Wealth, health and equity: convergence to divergence in late 20th century globalization

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Introduction or background: Debate over relationships between economic growth, wealth, health and health inequity is long-standing and ongoing. The main message of this paper is that economic growth, while necessary, is not a sufficient condition in itself for achieving equitable health.

Sources of data: This review surveys and draws on research into principal factors commonly linked with improving health—income, health care, individual behavior—suggesting, using work from the Commission on Social Determinants of Health, that these are better understood in a broader social determinants of health framework.

Areas of agreement: The paper acknowledges that post-war globalization has seen significant growth, poverty reduction and greater economic resources at individual and household levels all of which can contribute to better health. But it also highlights renewing inequity in global health during the period.

Areas of controversy: It argues that over-reliance on market-driven growth, which fails to address deep-rooted social inequalities in economic resources key to accessing social determinants of health, and in the key determinants of health themselves have contributed to increasing inequity in health outcomes.

Growing points: Commitment to market-driven growth remains evident in national policy-making worldwide.

Areas timely for developing research: With increasing health inequity, and calamitous global economic events in 2008–09, the centrality of this commitment needs urgently to be reviewed.

Keywords: growth/wealth/health/health equity/social determinants/globalization
Introduction

Health is central to social well-being, yet it has been repeatedly overshadowed by economic growth as the primary concern of development in the twentieth century. Wealth does not guarantee the best health, nor does it ensure health that is equitably distributed.

Besides economic growth, the provision of health care and, in richer countries, influencing individual choice have somewhat dominated health policy and investments.1,2 Yet evidence from the recent Commission on Social Determinants of Health (CSDH) suggests strongly that it is a wider and deeper set of social determinants of health—and deeply rooted social inequalities in these determinants, either directly or as a result of inequality in the economic resources that underwrite their access—that condition health outcomes and their fairness. This paper does not disavow the general importance of economic growth, nor its value in increasing available resources at individual and household levels with regard to capacity to improve health. However, it argues that at the population level of health equity, growth in economic resources without attention of policies regarding distribution is insufficient.

Market-oriented economic policies that characterize the last quarter century of globalization have been accompanied by uneven growth, increasing economic inequality, deterioration and increased inequity in key social determinants of health, and a notable reversal in the trend in global health (as life expectancy), from convergence between countries before 1980 to divergence afterwards. A growing body of evidence suggests that over-reliance on markets to deliver conditions for health and under-attention to the kinds of social institutions and distributive governance that ensure adequate provision of, and equitable access to key health determinants, contribute to this trend. The evidence remains incomplete—in particular in low- and middle-income countries. A primary and fundamental action by States interested in improving health equity-related policy must be to strengthen the collection of data, disaggregated by social and economic stratifiers, in order to understand better and act more effectively on inequities as they become apparent.2

Development, health and wealth

Since Aristotle, concepts of the good life have centralized the role of good health. Health occupies a special position in relation to rights, for example, being not only a measure of the quantity and quality of the
individual’s life but, axiomatically, the necessary condition for the fulfillment of all other life goals.

Health has come to occupy a central position in the concept and practice of social development. Yet, in a curious example of teleological displacement, social development has, itself, come to be associated most closely with economic growth and national wealth. ‘Growth of real GDP per person has become a key policy objective virtually in all countries’. Yet wealth, understood as national income, has a complex relation to health and, perhaps more pressingly, to health equity. Whilst there appears to be a clear relation between individuals’ economic resources and the levels of health they enjoy, ‘the link between economic prosperity and health…is [by no means] automatic’. In 2004, one in six dollars spent in the USA was spent on health. In the last 30 years, US health spending as a proportion of GDP more than doubled. Yet the USA performs less well across a range of health outcomes including life expectancy at birth (LEB) than a number of other, in some cases much poorer, economies (Table 1). There is a growing sense that ‘GDP growth is a poor, or perhaps quite misleading, indicator of changing well-being’.4

For health, ‘the economic dimension is by no means the only one that matters…some would consider other dimensions even more important’. In other words, for good health, it is not only how much money there is available, but equally to what socially productive ends it is channelled, while for health equity, it is not only the productive investment of money, but the degree to which different social groups—whether stratified by gender, or ethnicity or class, or caste—are able to access and benefit from those investments.† Key policy conditions, in

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Source: Ref. 45.

