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Vandana Desai is Senior Lecturer in Development Geography at Royal Holloway, University of London

Rob Potter is Professor of Human Geography at the University of Reading and Editor-in-Chief of the journal *Progress in Development Studies*

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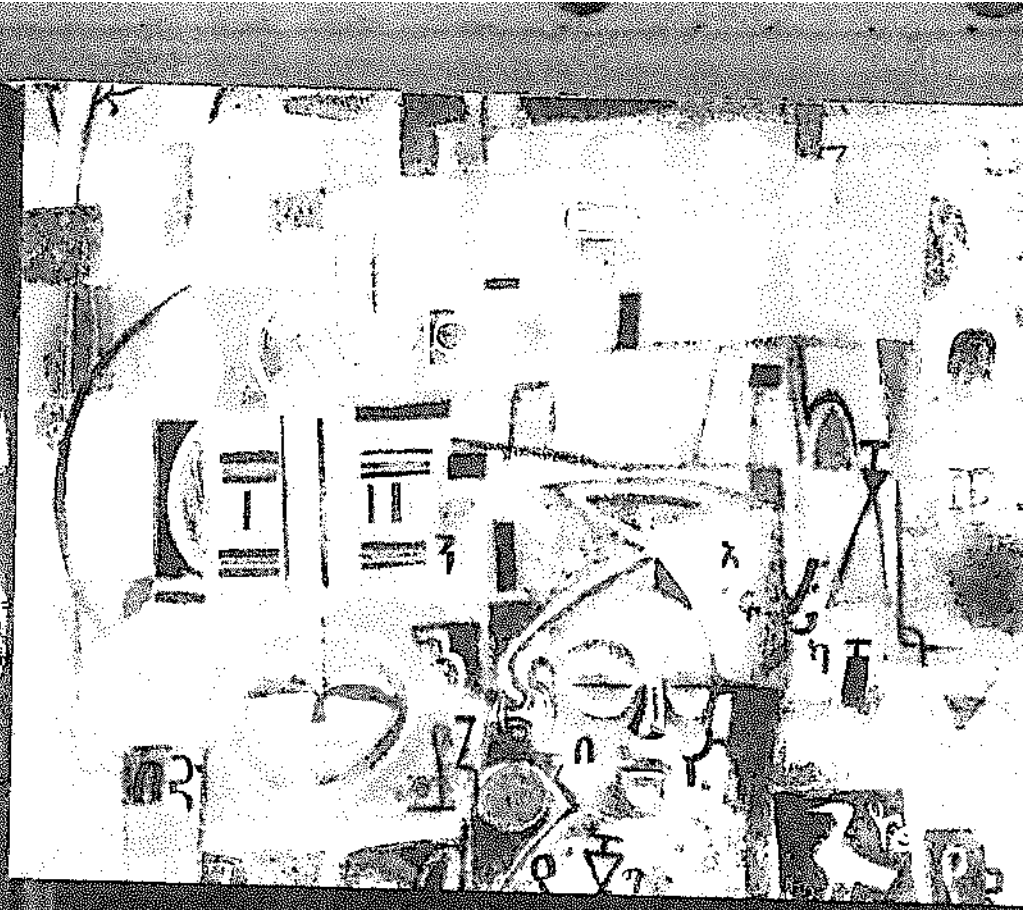

THE COMPANION TO DEVELOPMENT STUDIES

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EDITED BY
VANDANA DESAI
ROBERT B. POTTER

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8.6 Health inequalities

Hazel R. Barrett

Introduction

Over the past 15 years the pivotal role played by good health in the development process has been acknowledged. The shift to the human development paradigm which followed the publication of the first *Human Development Report* in 1990, has been enshrined in the UN Millennium Development Goals (MDGs), agreed by 189 countries in September 2000. Of the eight MDGs, three directly address health challenges: reducing child mortality (Goal 4); improving maternal health (Goal 5); and combating HIV/AIDS, malaria and other diseases (Goal 6). The other five MDGs all indirectly impact on health: eradicating extreme poverty and

hunger (Goal 1); achieving universal primary education (Goal 2); promoting gender equality and empowering women (Goal 3); ensuring environmental sustainability (Goal 7); and developing a global partnership for development (Goal 8).

