IneQUALITY AnD HeALTH

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Social Injustice is killing people on a grand scale.
WHO

In 1820 average world life expectancy was about 26 years. By 1890 it had risen to thirty years. There was rapid improvement in the 20th century – by the year 2000 global life expectancy had increased from 33 years in 1910 to nearly double that figure. In 2004 average world longevity was over 65 years, about the same as life expectancy in Europe alone in 1950. Much of the early improvement in life expectancy was due to declines in infant and child mortality, rather than to a general lengthening of the lifespan. Even in the years since 1960 the world’s under-five mortality rate has been more than cut in half, from 198 per 1,000 live births to 83 by the year 2000.

Yet general improvements have been accompanied by persistent inequalities in health which have recently increased. In every country the rich and more powerful live longer, healthier lives than do the poor. White men in the ten healthiest counties in the United States live over 15 years longer than black men in the least healthy counties. In Britain in 1930-32 the mortality rate of unskilled male workers was 1.2 times higher than for professional men, and by 1991-93 the gap had widened to 2.9 times higher. The life expectancy difference between males in unskilled versus professional occupations increased from 5.4 years in 1972-76 to 7.3 years in 2002-2005. The WHO Commission on the Social Determinants of Health reports that the male life expectancy in a socially deprived area of Glasgow (Calton) is 54, much less than the male life expectancy in India (62) and 28 years less than in an affluent area in Glasgow (Lenzie), only 13 kilometres away. Among the 30 OECD nations within-country inequality far outweighs between-country inequality. There are similar or even greater inequalities within non-OECD countries. The situation in Peru resembles that in other less developed nations: over 40 per cent of all child deaths in that country occur among the poorest 20 per cent of Peruvians, eight times the rate among the richest 20 per cent.
Internationally, poorer nations generally, but not always, have much worse health than the wealthy nations. Japan and Sweden have the highest expected years of healthy life (Health Adjusted Life Expectancy) at about 73 years; Angola has 29 years. A child born in Swaziland is 30 times more likely to die before the age of five than a child born in Sweden; a child in Cambodia 17 times more likely to die before five than a child in Canada. A 15 year-old Canadian male has five times as much chance of reaching 60 as a male in the Russian Federation. While there are general, if recently slowing, world-wide improvements in health, some regions or nations – notably sub-Saharan Africa, countries of the former Soviet Union, Iraq and North Korea – have been declining in life expectancy.

In the first decade of the 21st century we are confronted with a world of seeming paradoxes in health. There are simultaneous ‘epidemics’ – in the richest countries epidemics of obesity, in the poorest nations, epidemics of undernutrition, disease and death. The healthiest nations, such as Sweden and Japan, enjoy increasing life expectancy and extremely low infant mortality, while the US stands near the bottom of the thirty OECD nations in infant mortality in 2004, just better than Turkey and Mexico but worse than Poland and the Slovak Republic. In Russia life expectancy has actually been in decline, particularly since 1989. The life expectancy of Russian men and women was lower in 2004 than in 1965.

The relationship between wealth and health, nationally and internationally, is not the only one where inequalities are important. Sex and race/ethnicity are important too. Women generally live longer than men, although experiencing greater illness, while aboriginal or native populations in colonised nations show very poor health compared to their non-aboriginal counterparts. But it is with the relation between general socio-economic status and health that this essay is primarily concerned.

The massive health problems of the poor or developing nations, alluded to above, are not due to a lack of world capacity with which to correct these. We are not living in a world of scarcity but in a world in which resources are radically maldistributed relative to need. A very minor part of the amount spent on armaments, a tiny percentage of the GNP of the richer nations, or even only a part of the wealth of the worlds 1,000 billionaires would suffice. We have the ability to do something about world poverty, disease and premature death, but we don’t. When a comparatively small amount of money would help save lives yet is not spent one has to conclude that such a situation is both unjust and morally puzzling. Why isn’t more done? One of the answers to that question in today’s world is that until the economic crisis that was precipitated in 2007/8 the dominant political philosophy of
neoliberalism has justified doing nothing, or at least doing nothing much collectively.