†’Health inequity’ can be defined as health inequality that could be avoided or remediated but is not. Whilst ‘health inequality’ may describe differences in health between people and groups within and between countries, health inequity describes differences that are the consequence of social injustice. Health inequity will be used in this way throughout the paper.
this respect, are those relating to welfare financing, reducing inequalities in economic resources necessary to accessing health-related goods and services,\textsuperscript{7} and those relating directly to the entitlements people enjoy in a given polity to key determinants of health.

\textit{The Peoples Republic of China}

China is often celebrated as one of the great ‘winners’ of globalization. Certainly, China’s post-1978 economic reforms have produced ‘miraculous’ growth.\textsuperscript{4} But much of China’s improvement in health was achieved considerably before its period of major economic growth... (see Fig. 1) ‘mak[ing] it very hard to believe that improvements in health are the engines of economic growth... and present[ing] some difficulties for the ‘wealthier is healthier’ view.\textsuperscript{9}

Moreover, economic inequality and health inequity have risen dramatically in China during the period of reform and growth.\textsuperscript{8,10} ‘[T]he social determinants of health have become more inequitable; [and] imbalances in the roles of the market and government have developed. In 2003, public spending was 48 times higher in the richest than the poorest count[ries]’.\textsuperscript{8}

\begin{figure}
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\includegraphics[width=\textwidth]{income_mortality.png}
\caption{Income and infant mortality, India and China (UN data). Source: Ref. 9.}
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\textsuperscript{4}Much of the world’s observed reduction in absolute poverty can be attributed to reductions in China. In other regions, such as sub-Saharan Africa, rates of poverty actually increased over the same period.
Wealth, health and inequality

Level of national wealth alone does not guarantee a level of health equity. There are ‘major inequalities—inequities—within and between countries at all levels of economic growth’. In 2005, life expectancy for men in Calton, in Glasgow, Scotland was 28 years lower than those for men at another area in the same city (ibid.).5

Scandinavian countries have had remarkable successes in reducing inequality of opportunity, and increasing health status across their populations. These have been associated with strong welfare policies, using tax and transfer mechanisms to reduce income poverty among lower socio-economic groups. But even in these countries, some disparities in health have stubbornly resisted elimination.5 Marginalized groups, such as children of immigrants in Denmark, Iceland, Norway, Finland and Sweden were ‘more likely (compared with non-immigrants) to have stomach pain, headache, back pain, sleep disorders, dizziness and loss of appetite and low psychological well-being’ (ibid.). Canada has one of the healthiest populations in the world; yet significant disparities persist. Men in the lowest economic quintile in Canada have five fewer years of life expectancy than men in the highest quintile.11 ‘Injuries, including suicides, are the largest causes of potential years of life lost for First Nations on reserves... four times higher than the rate for all of Canada’ (ibid.). Inequity in health in Australia continues to reflect socio-economic inequalities; between 1985 and 1987, people living in the most disadvantaged areas experienced consistently higher rates of mortality.3

Globally, between the richest and poorest countries, life expectancy ranges from over 80 for women in Japan, to under 40 for women in some African countries. Levels of health inequality are persistent, though widely variable, among countries at lower levels of economic development. Brazil, for example, like other Latin American countries, has relatively large health inequalities, while comparable disparities in Vietnam are much smaller.6 The ratio of infant mortality rate between the richest and poorest in the population is 1.11 in Namibia and 4.17 in Bolivia (ibid.).

Pathways to health: wealth, health care, lifestyle, society

The Preston curve focused attention on the role of increasing national income. On the face of it, the curve appears to suggest that, up to

5 Life expectancy at birth (LEB) in 2005 in Glasgow: in Calton LEB was 54; in Lenzie North, it was 82.
a certain point (around $5000 per capita GDP), increasing national income strongly contributes to improving health; and that after that point, increasing income contributes little further (see Fig. 2). An alternative interpretation, however, is that the relation between per capita GDP—in and of itself—and population health is altogether more problematic, to the extent that at the left-hand side of the graph, countries at very similar levels of national income appear to be able to generate very different levels of life expectancy.4