The acceptance that good health is an essential element of the development process has stimulated much debate amongst academics and policymakers as to how to achieve the MDGs. It is now accepted that average health achievements, such as those stated in the MDGs is not a sufficient indicator of a country's performance in health, rather the distribution of health and health inequality is paramount (Gakidou et al. 2000). The January 2000 special issue of the *Bulletin of the World Health Organization* focused on the theme of inequalities in health. This stimulated much debate on the definitions of health inequality and how it should be measured, as well as the impact of poverty on health outcomes. The arguments have focused on the health of the poor and vulnerable as well as how to target those with most need (Gwatkin 2000, 2002; Wagstaff 2002; Marmot 2005, 2006; WHO various). Questions are being asked as to why in 2004 life expectancy was 82.2 years in Japan but only 31.3 years in Swaziland (UNDP 2006). Why is it that in 2004 in every country in the world apart from Botswana, Kenya, Malawi, Maldives, Zambia and Zimbabwe, women lived on average longer then men (UNDP 2006)? Why is it that under-five mortality is 300 per cent higher amongst the poorest 20 per cent of Brazil's population than the richest 20 per cent, whilst in Chad, a much poorer country, the rates are the same for both rich and poor alike (UNDP 2006)? Why are there differences in life expectancy between rural and urban areas and social groupings? These are key questions for those with an interest in health inequality.

Definitions and measures of 'health inequality'

Whilst there is much evidence to demonstrate the differences in health achievements between countries and the social gradients of health within countries (Leon and Walt 2001; WHO annual) there is no internationally accepted definition of 'health inequality'. Gakidou et al. (2000) define health inequality as 'variations in health status across individuals in a population' (p. 42), which allows cross-country comparisons to be made as well the study of the determinants of health inequality. According to Shaw et al. (2002) 'where the chances of good or bad health are not evenly distributed among groups of people (defined by the area in which they live or work or some other common characteristic), we say that there is *health inequality*' (p. 126). Gwatkin (2000) states that when referring to health inequalities 'the principal objective is the reduction of poor–rich health differences' (p. 6). Feacham (2000) expands this definition suggesting that health 'inequalities refer to relative health status – between rich and poor, men and women, ethnic groups, regions or simply between the most healthy and the least healthy' (p. 1). All these definitions acknowledge that health varies between countries and amongst different groups of people within countries. It is these differences that are known as health inequalities.

According to Gwatkin (2002) there is not only a lack of a standard definition of health inequality there is also a dearth of measurement strategies and indicators. The traditional measures of health inequality, the Gini Coefficient and Concentration Index, are both taken from the field of economics. The Gini Coefficient ranges from 0, which represents perfect equality, to 100, which is perfect inequality. In 2004 Sweden had a Gini Coefficient of 25, which was the closest to equality, whilst Nambia had the worst at 74.4 (UNDP 2006). This is often represented diagrammatically as a Lorenz curve. The Gini Coefficient is often supplemented with the Concentration Index which indicates the extent to which a health outcome is unequally distributed across groups with ranges between –1 and +1. Interestingly the concentration index for sub-Saharan Africa is lower than the global mean and lower than for Latin America (Gwatkins 2002). These two measures focus on health status as measured by morbidity and mortality. Due to sparse and unreliable data for adult mortality and social status in developing countries, infant and under-five mortality rates are usually used, often derived from demographic and health surveys.

But health inequalities can also be measured according to need, access, efficacy and the effectiveness of health systems. In 2000, *The World Health Report* (WHO 2000) unveiled a new measure called the Health Inequality Index. Based on the child mortality data of 191 countries, this index measures the performance of different national health systems, based on fairness and achievement. This index identified that 35 of the 50 worst global health systems were in sub-Saharan Africa. The index, which is not based on any preconceptions about the dimensions along which mortality is unequally distributed, has been robustly criticized as it 'bears little relationship to socio-economic inequalities in mortality' (Houweling et al. 2001: 1672; Wolfson and Rowe 2001). Whilst there is much merit in a measure of health inequality that focuses on health delivery systems, it tells us little about the health risk environment and the socio-economic factors that result in health inequality.

The Gini Coefficient is still the most commonly used measure of health inequality, but its usefulness is being questioned and 'its position is slipping' (Gwatkin 2000: 8). But whilst several other indicators of health disparity are under consideration, such as the Health Inequality Index, there is no clear consensus of what should replace it.