CAPITALISM AND NEOLIBERALISM

Contemporary health inequalities have developed within a world capitalist system with a long history. But capitalism is not unitary. It has developed through particular phases, the latest of these being global neoliberal capitalism. Contemporary capitalism also displays specific types, in the advanced nations these usually are viewed in terms of different kinds of welfare states. Despite its recent dominance, neoliberalism, based on the doctrine that economic growth solves all problems and that free markets and free trade are the best way to produce economic growth, has lost its credibility. Even before the current crisis, the ‘trickle-down’ theory of the benefits of capitalist growth had been decisively disproven, although powerful business interests have managed to keep it alive.

We are now in the midst of a global economic crisis and the future of capitalism itself is unclear. We may be faced with more of the same, a newly-regulated capitalism, or more radical changes. But whatever the long-term outcome, the hegemonic status of neoliberalism, the ideology and practice of the dominance of markets over society, has been seriously undermined. This particularly implies a challenge to the ‘surplus’ inequality produced by the pursuit of neoliberalism over and above the inevitable inequalities associated with any form of capitalism. Paradoxically, the dominance of neoliberalism and the vast inequalities it has created has led to increasing attention being paid to health and health inequalities as measures of human well-being, and a questioning of the economistic view which equates increases in GNP/capita with human betterment.

This change in the balance of class forces lies behind both national differences in health status, and the inequality in health within nations. Class mobilisation and politics are critical for health and health inequalities, because progressive social and class movements and parties are the dynamic forces pushing for improvements in the human condition, rather than simply more of everything for the rich. Improvements in human life require social struggle. Many if not most of the material benefits ‘brought by capitalism’ in the world today were only won after immense struggles against the powerful forces of capital seeking to prevent them.

Ironically, in view of the prominence in the literature on the social determinants of health of the idea that ‘social capital’, social cohesion and trust are key contributors to health, neoliberals attacked all forms of collective or state action. In their view we have to face markets only as individuals
or families. But the lack of non-contractual connections amongst citizens, which follows from the reduction of all social relations to market relations, implies a generalised increase in scepticism or distrust towards others. It is thus utterly perverse that so much is now being made of the notion of ‘social cohesion’ and ‘social capital’ as means to improved health status and more inclusionary societies within the OECD and the EU, where neoliberal policies have been almost entirely anti-collectivist.

The Anglo-American nations, and particularly the United States, have been instrumental in implementing neoliberal policies directly as well as through their influence on international organisations. Yet there is change. The IMF and the World Bank have been shaken in their fundamentalist beliefs through public opposition and the failure of many of the reforms they initiated. There are glimpses of recognition of the social embeddedness of economic life. The World Bank now focuses on poverty, social capital, social infrastructures such as health and education and not simply on free-market panaceas. Previous rhetoric about economies simply being engines to human improvement are now passé; economies, states and civil societies are viewed as parts of the same social formations, inextricably intertwined. Well-functioning and governed societies are as much a determinant of economic growth as economic growth is in producing improvements in human well-being. The conclusions of the WHO Commission on Macroeconomics and Health illustrate the reciprocal influence of economic growth and health.

While all countries were affected by neoliberal economic globalisation the social structures of some of the more social-democratic ones were more resistant to privatisation, commoditisation and attacks on welfare than were the Anglo-American nations. A major explanation for differences in welfare regimes or between nations with differing welfare profiles is a class or class coalitional perspective. Greater working-class strength and/or upper-class weakness, and various combinations of class coalitions and degrees of class cohesion and organisation, produce stronger welfare regimes – or at least help preserve them in the face of attack.

THE SOCIAL DETERMINANTS OF HEALTH

Any really serious analysis of health today starts out from the premise that health is more a product of the way we live than it is of health care. This approach began with Virchow, Engels and Chadwick who, in the 19th century, wrote about the stunting and early deaths of the working classes as produced by their horrendous living and working conditions. And, as McKeown showed, most health problems were indeed declining long before any medically efficacious remedies had been introduced.
determinants of health approach has been supported in recent years by reports
of the WHO Commission on the Social Determinants of Health.