Taking as given the fundamental and intuitive association of increasing income, reduced poverty and better health—richer people and richer countries tend to have longer, healthier lives and life expectancies, on the whole—the Preston curve raises questions about what per capita GDP actually signifies for population health and the distribution of health-related benefit; not least because, over time, the curve as a whole moves upward, suggesting other factors as well as income contributing to health. National income, in this sense, may reflect wealth at the level of individuals and the economic resources available to households, but it may also reflect public sector spending, or investment in medical technologies and health care, or in improving access to nutrition, treated water and sanitation;12 and it may reflect investments further ‘upstream’, in education or employment, or social protection. It is arguably the case that health equity can be better understood as the outcome of a combination of, on one hand, the level of economic resources in the hands of individuals and families, and on the other, direct access, provided on the basis of universal entitlement, to key determinants of health.

![Fig. 2 Preston curve, 2000. Source: Ref. 9, reproduced from Deaton 2004.](https://academic.oup.com/bmb/article-abstract/91/1/29/314341)
Health care

While increasing wealth has enabled investment in technological advances that have revolutionized the effectiveness of health-care services over the last 200 years, bio-medical models of the production of health have extended an arguably untoward dominance in policy and investment.\textsuperscript{13–15} Health care is, clearly, a vital determinant of health. But over-reliance on bio-medical intervention presents at least two problems for improving health and health equity.

First, health expenditure does not correlate with consistently better life expectancy (see Table 2). Health-care investments have been directed substantively towards curative care. Investments in the Primary Health Care model (as envisioned at Alma Ata in 1978) have remained the poor cousin. Yet, as the Commission on Social Determinants points out, poor health is not the result of poor medical care; heart disease is not caused by a lack of appropriate medicines; tetanus is not caused by a shortage of vaccine. Responding to the (increasingly chronic) burden of illness with (increasingly expensive) technical fixatives is hardly a rational (or cost-effective) approach if the developmental goal that unites rich and poor countries is the social production of good health. To understand population health and health inequity, it is vital to understand the health effects of wider social and economic policies than those embodied in the health sector alone.\textsuperscript{1} In the global context of a double burden of infectious and chronic diseases, and increasingly long-lived, ageing and chronically ill populations, health care that focuses on treatment is simply economically unsustainable.

Second, health-care systems, as currently commonly constituted, manifest an almost universal propensity to maintain, and aggravate, health inequity. The inverse care law\textsuperscript{16} suggests that, without attention to underlying social conditions, health-care systems tend to reflect and reproduce wider social inequalities, so that those who need health care most are those who are least able to access it, use it and benefit from it.

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Source: Ref. 45.
These questions lead—or should lead—to a more fundamental question: what do we mean by ‘wealth’ in general and in its relation to health? Deprivation in terms of income may reflect and lead to deprivation in a much broader set of resources, and deeper deprivation in terms of the power people have to shape the social conditions in which those resources are accessed. Wealth, in this respect, can be understood, like health, as a ‘multidimensional’ condition. The Preston curve supports the case for re-thinking what economic growth means for health, and for re-thinking ‘the very definition of development’.

Research conducted by the World Bank has shown that increases in income contributed only about ‘a fifth of the decline in mortality between 1960 and 1990’. The same research found that women’s education and development and application of technology contributed more strongly. The CSDH concluded that: ‘good and equitable health does not depend on a relatively high level of national wealth’. Rather, good health depends on a range of social factors—social determinants—such as education and health care, employment, housing and residential conditions.

None of this is to argue that economic growth and attendant increases in wealth, advancing health care and behavioural choices are unimportant in relation to better and fairer health. But it is to argue that the imagination of economic growth and health care as direct solutions in relation to complex socially embedded processes that produce population health is inadequate. It is to argue that wealth and health care—indeed the health-related behaviours people exhibit in patterned, stratified ways—need to be understood as embedded in wider social structures.