Poverty and health inequality

Poverty has traditionally been accepted as an important determinant of health, with levels of income seen to be closely related to health outcomes (Wagstaff 2002; Curtis 2004). Empirical studies have often worked within this framework. For example Stillwagon's (1998) study of health in Argentina was based on the premise that 'health is primarily an economic, not a medical, problem' (p. 8). Not surprisingly her main conclusion was that health inequalities require an economic solution. Statistically based studies of health inequalities, such as that reported by Wagstaff (2002), which used Demographic and Health Survey data on child mortality from 42 developing countries, also conclude that there is a strong positive correlation between health inequality and average income. However the study also showed that, as countries get richer, health inequalities widen. Marmot (2006) suggests that the relationship between national income and life expectancy is strong up to a per-capita income of US$5000; after that there is little relationship between income and life expectancy. This irony demonstrates that the links between income and health are not straightforward or well understood.

Sen (2001), whilst recognising that there is a close connection between economic progress and health achievement, suggests the association depends on how the income generated by economic growth is used and if major health improvements can be achieved using available resources in a socially productive way. As he states: 'There is much merit in economic progress, but there is also an overwhelming role for intelligent and equitable social policies' (pp. 343–344).

The simplistic analysis that suggests income and health are directly linked has become problematic as the issue of poverty has been reconceptualised within the human development framework. Poor health is no longer regarded as the outcome or cause of poverty, instead poor health is now recognised as a component of poverty (Feacham 2000; Wagstaff 2002). Wagstaff (2002) asks, how can poverty be the driving force of poor health, when poor health is part of the factor? It is now recognised that researchers and policymakers need to go beyond the explanation that material deprivation is responsible for poor health and inequality (Marmot 2006; Whitehead and Bird 2006).

Over the past five years the concept of health inequality and its link to poverty has been contested. A recent study on intra-country socio-economic inequalities in infant and child mortality shows that inequalities appear to be smaller in sub-Saharan Africa than other parts of the world, with Latin America having the largest inequalities (Gwatkin 2002). Yet many would argue that the

health situation and needs of sub-Saharan Africa are more serious than those in Latin America. Also reductions in health inequality do not always mean that the health situation of the most disadvantaged has been enhanced, instead it could mean that improvements in health amongst advantaged groups has slowed, stopped or been reversed (Gwatkin 2000). The debates have thus moved on to health inequity and issues of social justice.

Health inequality or health inequity?

Many would argue that any inequality in health is unjust or unfair if it is economically or socially determined. As Gwatkin (2000) states, 'those concerned with health inequalities are concerned with righting the injustice represented by inequalities or poor health conditions among the disadvantaged' (p. 6). The debate is thus moving from a focus on health inequality to the issue of health inequity. Fotso (2006) explains the difference between the two terms: '*health inequality* is a generic term used to designate differences and disparities in the health achievements of individuals and groups, whereas the term *health inequities* refers to inequalities that are unjust or unfair' (p. 9).

Whilst the term 'health inequalities' has become widely used, it is being confused with and used interchangeably with 'health inequities'. However, the distinction is an important one. Gatrell (2002) explains: 'Inevitably, there will be unevenness of variation in health outcome, whether from place to place or along some other dimension. But what really matters, and what 'inequity' implies, is the fact that these differentials may be avoidable, and should be capable of being narrowed; their existence is, in a sense, unethical' (p. 91). Thus all factors, including economic determinants, that contribute to health inequity must be addressed. If poor health is a component of poverty we need to determine the factors responsible for poverty and hence identify those contributing to health inequity.

Marmot (2005, 2006), building upon the work of Sen and Stern, suggests that health inequalities and inequities can be explained by two factors. The first is the material conditions for good health, which includes a nutritionally balanced diet, clean water, sanitation and the provision of medical and public health services. The second factor is empowerment, which includes community social cohesion, depth of social capital and systems of governance, as well as individual empowerment with respect to social networks, community engagement, lifestyle preferences, health perceptions and personal stresses. What Marmot suggests is that health inequalities can be explained by a lack of material conditions for good health, with health inequity the result of a lack of community and individual empowerment. For him health inequalities and inequities are a clear outcome of social injustice.

The arguments and empirical evidence that social action can improve health resulted in 2005 in the WHO setting up a Commission on Social Determinants of Health. The Commission is chaired by Marmot. The driving principle of the Commission 'is social justice: to reduce unfair differences in health between social groups within a country and between countries' (Marmot 2006: 2091). Using evidence-based policy the Commission is due to report in 2008 with recommendations on what can be done to reduce health inequalities and inequities. In line with the human development paradigm, the Commission hopes to change social conditions to 'ensure that people have the freedom to lead lives they have reason to value' and which will 'lead to marked reductions in health inequalities' (Marmot 2006: 2082). This philosophical position draws attention to the central role played by human freedoms in health and calls for social action to achieve the MDGs and reduce both inter- and intra-country health inequity. Based on the premise that inequalities in health between and within countries are avoidable and are the result of social injustice (Marmot 2005) the Commission will contribute to the ongoing debate as to how best to reduce inequalities and inequities in health.