Yet one must be careful not to push the social determinants of health
thesis too far. Health care is more important at some times than others,
and in some nations or regions more than in others. While material social
conditions may have predominated as causes of mortality until about the
1970s, after that time health care was of increasing importance in the
developed nations. This is partly because the richer nations had developed
a pattern of mortality in which most deaths occurred at older ages from
chronic diseases. For example, medical care has probably played a significant
role in the recent decline of deaths due to cardiovascular disease.\textsuperscript{16} Nutrition,
sanitary and social conditions are more crucial in poor nations. But the
 provision of simple primary health care such as oral rehydration therapy for
infants, and immunisation, could also radically improve the health of the
least healthy nations of the world. Underlying the increasing emphasis on the
social determinants of health is the traditional public health conceptualisation
of disease in terms of host, pathogen, environment interaction. Hence the
importance of adequate nutrition and water supplies which enhance human
robustness and individual resistance to disease. Health is produced by both
social factors and by healthcare systems.

Not only is the incidence of disease socially conditioned, healthcare
systems themselves are socially and politically determined. Even in countries
where there are few if any financial barriers to getting health care the poor
tend to receive less, or at least not as effective or as high quality, care than
the rich. The ‘inverse care’ law first noted by Tudor Hart,\textsuperscript{17} that health care
is provided in inverse proportion to its need, is still the rule, although more
so in nations with market-oriented systems.

Measuring health and health inequalities is not always straightforward.
Many studies rely on rates of infant mortality (IM) or of life expectancy (LE).
Infant mortality is assumed to more directly reflect current social conditions
(conditions that for example influence the health of mothers) than does
longevity. Life expectancy, especially in the developed nations characterised
by a high incidence of chronic diseases, is a product of long-time exposure
to various risk factors. Childhood deprivations play a substantial role in
influencing later health and development, which means that a life-course
perspective is important: past social conditions influence current patterns
of health. Both absolute and relative health inequalities are significant. A
decline in the Swedish infant mortality rate of 33 per cent would mean
that one more infant per thousand would survive to one year of age. In
Angola, on the other hand, the same percentage decline would refer to
an absolute change from 154 infant deaths per 1,000 to 103. Two nations could have similar relative inequality in mortality between manual and non-manual workers although one nation might show twice the absolute manual mortality rate of the other.

In leaving this issue something should be added about ‘socio-economic status’ or SES, which is used throughout the literature as an index of the factors which make up the social determinants of health. People with high SES do indeed live longer than those with less. SES, however, is a mere ranking of people according to income, educational attainment or occupational position. It reflects standards of living generally, and because these standards are related to many different types of disease, it is a good correlate of health status. But SES is itself a result of class forces. The nature of the capitalist class structure, and the outcome of class struggles, determine the extent and type of socio-economic inequalities in a given society, and socio-economic inequalities in turn shape the pattern of health – and of health care. But while many theorists of the social determinants of health proclaim an interest in the basic determinants of health and health inequalities, much of their literature omits any consideration whatsoever of the political and class causes of SES and the SES-health relationship. While they speak of analysing the ‘causes of the causes’ of disease, they seldom go far enough up the causal chain to confront the class forces and class struggles that are ultimately determinant.

EXPLANATIONS OF HEALTH INEQUALITIES WITHIN AND BETWEEN NATIONS

A seemingly obvious explanatory factor for health improvements is economic growth, because economic growth and improvements in health show parallel trends. The per capita incomes of nations (economic level) is highly correlated with their average health status although improvements in infant mortality flatten out at higher levels of GNP per capita. However, the relationship between economic growth and health is much less consistent and historically variable. The real difficulty with the economic growth argument historically, however, is that many factors co-vary with economic growth, particularly advancements in health-relevant knowledge, from understanding about water and milk contamination to more recent knowledge about the health effects of smoking and nutrition, as well as factors like administrative competence versus inefficiency, patronage or corruption. But crucial to all of these are the class struggles and social movements which help translate economic growth into improvements in human well-being.