To understand the dynamics of wealth, inequality, deprivation, health and health inequity, it is important to understand inequality in both the material and the psychosocial dimensions—and to understand material and psychosocial factors as inter-linked. Health inequity is ‘deeply rooted in social inequality’, ‘[i]t is not simply that poor material circumstances are harmful to health; the social meaning of

\[\text{As economies grow in wealth, the classical epidemiological transition from a predominance of infectious disease, conceived of as exogenous to the individual, to chronic conditions conceptualized as endogenous, internalized in the behavioural choices of individuals’ lifestyles, can support an increasing emphasis on choice as a driving factor in people’s health in general and their relative health chances in particular. The assumption that individuals are all, equally, able to exercise a full range of choices with respect to the social conditions that affect health – that, therefore, the major role of the State is simply to provide individuals with the choices, or ‘opportunity’, to optimize their health experiences – does not adequately acknowledge the limits people experience, differentially depending on social status, in determining the conditions in which they live.}\]
being poor, unemployed, socially excluded or otherwise stigmatized also matters. A key missing ingredient in concepts of health focusing on economic growth, health care and the idea of behavioural choices is the role of social structure—social hierarchy—in determining how wealth, in its various health-related forms, benefits health across populations. A more articulate model of health and growth is one that explores the determinants of health, and the way access to these determinants is distributed within and between countries.

Global growth and health

The twentieth century has seen ‘unprecedented economic growth in many parts of the world’. Health—in the form of life expectancy, infant and child mortality and technological advances in care—has made enormous upward strides. But the process has been uneven, both with respect to trend over time and with regard to the distribution of these benefits amongst the world’s population. While some countries have prospered, others have been left behind. In the economic dimension, global inequality rose between 1980 and 2005. ‘[E]mpirical evidence... shows that the current era of globalization has not been associated with convergence in economic outcomes; instead less-developed countries have suffered from increases in international income inequality’. The ‘current era of globalization’ refers, roughly, to the last quarter of a century, from the end of the 1970s/early 1980s. It can be characterized by a newly emerging set of market-oriented economic policies initially among wealthy countries, but remarkably quickly and powerfully exported to low- and middle-income countries around the world—a newer, deeper version of globalization. This has had significant impacts on social determinants of health, with quite dramatic results in terms of health and health equity.

Market-oriented growth

In the decades after the war, prominently in the 1970s, and culminating in the call for a public health revolution at the Alma Ata conference, distributional issues dominated in international health debates and policy. Immediately following Alma Ata, however, emergent debt

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#Globalization can be defined as ‘the increasing integration of economies and societies – through flow of goods, services, capital and of ideas, norms, and peoples’.
††The emphasis of following analysis is on global health inequity, between countries, during the period.
crises among poor, heavily indebted countries, the second oil shock, seismic shifts in economic philosophy in the Soviet Union and China, and increasingly antagonistic labour relations in advanced economies, contributed to the emergence of a new (or revivified) model of classical, liberal economic management. Central to the model was the removal or reduction of the role of the State, and the elevation of the market as a principle socio-economic mechanism. The new model (called the ‘Washington Consensus’) emphasized “stringent macroeconomic stability, rapid liberalization of domestic markets, privatization of state-owned enterprises and public utilities, the removal of barriers to international trade and financial flows, and the search for market-based solutions also in the field of ‘public goods’”.24

**Structural adjustment**

A major lever in the rapidly influential spread and uptake of the Washington Consensus agenda globally was the series of ‘structural adjustment programmes’ (SAP) negotiated and in some respects imposed by the international finance institutions (primarily the International Monetary Fund and the World Bank) on poor countries in return for rescheduling their critically unsustainable debts. Structural adjustment included currency devaluation, liberalization of trade, deregulation and privatization to expand local access for foreign and transnational corporations. It also included major cuts in or caps on public spending in pursuit of fiscal austerity.

Few would argue that many poor countries in the late 1970s and early 1980s were in or verging on economic freefall, and that adjustments were urgently needed. But many have contested the process and severity of the resulting adjustment policies, not least in terms of the evidence of significant adverse impacts on health and health equity. Reductions in government expenditure on basic services were found to be key in the deterioration of child health and access to determinants of health.25 The Commission on Macroeconomics and Health found that SAPs had been broadly health negative in Africa.26 The Commission for Africa (2005) identified domestic austerity associated with structural adjustment as an important causal factor in the rapid rise of AIDS in Africa. Deceleration in the rise of life expectancy, and in reducing infant mortality in the Latin American region were associated with changes in public spending. ‘Adjustments in macroeconomic policies had a negative effect on social indicators, specifically those that had to do with health conditions in Latin America and the Caribbean’.27

The most egregious severities of structural adjustment have, at least on paper, been mitigated by newer generations of debt relief and aid
conditionality.‡‡ However, the underlying philosophy and major structural components of the Washington Consensus have remained dominant in global and national economic policy—in particular, continuing diminution of the role of the State, and expansion in the role of markets. This has resulted in ‘an over-reliance on markets to solve social problems’.18 And—as has become dramatically clear in the course of 2008 and 2009—markets are capable of failure.

