Chapter 1

THE LETHAL DIVIDE: HOW ECONOMIC INEQUALITY AFFECTS HEALTH

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What are the connections between globalization, growing inequality, and the health of populations? This chapter asserts that inequality is the fundamental cause of poor health and premature death. Global inequality has produced a world where millions die of preventable causes every year. Globalization, as described in the introduction, appears to increase inequality both among and within countries.[1] Thus, although a multiplicity of factors affect health, we posit that corporate-centered globalization alone will have a profoundly negative impact on international health in the twenty-first century.

Measuring the health of a group of people is different from looking at the health of individuals. We can assess various indicators of poor health—signs of illness, disability, subjective well-being—in individuals. But the measures used to gauge the health of a population typically involve comparisons of mortality-related rates such as life expectancy (average number of years lived at current mortality rates) or infant mortality (proportion of babies born that die in their first year of life).

All rich countries and a number of poor countries track births and deaths and publish rates annually, which makes comparisons easy. In poorer countries where vital statistics are not collected, surveys estimate infant mortality and other health measures with some precision. And since death is often the end result of long-term health problems, they are intuitively a useful indicator of patterns of illness and injury. This chapter uses lower infant mortality rates and longer life expectancy as indicators of better health.

What Produces Good Health?

Many discussions about human welfare do not attempt to identify the most basic determinants of health and well-being. Yet it's clear that the fundamental prerequisites for a healthy society are access to the basic necessities of life, such as adequate food, clothing, sanitation, housing, and health care. Much of the world today lacks the ability to provide those necessities, with an estimated 3 billion people living on less than two dollars a day.[2] Even worse, for many the situation is deteriorating: At least 100 countries underwent serious economic decline during the 1970s, 1980s, and 1990s.[3]

This kind of deprivation takes a terrible toll on the health of people living in developing countries. The immense health gap between people living in the poorest countries and those in wealthier countries is dramatically illustrated by comparing women's risk of dying from childbearing-related causes. In the industrialized countries that risk is approximately 1 in 2800, while in sub-Saharan Africa the risk is 1 in 16.[4] Infant mortality is as much as 15 times higher in much of Africa than in the developed world.[5]

Such global inequities are a legacy of colonialism, but they also reflect in large part a global economic order that maintains the advantage of the rich countries at the expense of the poor. And the desire of rich countries to maintain their advantage, while all the time espousing a desire to improve human welfare, is not new. A US State Department policy planning study in 1948 explicitly spelled out the task,

> The US has about 50 percent of the world's wealth but only 6.3 percent of its population. This situation cannot fail to be the object of envy and resentment. Our real task . . . is to devise a pattern of relationships which will permit us to maintain this position of disparity without positive detriment to our national security.[6]

Even in wealthier countries, we see a wide range in average life expectancy. For example, Japanese live 4.6 years longer than people in the US.[7] Clearly, spending on health care alone does not produce good health: The US accounts for close to half of the world's spending on health, and it ranks behind 25 other wealthy countries in life expectancy.[8]

Another prescription for good health in the developed world stresses individual behavior: Eating a healthy diet, getting regular exercise, avoiding smoking, and other "preventive" measures. However, when taken to the population level such reasoning often does not hold. The country with the highest life expectancy in the world, Japan, has the greatest proportion of smokers of all rich countries—Japanese men smoke at twice the rate of American men.[9] Even among smokers, mortality associated with this

behavior appears to be much lower in Japanese men than in American men.[10] Similar paradoxes can be found related to low-fat or other special diets, exercise, and other "healthy" individual behaviors. While we are not advocating that governments and employers cut back on measures that support preventive health care, the relative importance of individual behavior must be understood in relation to more basic determinants of population health.

In an effort to identify other factors, a number of research studies have focused on the relationship between a country's income distribution and its infant mortality and life expectancy rates. These studies found strong and consistent relationships between income distribution and health: A greater difference between the incomes of the rich and the poor within a country meant worse overall health.[11] The strength of this effect is maintained even after epidemiological correction for average incomes, rates of smoking, poverty, and other factors that might be expected to explain the relationship.[12] More recently, studies in the US show that wider gaps between the incomes of rich and poor people are associated with increased mortality rates, a greater number of teen pregnancies, violent crime, poor educational outcomes, and obesity.[13] After basic needs are met, people who live in settings with smaller income differences appear to be healthier.[14] With further research we may come to agree with Nobel Prize–winning economist Amartya Sen, who said, "I believe that virtually all the problems in the world come from inequality of one kind or another."[15]

Opinion is divided on the mechanisms that produce these effects, although most explanations are not mutually exclusive. A neo-materialist view suggests that a larger gap indicates there are more poor people who are less able to purchase material goods needed to maintain their health. This undoubtedly is at least part of the problem in very low-income countries. In contrast, a psychosocial interpretation posits that social anxiety and shame, which are created by living in a hierarchical social system, eventually produce poor health; in industrialized countries, this interpretation of the equity-health relationship is gaining currency. Central to the psychosocial interpretation is the concept of hierarchy or social stratification—which considers factors such as net worth, job status, lifestyle, income, possessions, dress, ethnicity, and language. In most societies, these markers ascribe value and worth to individuals.