Despite the high correlation of infant mortality and other measures of
health with national income, for the most advanced nations the notion that ‘national wealth is related to national health’ does not hold. Taking the thirty OECD nations, the richest in the world, higher GNP per capita is unrelated to average national health indicators, although for the non-OECD countries there is a close correlation between GNP and health status. This fact, in conjunction with the universal finding that, within nations, the higher the wealth or income the higher the health, has led to a variety of hypotheses seeking to link these two diverse findings.

Explanations of health inequalities amongst the rich and amongst the poor nations may differ because the rich nations show quite different disease and mortality profiles from poor countries. In the former, infant mortality rates are low and most people die after the age of 70 from various forms of chronic disease. In the poorest nations, infant mortality is high and the mortality pattern is characterised by the effects of infectious disease at early ages, though non-communicable diseases are also important in later life. These characteristics have led to the richer nations being viewed separately from the developing nations.

The most prominent, but still contentious, contemporary hypothesis regarding health status and health differences focuses on income inequality. Wilkinson has argued that the major determinant of the health of the developed nations (hence, of between nation inequalities) is not GNP/capita but rather the degree of income inequality itself. On this view hierarchy (i.e. a wide spread of socio-economic status) is related, through bio-psychosocial mechanisms, to lowered self-esteem. The influence of socio-economic hierarchy is shown, for example, by the fact that high level bureaucrats in the British Civil Service have better health than somewhat lower level managers, although the second group have ample access to adequate material conditions for good health. A further social consequence of inequality from the Wilkinson perspective is lowered social capital/cohesion or trust, which itself contributes to poorer health. Wilkinson’s explanation views income inequality as explaining both within-nation health inequalities (seen as an effect of the socio-economic status ‘gradient’) as well as the between-nation inequalities among OECD nations (seen as effects of their respective degrees of income inequality).

However, the income inequality hypothesis, while having many adherents, has been criticised on a variety of grounds. It is argued that the relationships found by Wilkinson are artifactual – if, in fact, the relationship between income and health within nations is curvilinear – any decrease in a country’s income inequality would ‘automatically’ bring increases in average levels of health because it would improve the health of the poor more than
it would decrease the health of the rich.\textsuperscript{23} My own approach and that of Navarro, Muntaner and colleagues is that income inequality is really a proxy for many forms of social inequality which all influence health and which reflect differences in the degree to which different regions or nations provide for the well-being of their populations.\textsuperscript{24} A broader conception of the causal sequence produces a picture of class-related structural factors which produce both elongated SES hierarchies (and many other kinds of social inequality), and worse average levels of health. Income inequality per se is important but it does not have the singular causal significance given it by Wilkinson and colleagues.

A third hypothesis, not very well explicated, implies that national differences in health and health differences within nations are due to the differential speed and spread of health-relevant knowledge, technologies and capabilities.\textsuperscript{25} Within nations those higher in status and education are quicker and more able to adopt healthy ways of living, and have access to more health promoting resources, than those with lower status and education. This would explain, for example, not only why the obesity epidemic in the richer nations mentioned earlier is worse in some than in others, but also why within the rich nations at least it is the poorer strata, those lower in SES, who now tend to be more obese. Similarly there are historical changes in cross-national and within-nation differences in tobacco use; in the past upper classes and wealthier nations had higher smoking rates, while the opposite is now generally true. There certainly is some evidence to support the view that economic growth and health innovations, for example, will, or can be, taken advantage of more quickly by the more educated and those with greater resources, than by the poorer and less educated.

What can reconcile these perspectives is a move away from the notion of particular ‘variables’ or separate factors producing health and health inequalities. Instead the three hypotheses mentioned could all be accommodated within a perspective which focuses on asking what particular types of society are associated with enhanced human well-being. We are talking about different kinds of society, rather than simply those with low or high income inequality or other single ‘variable’ explanations.