Markets are, in the first instance, inherently poor at supplying public goods, including those critical to public health and health equity.8,18 Secondly, markets can actively increase inequality (between individuals, between groups, between countries), to the extent that their rewards tend to flow disproportionately to those with higher initial levels of assets (financial, human, institutional). Unfair distribution of ‘initial assets’ reflects deep-rooted social inequalities within and between countries, accrued through reinforcing generations, over very long periods of time. Markets, in and of themselves, are ill-equipped to correct for deep structural social inequalities.41,§§ The heavy market orientation of economic management and growth under contemporary globalization has proved damaging to the adequate and equitable provision of key social determinants of health, and hence to health equity. Three examples—reduced public revenue and spending, increased precariousness of labour, and fragmented and commodified health care—can be given.

Public spending

‘Universal public services and infrastructure played a vital role in historical development of today’s rich countries’. Economic growth is, clearly, vital in increasing the total wherewithal available to individuals, households and governments to finance health-productive supply and access. Without adequate public revenue, such investments are more or less impossible to make.28 The role of public spending in ensuring welfare in income terms for poorer households, in

‡‡For example, the growth of poverty reduction and pro-poor strategies in aid financing and debt relief mechanisms such as the Poverty Reduction Growth Facility.

§§Individuals privileged by chance of birth with higher educational attainment are liable to derive greater benefit from market transactions than individuals entering the market with lower educational skills. At the global level, countries entering the market with a few, basic commodities to trade (such as cocoa, bananas, coffee or tin) are likely to be more highly exposed to volatility in global prices they can command, and thus to significant fluctuations in national income with all the obvious consequences for investments in building human and social capital, than countries entering the market with a highly diversified range of primary and advanced commodities.
underwriting the supply of public goods and in ensuring attention to
distribution is well acknowledged. Globalization policies promoting
trade openness, however, have had a negative impact on indirect (trade
and tariff-related) tax revenues in particular in poor countries where,
in the context of often very weak direct (income) tax bases and insti-
tutions, total government revenues have been heavily hit (see Fig. 3).

The capacity of government to distribute (or redistribute) national
income is well established.

Empirical evidence from Latin America suggest very clearly that
small amounts of redistribution of income, via progressive taxation
and finance to social programmes for specific disadvantaged groups
can achieve more in terms of substantive poverty reduction than
years of strong economic growth. A key element connecting social
policies and health performance among the Nordic countries is the
reduction of relative poverty rates through State-led redistributive trans-
fers. The level of generosity of social protection transfers has been posi-
tively associated with reductions in poverty and infant mortality.

Fig. 3 Proportion of tariffs in total revenue by region, 1980–1998. Source: Ref. 18.

Strengthening national revenues to strengthen public health investments, improving
health and health equity in poor countries is, likely, a long-term agenda. A stronger tax
base depends on improving economic productivity and considerably stronger
institutional capacity. In the short- and medium-term, augmenting national income will
rely substantively on external sources of support (aid and debt relief). High levels of
debt are negatively associated with public spending; whilst aid, properly delivered, can
stimulate public spending. Yet aid from the major donors remains considerably below
the 0.7% of GDP to which OECD countries committed almost 40 years ago while,
notwithstanding some admirable achievements in debt relief under the Highly Indebted
Poor Countries (HIPC) programme, debt repayments continue to dwarf aid and other
income flows, further limiting national income for public sector spending.
In practical terms, reducing disparities in household income, and income poverty as a whole, through tax-related transfers has been shown to be an effective mechanism in improving health conditions in poorer sections of the population. The generosity of ‘family policies’ in Nordic countries have been associated with reduced rates of infant mortality irrespective of overall level of economic development. \(^1\) Similar benefits among poorer households’ health have been noted in conditional cash transfer programmes in countries such as Mexico (the *Opportunidades* programme) and Chile (*Chile Solidario*).