GUIDE TO FURTHER READING

Gakidou, E.E., Murray, C.J. and Frenk, J. (2000) 'Defining and measuring health inequality: An approach based on the distribution of health expectancy', *Bulletin of the World Health Organization*, 78(1): 42–54. A seminal paper which raises pertinent issues about defining and measuring health inequalities.

Gwatkin, D.R. (2002) 'Reducing health inequalities in developing countries', *Oxford Textbook of Public Health*, fourth edition. Chapter which traces the history of concern about health inequalities, explores the main concepts associated with poverty and inequality, and discusses policies for reducing inequality.

Leon, D. and Walt, G. (2001) *Poverty, Inequality and Health: An International Perspective*, Oxford: Oxford University Press. This book contains 17 chapters written by leading experts, and covers issues of measurement, economic and social determinants of health inequality, life-course approaches through to health care systems and their roles in health inequality.

Marmot, M. (2006) 'Health in an unequal world', *The Lancet*, 368: 2081–94. This paper makes the case for understanding the socio-economic determinants of health inequality and inequity. It particularly stresses the importance of social justice in reducing health inequalities. Examples are taken from both the developed and developing world.

World Health Organization (annual) *The World Health Report*, Geneva: WHO. Gives an annual review of the global health situation. Each report focuses on a different health issue.

REFERENCES

Curtis, S. (2004) *Health and Inequality*, London: Sage Publications.

Feacham, R.G.A. (2000) 'Poverty and inequity: A proper focus for the new century', *Bulletin of the World Health Organization*, 78(1): 1–2.

Fotso, J. (2006) 'Child health inequities in developing countries: Differences across urban and rural areas', *International Journal for Equity in Health*, 5(9). Accessed at http://www.equityhealthj.com/contents/5/1/9

Gakidou, E.E., Murray, C.J. and Frenk, J. (2000) 'Defining and measuring health inequality: An approach based on the distribution of health expectancy', *Bulletin of the World Health Organization*, 78(1): 42–54.

Gatrell, A.C. (2002) *Geographies of Health: An Introduction*, Oxford: Blackwell Publishers.

Gwatkin, D.R. (2000) 'Health inequalities and the health of the poor: What do we know? What can we do?', *Bulletin of the World Health Organization*, 78(1): 3–18.

Gwatkin, D.R. (2002) 'Reducing health inequalities in developing countries', *Oxford Textbook of Public Health*, fourth edition.

Houweling, T.A.J., Kunst, A.E. and Mackenbach, J.P. (2001) 'World Health Report 2000: Inequality index and socioeconomic inequalities in mortality', *The Lancet*, 357: 1671–2.

Leon, D. and Walt, G. (2001) *Poverty, Inequality and Health: An International Perspective*, Oxford: Oxford University Press.

Marmot, M. (2005) 'Social determinants of health inequalities', *The Lancet*, 365: 1099–104.

Marmot, M. (2006) 'Health in an unequal world', *The Lancet*, 368: 2081–94.

Sen, A. (2001) 'Economic progress and health', in D. Leon and G. Walt, *Poverty, Inequality and Health: An International Perspective*, Oxford: Oxford University Press, pp. 333–45.

Shaw, M., Dorling, D. and Mitchell, R. (2002) *Health, Place and Society*, London: Pearson Education.

Stillwagon, E. (1998) *Stunted Lives, Stagnant Economies: Poverty, Disease, and Underdevelopment*, London: Rutgers University Press.

UNDP (2006) *Human Development Report 2006*, Basingstoke: Palgrave Macmillan.

Wagstaff, A. (2002) *Inequalities in health in developing countries*, World Bank Policy Research Working Paper 2795, Washington, DC: The World Bank.

Whitehead, M. and Bird, P. (2006) 'Breaking the poor health–poverty link in the 21st century: Do health systems help or hinder?' *Annals of Tropical Medicine and Parasitology*, 100(5&6): 389–99.

Wolfson, M. and Rowe, G. (2001) 'On measuring inequalities in health', *Bulletin of the World Health Organization*, 79(6): 553–60.

World Health Organization (annual) *The World Health Report*, Geneva: WHO.

World Health Organization (2000) *The World Health Report*, Geneva: WHO.