**OECD HEALTH AND HEALTH INEQUALITIES**

The Thatcher and Reagan regimes in the UK and the United States, followed by similar regimes in other Anglo-American nations introduced a new fundamentalist and dogmatic brand of liberalism. These regimes and their neoliberal policies are closely tied to rapidly increasing social inequalities. Prior to the 1970s income inequality was declining in the US
and the UK. However, beginning about 1968 in the US and 1977/78 in the UK, income inequality began a steep and rapid rise and both nations reached inequality levels that had not been experienced in decades. There was a massive enhancement of the wealth of the rich. The increases in inequality under Thatcher in the UK were mostly halted, although not reversed, under subsequent Labour governments. A similar but even more dramatic increase in income inequality was sustained in the United States during and after the Reagan regime. In the US the lowest 60 per cent of households actually experienced a decrease in after-tax income between 1977 and 1999. Dooley and Prause reveal that ‘American males in the 25th percentile earned less in real terms in 1997 (a year of supposedly ‘good’ economic times) than their 25th percentile peers did in 1967’. During the same period, the incomes of the top 5 per cent of households grew by 56 per cent and those of the top 1 per cent mushroomed by 93 per cent. Income inequality also increased in many, though not all, OECD nations.

However, not all countries were as neoliberal as the English-speaking nations. OECD data indicate that welfare regimes actually did what they were supposed to do, lessen poverty and inequality. Comparing nations, not only the US and the UK but also Canada and Australia show much higher income inequality than Switzerland, Germany and the Netherlands which, in turn, show higher inequality than the Scandinavian countries. After the turn of the century the neoliberal nations showed higher inequality than the still significantly social-democratic nations with Gini indices ranging from .32 to .38 as compared to the social-democratic nations range of .23 to .28 (the higher the Gini the greater the inequality). The incomes ratio of the top 10 per cent to the bottom 10 per cent of the population was even more extreme, averaging about 2.9 in the social-democratic nations and 4.66 in the neoliberal countries.

Not surprisingly, despite economic expansion in the 1970s and 1980s, health inequalities increased. A study showed all-cause inequalities in mortality between low and high SES areas to have risen amongst adults in the US by 50 per cent for males and 58 per cent for females from 1969 to 1998, while in Britain health inequalities between occupational classes and between deprived and rich social/geographical areas at the end of the century were higher than they had been for decades.

If we then examine national levels of health by directly comparing more neoliberal with the more social-democratic regimes amongst the more developed nations, we find that the neoliberal nations had poorer average levels of infant mortality for all decades from the 1960s through to the year 2005. Moreover, between 1960 and 2005 the US, the UK, Ireland and
Canada all ranked increasingly poorly relative to all the other OECD nations in respect to infant mortality. Using measures of ‘de-commodification’ as an indication of the degree of a country’s welfare orientation, rather than welfare state type, decommodification is much more highly related to national levels of infant mortality than is GDP/capita.\textsuperscript{33} Navarro and others have also shown that welfare measures, and health, are positively related to basic class/political institutions such as higher union membership or years of left political party power.\textsuperscript{34}

The more Social Democratic nations thus show greater equality, less poverty and better overall health status. 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 and lessened health inequalities. Even within the category of neoliberal nations the degree of market-orientation makes a difference. Studies comparing the United States and Canada, the latter with a more developed social welfare system than the former (including a public health insurance system), find that Canadians have better health status than Americans, as well as less income inequality and a weaker relationship between income inequality and health.\textsuperscript{35}

THE NON-OECD WORLD

For studying differences in health indicators between poorer countries there are as yet no fully developed equivalents to the typology of different kinds of welfare states used in the previous section although Gough, Wood and colleagues, Moore, and Labonte and collaborators have made steps in that direction.\textsuperscript{36} It is obvious, however, that class relations in the developing nations are different from those within OECD nations. The developing nations are much more diverse than the richer countries and show quite different political economies – many are either still mainly agrarian peasant-based economies, or are in transition from peasant to industrial societies, while others are highly industrialised. Moreover they are ‘developing’ in a world dominated by already developed states though market theories assume an approximately ‘level playing field’. Tommy Douglas, the father of medicare in Canada, had a saying for such a situation: ‘Everyone for themselves said the elephant dancing amongst the chickens’.