**Health care**

Health care in many countries around the world has been undergoing major reform. A key aspect of that reform has been to encourage private sector provision of health services relative to State-led health care, and to introduce user fees on public health care. This has led to fragmentation of service provision and increased costs. This kind of commercialization in care can lead directly to significant impoverishment. One hundred million people are pushed into poverty yearly through catastrophic household health costs that result from payments for access to health services. \(^31\) Out-of-pocket payments for health-care services generate utilization inequalities and impoverish women and lower income and socially marginalized groups.

Proportionally higher private sector spending on health (relative to all health expenditures) is associated with worse health-adjusted life expectancy. Public spending in health, in contrast, is positively associated with health adjusted life expectancy\(^32\) (see Fig. 4).

Public spending on health is significantly more strongly associated with lower U5MR levels among the poor compared with the rich. \(^18\) In both Asia and Africa, public spending on health has been shown to be effectively redistributive. \(^33,34\) Public health care spending has a greater impact on mortality among the poor than the non-poor.

Again, in practical terms, programmes such as the ‘Family Health Programme’ (PSF) in Brazil have shown positive impact on health inequity (measured in terms of infant mortality). The PSF, comprising a broad base of primary health services, focusing in the initial instance on poorer areas of the north and north-east of the country, showed greater positive impact in municipalities with higher IMR and lower localized human development indices. \(^35,36\)

**Employment**

The adverse impacts of unemployment on health are well-documented; economic resources consequent on availability of labour have a direct
impact on the capacity of individuals and households to finance health-positive expenditures. But the conditions of working life are also strongly contributory to health and health equity. Contemporary globalization has had unquestionably positive effects on employment (for example increasing employment and economic empowerment opportunities among women). But it has also had unquestionably negative effects on the quality of working conditions in both rich and poor countries. Competitive market pressure for lower production costs can drive down remuneration to labour, and dangerous relaxation of regulatory regimes. Companies seek the least expensive contracting relations with their labour force, leading to shorter term, non-formal employment agreements and increased ‘precariousness’ of job tenure.

‘In high-income countries there has been a growth in job insecurity and precarious work arrangements (such as informal work, temporary work, part-time work and piecework), job losses and a weakening of regulatory protections’. In poor countries, the majority of the workforce exists in the informal sector, unenumerated, largely unprotected by health and safety and other regulatory protocols. Exposures to health hazards tend to cluster in lower status occupations.

It is predicted that globalization-related changes in labour regimes will increase inequality in coming decades: ‘Labour market changes will lead to increased economic inequality in countries accounting for
86% of the developing world’s population over the period until 2030, with the ‘unskilled poor’ being left further behind. Conditions are expected to worsen under the current global downturn in productivity and labour demand.

Disadvantage with regard to availability and conditions of work feeds into relatively higher work-related adverse health outcomes, thus increasing work-related health inequality. Precarious forms of employment, for example, have been strongly associated with poor mental health (see Fig. 5). Perceived work insecurity has significant adverse effects on physical and mental health. Mortality is significantly higher among temporary compared with permanent workers.

Again, from the point of view of practical options for progressive action on the conditions underpinning equitable health, some countries have shown strong policy leadership in protecting access to employment and promoting labour demand. The Indian National Rural Employment Guarantee programme aspires to ensure 100 days minimum wage labour to one household member nationally. Whilst this is as relatively new programme, with considerable disparities in

Fig. 5 Effect of job insecurity and unemployment on health. Black bars represent long-standing illness and grey bars poor mental health. Source: Ref. 43.
practical implementation, there is evidence that the programme has had positive impact in states where it has been implemented properly.\textsuperscript{18}

**Conclusion: health and wealth—from convergence to divergence**

This paper does not take an ‘anti-growth’ stance. Increasing economic resources in the hands of the poor is vital—at the national, the household and the individual levels. However, evidence suggests that economic growth alone is insufficient to ensure health improvement and equitable health. To be sure, post-war improvements in global health, including health in poor countries, resulted in convergence in global health (measured as life expectancy) between 1950 and the 1980s. But in the decades after 1980, there is evidence of a reversal in the trend towards increased global health inequity\textsuperscript{21} (see Fig. 6). ‘[T]he emerging picture of variable mortality trends and regional setbacks indicates that future health gains are not guaranteed by any general deterministic process of convergence’\textsuperscript{38}

