along the US-Mexico border, workers protest against unsafe conditions on the shop floor. At other times, protest against conditions linked with neo-liberal economic policies is less ambiguous and more overtly political. This was spectacularly true with the uprising of the Zapatista Army of National Liberation on January 1, 1994, when Mexican peasants rose up in arms to protest against neo-liberal policies on the same day that the North American Free Trade Agreement was implemented. Farther north, in Ontario, Canada, public and private sector unions mobilized in eleven one-day strikes from 1995 to 1998. During these 'Days of Action' against the policies of the then-Conservative provincial government, unions and social movement participants voiced their protest against neo-liberal policies, such as the freezing of the minimum wage, the relaxation of health, safety and environmental legislation and attacks on the poor, including the stigmatization and criminalization of welfare recipients. At the national level, the Council of Canadians, the Canadian Centre for Policy Alternatives and others have created a coalition against the threatened privatization of water, linking with similar movements in Britain, Ecuador and elsewhere.

Like the World Social Forum, the European Social Forum, opposed to neo-liberalism and a world dominated by capital, meets under the slogan 'Another World is Possible'. Many of these meetings emphasize health and health inequalities. Often, such movements of opposition to neo-liberalism speak in the language of human rights. These rights are reconceptualized to challenge neo-liberal models that imagine human rights only in the context of private individuals. Instead, 'alterglobalist' NGOs insist that human beings are embedded in communities, with mutual responsibilities towards one another. The 'rights of the human person' as a social being are juxtaposed against the rights of capital.

One aspect of many of these movements has been a focus on health, on the health effects of environmental degradation and on equal access to health care. For example, the World Social Forum, held in Delhi, India in November 2006, proposed sessions on women, sustainable development and social services that explicitly addressed the links between these broader topics and the issue of health and health inequalities. (see <http://wsfindia.org/isfconsultation.doc>). In this way, non-government organizations emphasize the extent to which health inequalities can be understood only within a broader political economy concerned with – among other issues – wealth and poverty, the privatization of the global commons and public services and the everyday experiences of women.

The struggle against the privatization of water is emblematic of the ways in which advocacy and mobilization around health and health inequalities are explicitly linked to broader challenges against neo-liberal economic policy. Around the world, a wide range of non-government organizations are united in

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their calls to maintain access to water as a publicly provided good, a basic human right, and a necessity for good health, against neo-liberal privatization schemes. Privatization brings unequal access to a fundamental human health resource. This includes the American based group 'Water for All' operating through the NGO Public Citizen, the Council of Canadians and the 'Anti-Privatisation Forum' based in Johannesburg, South Africa, which links its struggle against the privatization of water to broader struggles against neo-liberal macroeconomic policies that deny basic human needs essential for health (see www.apf.org.za/). Likewise, the Ghana National Coalition Against the Privatization of Water, which successfully mobilized in 2001 against a World Bank conditionality proposing the privatization of the urban water supply, seeks to uphold access to water as 'a human right against corporate exploitation' (see www.ghanacap.org/page.aspx). For these groups, access to safe potable water is explicitly conceptualized as part of a broader international struggle emphasizing 'need versus profit' and stressing that basic goods and services are rights rather than commodities. International mobilization around health is organically linked to broader struggles over neo-liberal economic policy and the states and international institutions, like the World Bank, that support them.

Health, including but not confined to health inequalities, has become a focus of progressive forces. Health and health equity provide potent weapons against global neo-liberalism – it is difficult to argue against health and health equity as positive goods. Involved in these battles have been quasi-professional organizations such as those involved in public health, in health and health care ethics, and those involved in the rights of the poor, including their rights to resources that would permit health improvements. Health is enmeshed with human rights, the environment, and anti-economic globalization social movements generally. It is through and by these groups, connected with political movements, or simply as movements in civil society, that health inequalities have become part of national and international agendas. Health connects with and resonates with broader struggles to tame an international capitalism reflecting the interests of the few.

Struggles over health and health inequalities are not simply matters of scientific 'fact'. Health struggles are political struggles. Scientists play a part in these on one side or another. One way in which some scientists can contribute is to document existing health and health inequality issues. Often these are hidden through the absence of relevant data. Revealing so-far obscured inequalities is a first step in leading to action to reduce them.

Action can be taken in many ways and at many levels, one form being participation in collective organizations. National political activities are obviously significant. Collections of ordinary citizens have proven crucially important in

documenting what some ignore. We cannot, however, escape our own individual responsibility to take whatever actions our capabilities and environments direct us to. There is no one way to improve the human condition but many ways.

We are faced internationally with degradation of the planet and a vision of the earth's resources as finite. Are these to be sold to the highest bidder in the market or can they be employed in a more just and equitable manner? These are the fundamental questions with which we are faced and about which we have to make our own individual commitments.

Discussion

Health inequalities are the central focus of health policy in the European Union. Internationally, the WHO and the UN both emphasize health inequalities and the links between poverty and health (as now does the World Bank). The failure of IMF doctrines has had an effect. 'Free' trade is never free and does not inevitably lead to economic growth. Economic growth is only conditionally related to improvements in wellbeing – better health and lower health inequalities. And, perversely, neo-liberalism produces increased social and income inequalities and lowered social cohesion, which are themselves related, through various avenues, to health inequalities.

On the one hand have come attempts to document how health inequalities are linked to their proximate determinants. More recently have arisen efforts to show how economic and political policies produce or ameliorate within and between nation inequities. The latter are by far the most stark. Paradoxically, corporate attempts to escape national controls have given rise to a truer version of globalization, which implies and makes overt the fact that we cannot ignore what happens in other regions, areas or nations.

One cannot have 'any' kind of economy with 'any' kind of society. Neo-liberal economies are part of neo-liberal societies, which have the detrimental effects noted. What we should be talking about practically and theoretically are different types of societies and economies and different types of economic growth rather than the uncausal and monolithic image presented by neo-liberal orthodoxy. The problem is not necessarily with the nature of developing societies, although that is indeed an issue, but with the dominant, unilingual, Anglo-American version of what is good for everyone.

Influential Americans assert 'the end of history'. Rather, globalization writ large has led us to the beginning of history. It is a beginning because, perhaps for the first time, we cannot divorce the fate of others entirely from our own. We are being forced to realize that we are not simply the subject of economic laws; we are not going to be ruled by them. We created our world. We can change it.

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