We mentioned earlier the huge differences in child mortality that exist between the developing and the developed world. 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.\textsuperscript{37} While some countries seem to have been
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successful in translating wealth into improvements across society, others have been less so. For example, despite India’s significantly improved per capita GDP in recent years, some Indian states have amongst the highest child and maternal mortality rates in the world.

Categorising nations according to under-five mortality levels, Ruger and Kim found three distinct groups: 117 low under-five mortality countries, 45 with mid-level mortality and 23 with high mortality. Thirty-eight of the 23 countries with the highest under-five mortality were in sub-Saharan Africa (the twenty-third was Afghanistan). A similar pattern was found in adult mortality (ages 15–60). Both these patterns of inequality in mortality persisted from 1960/70 to 1990/2000. This was especially true for adult mortality, in which gaps have actually become wider, primarily because of rising mortality in sub-Saharan Africa.

Average national health levels do not reveal within-country inequalities. Out of a group of 22 low- or middle-income nations studied over a three to six-year period in the late 1990s, 14 had increased inequality by income for under-five survival rates, while eight had less. 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.

There are similar inequalities in almost every nation. Within India the death rates for children under five in Kerala was 19 per thousand as opposed to 123 in Uttar Pradesh. Kerala also showed other positive health data, such as 80 per cent of children receiving vaccination compared to 11 per cent in Bihar. It is relevant that Kerala for many years had a communist led coalition government; literacy is amongst the highest in India at 91 per cent, the state has been ranked as the least corrupt, and political participation is high. China has achieved rapidly increasing economic growth in the past two decades, yet has witnessed a slowing of improvement in average health and rapidly increasing income and health inequalities. The under-five death rate is 8 per 1000 in Shanghai and Beijing compared to 60 in Guizhou, the poorest province. The situation is similar in other world regions – ten times as many children of the poorest 20 per cent of people in Bolivia are severely under height for their age as those of the richest 20 per cent.

The Structural Adjustment Policies of the IMF and similar programmes aimed at market liberalisation between and within nations created many more economic, social and health problems than they solved. Extremely poor nations, dependent on the IMF for loans, had little choice but to submit to lengthy lists of IMF prescriptions for smaller government, less subsidies, including for food or basic commodities, and moves towards markets in
health and health care. They often had to pay more to repay loans than on health and education combined. In some nations there was a net capital drain when debt repayments are taken into account.

It is true that most of the unhealthiest nations are also the poorest. However, there are wide disparities in health for nations at similar levels of GNP/capita. Vietnam has better infant mortality levels than Malaysia, which has over three times Vietnam’s average income. Sri Lanka has better infant and adult mortality levels than both Thailand and Indonesia, which have twice Sri Lanka’s income per head. Ecuador has just as good health data as the twice as rich Brazil. Costa Rica and Cuba are respectively middle income and very poor countries yet both have better adult death rates than the United States, one of the richest nations in the world. There are sometimes startling comparisons, even between the developed and the less developed world. The infant mortality rate among white people in the US is worse than Malaysia’s.