In many countries, not all of them were low income, LEB in 2001 was lower than in 1960, 1980 or 1990. While life expectancy in OECD countries has risen by around 3 years, life expectancy in sub-Saharan Africa overall has dropped by 6 years.\textsuperscript{24} Inequality between rich countries and the rest of the world has increased—with a 10-fold gap in under-5 mortality in 1990 rising to a 14-fold gap by 2000.\textsuperscript{39}

![Fig. 6 Dispersion measure of mortality (DMM), 1950–2000. Source: Ref. 44.](https://academic.oup.com/bmb/article-abstract/91/1/29/314341/1129314-341)
Some analysis of increasing health inequity during the latter period of globalization suggest that its effects can be largely attributed to special adverse conditions in the former Soviet Union (economic collapse) and sub-Saharan Africa (HIV/AIDS); some analyses suggest that these two regions are effectively anomalous exceptions in an otherwise positive picture. However, recent regression analysis conducted for the CSDH suggests that increasing health inequity between countries remains robust even with the removal of the sub-Saharan African group of countries, implying that the general trend in inequality in health cannot be explained by HIV/AIDS alone. This analysis suggests, instead, a broader set of factors, including ‘declines in revenue collection and public health spending associated with globalization-driven tax reforms, tax competition and informalization of the economy; rise in local conflicts... changes in the structure and stability of households; and...the slow or negative growth and soaring income inequality observed over the last 20 years in many developing and transition countries...’.

Some of the major adverse effects of global, regional and national health in the last quarter century can be traced back to structural reforms in growth-related policy, primarily shifting emphasis from States to markets. ‘[E]mpirical evidence from 25 post-Soviet countries from 1989 to 2002... finds that that mass privatization... significantly reduces male life expectancy by increasing heart disease, suicide, homicide and alcohol-related mortality rates with the greatest overall effect on working age men.40 While Russia has clearly undergone profound transformation in the dimension of privatization and trade liberalization, it has not undergone a parallel transformation in the quality of the ‘wider set of institutions conducive to long run growth’. It is arguable that this imbalance in attention between market mechanisms and the social and political institutions that are required to guide them in the direction of collective benefit is a significant factor in the disastrous impacts of Russia’s economic reforms on its health and health equity performance. So critical has the inequity impact of China’s reforms been that, at the beginning of 2008, “the government stated that ‘a wrong concept in the socialist market economy is that the medical and health care system should be market-oriented depending on market forces to meet the medical care needs of the people’.”

The evidence, across the board, suggests that economic growth and consequent wealth, on their own and without attention to distributive policies, do not assure countries of greater health. Economic growth, under-governed by institutions geared to ensuring fair access to and benefit from material and psychosocial resources, can reflect and reproduce deeply rooted and axiomatically unjust social inequalities. Social inequalities play through social determinants into inequities in health.
This is not inevitable and is certainly undesirable. The experience of East Asian countries over the last three decades shows how rapid growth can be achieved with low and even falling levels of economic inequality. It is suggested that this is, at least in part, the result of social policies aimed at reducing underlying inequalities in physical and human assets. Institutions matter for growth performance. But as importantly, if not more so, government activity—using public expenditure to ensure provision of ‘public utilities, infrastructure, regulation’ and other public goods—is vital to addressing inherent market failure (ibid.). Wealth cannot be dismissed as a fundamental contributor to better health. But economic growth on its own ‘will not be enough to improve population health, at least in any acceptable time’ (Angus Deaton in Labonte & Schrecker, 2007).

If markets fail to produce adequately and fairly the kinds of public goods on which good public health depends; if markets reflect and reproduce deep-rooted social inequalities whose nature is quintessentially unjust, under any terms of collective, uniform human rights; then the heavy reliance on the market in contemporary global growth policy presents a perplexing ideological commitment in the face of growing empirical evidence of unacceptable and iniquitous global harm. Altogether, a more nuanced analysis of the effects of globalization, and a more nuanced and balanced conceptualization of the important roles of markets and governments are urgently needed to strengthen efficacy and equity in economic, social and health policy-making.

References