What differentiates poor nations with good health from less healthy poor nations? The evidence suggests that those which retain some control over their role in the world economy are both able to profit from processes of globalisation in terms of economic growth, and better able to translate that growth into improved health. One study compared the policies and policy 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, and had negative health outcomes. Malaysia, on the other hand, pursued its own independent policy, and the crisis had little impact on its health status. The author of this study noted the ‘importance of social safety nets and the maintenance of government expenditures in minimizing the impact of economic shocks on health’. Analysis of health and health inequalities amongst non-OECD nations leads to the following conclusions: 1) even among the developing nations high GNP/capita is not a necessary condition for good average national levels of health; 2) some types of economic growth, of ‘development’, are better than others. Some forms of development bring general improvements in health and fewer health inequalities, while others exacerbate inequalities. All of this is not to downplay the importance of economic growth for the very poorest countries. It is to recognise that to get out of economic poverty-health traps means focusing on how higher ‘human capital’ can improve national income and how national wealth can actually be translated into higher human well-being and not only on economic growth.
HEALTHCARE SYSTEMS

Much of what we have noted regarding the social determinants of health also applies to health care. Neoliberal policies undermined the positive social determinants of health and also weakened those social institutions which might have buffered the negative influence on health of weakened social structures. Health care can be classed in the ‘buffering category’. Whether or not nations had national health systems, as in Britain, or national health insurance schemes, as in Canada, or mixtures of public and private systems (in fact no system is entirely public, or entirely private), as in the United States and perhaps Australia, all must be considered, as Navarro has argued, as products of the differential balance of class power in these various nations. Higher working-class power and weaker right-wing power means more equitable healthcare systems. Many of the poorest nations in the world, however, do not have the funds to provide even the most primitive forms of primary care without external help. In many African countries the lack of infrastructure means that even the care that does exist is difficult for the poor to access. Other countries have quite mixed healthcare systems with good health care for some and very poor for others. Even in some OECD countries out-of-pocket payments, sometimes including bribes for healthcare workers, are common and a major barrier to access for the poor.

Healthcare systems are at the confluence of powerful forces – the healthcare industry, dominant providers such as the medical professions, states, and business interests. Navarro’s comments on class, referred to above, were intended as a corrective to the then prevalent idea that medicine determined everything within health care. He pointed out that medical power was contingent on the broader class structure of interests. Today, paradoxically, even within such countries as the United States, the collective financing of health care is as much in the interests of major sections of big capital as it is against it, though it contradicts key elements of neoliberal doctrines. Yet, internationally big capital, together with neoliberal international organisations, has pushed hard for the marketisation of health care in the developing world – even though the experience in the developed world shows that public systems, and perhaps single-payer systems in general, are more efficient and more effective than private systems.

A prime example here is Canada’s health system, contrasted with the complex mixture of mostly private ‘non-systems’ in the neighbouring US. US health care is more expensive, spends more money on administration, and covers only part of the population for a smaller number of procedures than does the Canadian system. But in policy-making for the developing countries these lessons were ignored. In the current crisis, a somewhat
chastened IMF and World Bank are departing from their previously ideologically rigid doctrines. The very poorest nations would in any case benefit more from improved nutrition, water and hygiene than from formal health care per se.

No matter what the form of financing and organisation, however, Tudor Hart’s ‘inverse care law’ is still in effect in both rich and poor nations. Studies in Britain and the more industrialised nations demonstrate that wealthier areas still tend to get greater funding than poor areas. Britain is in advance of most countries in policies aimed at bringing the poorest health regions closer to the national average. At the same time Britain and other nations are still being pressured to introduce ‘competition’ between the public and growing private systems which tend to cream the easiest and most lucrative cases from public systems. In Canada only the fervent support of the public has prevented governments from succumbing to the continual pressure from private health interests to commodify parts of the national health insurance system. Such pressure is inevitable within a capitalist system. Decommodified services, from health to education, are always in a continuous struggle to resist private takeover.

In the poorest nations, despite efforts to aim programmes at the most underprivileged, the rich continue to benefit more. In one study of 21 countries or areas within countries in 2003, the top 20 per cent of the population in income gained on average over 26 per cent of total financial subsidies provided through government health expenditures, while the lowest income quintile received less than 16 per cent. There are also, predictably enough, much greater inequalities in private than in government services, with income differences in service twice as great as in the public sector. In a study of fifty developing countries the distribution of six maternal and child services such as full immunisation and medically attended delivery were all regressive, favouring the more well-off, particularly regarding attendance at childbirth. In 41 developing countries full immunisation coverage was 66 per cent in the richest quintile compared to 38 per cent in the poorest quintile. For seven African nations, those most in need, the percentage of benefits of services gained by the top 20 per cent in income was five to twenty times higher than those gained by the poorest 20 per cent. One researcher concluded: ‘In brief, health systems are consistently inequitable, providing more and higher quality services to the well-off who need them less than the poor who are unable to obtain them’. In both China and India healthcare systems were increasingly privatised after the 1980s, although both nations are now trying to remedy the resulting inequalities and lack of services. India has one of the most privatised systems in the world producing
untold human suffering from disease and from the costs of health. The lack of public systems in many nations means that illness is a major cause, and not only the result, of poverty. In the meantime healthcare workers, trained at great public expense, are drawn off to work in Europe or North America. For example, 900 doctors and 2,200 nurses trained in Ghana are working in high income countries despite the fact that Ghana has only 0.92 nurses per 1,000 people while Britain, for example, has 13 times as many.\textsuperscript{50}

CONCLUSION

We are in the midst of yet another capitalist crisis. What is to come is unknown. Capitalism means market inequality. Neoliberal capitalism means extreme and far-reaching inequalities not seen since before the Second World War. Capitalism has brought unimaginable wealth for the few but that wealth coexists with the most profound poverty, illness, disease and personal stunting for billions of the world’s population.

How can there be health equality in fundamentally unequal societies? The wealth and resources are there, the equitable distribution is not. The very system which produces goods and services militates against their equitable use. But there is today a legitimation crisis touching on the core of capitalist beliefs and certainly the core of neoliberal ideology. The old certainties about economic growth leading to all good things are vanishing. When Jeffrey Sachs, one of the authors of Russia’s capitalist shock therapy, writes about \textit{The End of Poverty} and lauds the social democratic nations in \textit{Common Wealth}, something has changed. Even the central policy discipline and the main academic legitimator of free-market capitalism, economics, cannot evade re-examining its own premises, now clearly inadequate as documented even by its most prominent international practitioners.\textsuperscript{51}

The economic crisis from 2007 to the present had its roots in the rise of an unalloyed corporate dominance established in the 1970s and 1980s. The overwhelming predominance of business power exacerbated the tendencies within capitalism towards a huge imbalance between the immense profits and wealth of capital and the ability of the vast majority of workers to buy the goods and services produced. The ‘resolution’ of the crisis to date involves sacrificing the financial and social well-being of populations to save capitalism from the consequences of the dominance of capital itself.

Health reformers have been central critics of pure market capitalism and this is as true in the 21\textsuperscript{st} century as it was in the 19\textsuperscript{th} century, although recent critiques tend to avoid direct mention of class politics. A focus on health does lead to assessing societies, not simply by their GNP/capita but more by the degree that they improve the welfare of their citizens. And, it is in
improving the human condition throughout the world that neoliberalism has proved a dreadful failure.

No one now has legitimacy in an era of widespread and profound cynicism. However, it is clearer today than previously that there are alternatives. It is in such a field of contestation that a multitude of organisations, institutions, reformers, NGOs and individuals, some affiliated with traditional class organisations, others not, focus on some facet of human health and well-being and in so doing, challenge the limitations of a system based on the exploitation of the many by the few.

NOTES


3 Jeroen Smits and Christiaan Manden, ‘Length of life inequality around the globe’, Social Science and Medicine, 68(6), 2009: 1114-23.


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24 Coburn ‘Income inequality’ and ‘Beyond the income inequality hypothesis’.


32 UK Department of Health, *Tackling health inequalities*.


39 K.A. Moser, D.A. Leon and D.R. Gwatkin, ‘How does progress towards the child mortality millennium development goals effect inequalities between the poorest and least poor?’, BMJ, 331(7526), 2000, pp. 1180-82, Table 1.


44 V. Navarro, ‘Why some countries have national health insurance, others have national health services, and the US has neither’, Social Science and Medicine, 28(9), 1989, pp. 887-98.