Although hierarchy is not easily measured, income—a measure of economic stratification—is often used as a proxy for the social stratification that hierarchy represents. Yet however it is measured, in both rich and poor

settings, the association between inequality and health status is remarkably strong and consistent.

Growing Inequalities

What is the evidence that inequality is growing, and that it is related to what we call globalization? The extent of global economic disparities today is stark: per capita gross national incomes reported in 2003 for the 50 least developed countries in the world, containing nearly 700 million people, was $295, compared with $28,210 in the industrialized countries—nearly a 100-fold difference.[16] The growth of inequality since the 1970s, thought of as the period of globalization, is well documented in today's economic literature. The gap in incomes between the richest 20 percent and the poorest 20 percent of the world's population was 30 to 1 in 1960; 60 to 1 in 1990; and 74 to 1 in 1997.[17] By 1997, the richest 20 percent of the world's population shared 86 percent of the world's gross domestic product, while the poorest 20 percent had only 1 percent.[18] Conversely, between 1980 and 1993, a billion people saw their real incomes fall.[19] For example, the average African household consumed 20 percent less in 2000 than it did in 1975.[20] This trend of growing inequality also holds within countries, including many industrialized countries. In the US, the top 1 percent owned 22 percent of household wealth in 1976; by 1998, they owned 38 percent.[21]

Is there a strong link between the growing inequality and globalization? There are ample reasons to assume that there is. As explained in the introduction, we refer to globalization simply as the system of global capitalism as it has evolved since the 1970s. Underlying the current world order is an explicit requirement for growth of national economies, and an implicit requirement for the expanded role of multinational corporations in promoting that growth, while increasing their own profit margins. Trade is seen as the key to economic growth. And today's de facto trade rules effectively require markets in poor countries to be free or unregulated, while maintaining state subsidies for key industries in the industrialized countries. Those subsidies overwhelmingly benefit large corporations at the expense of smaller entities, even within the rich countries, and they wreak devastation on the poor. (More detail on the effects of trade agreements is provided in Chapter Seven.)

Although globalization and the growth of economic inequality occurred simultaneously, a causal association between the two phenomena is not easy to prove. However, a landmark trade agreement took place in 1993 that to many symbolizes the strategies and results of the "free trade" movement. The

North American Free Trade Agreement, or NAFTA, provides 10 years of evidence on the effects of the neoliberal approach to economic growth on inequality in Canada, Mexico, and the US. NAFTA promised to produce both jobs and prosperity in all three countries. Ten years later, analyses of the economic effects of NAFTA range from cautiously positive (by its proponents) to strongly critical.[22]

In Mexico, the NAFTA decade was a decidedly difficult one for farmers and workers. In the first five years, the purchasing power of the minimum wage dropped by 20 percent.[23] Farmers growing corn, the Mexican staple food, find themselves undercut by heavily subsidized American corn: Mexican farmers faced price reductions of up to 60 percent within the first five years of the agreement.[24] Economic growth in Mexico averaged an anemic 1 percent per capita annually for the NAFTA decade—a stark comparison with that of other countries such as Korea, which averaged 4.3 percent, or China, at 7 percent.[25]

In the US, NAFTA is documented to be directly responsible for a net loss of nearly 900,000 jobs between 1993 and 2002.[26] Although that number was small as a proportion of the national workforce, many more jobs were transformed from the relatively higher-paying manufacturing sector to the much lower-paid service sector. This change contributed to a growing income inequality within the US.[27] Not surprisingly, the benefits of NAFTA appear to have accrued primarily to the corporate entities that were its supporters in the first place. Despite growing evidence of NAFTA's failures, the US is currently negotiating similar trade agreements similar to NAFTA with countries around the world.

Globalization Harms Health

Some who support corporate-centered globalization claim that it has improved health in poor countries.[28] And health, measured by infant mortality and life expectancy rates, has steadily improved throughout most of the world during the 19th and 20th centuries.[29] Yet one way to measure how globalization has contributed to that improvement is by comparing health statistics in the 1980s and 1990s, when the current model of economic globalization became firmly entrenched, with statistics from the 1960s and 1970s. Improvements in life expectancy were significantly higher for most countries in the earlier period than in the later years.[30] Similarly, infant and young child mortality improved more quickly in the 1960s and 1970s compared with the following two decades.[31] Even national economic growth, an important measure of economic success for supporters of corporate

globalization, was higher for most countries in the two decades before 1980 than since then.[32]

More evidence linking globalization with declining health in poor countries comes from a study of infant mortality and the debt burdens of countries in sub-Saharan Africa between 1970 and 1997. In 1970, there was essentially no relationship between the severity of a country's national debt and its infant mortality. However, as the structural adjustment policies of the international lending agencies were put into place in the 1980s in response to staggering debt loads (see Chapter Four), the association between debt and infant mortality grew.[33] Structural adjustment led to higher prices for food and other necessities, such as education and health care, with well-documented effects on health. By 1997, countries with proportionately greater debt had significantly higher infant mortality than countries with lower debt.[34] Researchers estimated that without debt burden in this period, infant mortality would have been reduced by 15 deaths per 1,000 births, or 80 out of 1,000 instead of 95 per 1,000.[35]

In the Soviet Union, the quick switch to a capitalist economy, advised by US experts and national elites, led directly to declines in health. Between 1990 and 1994, life expectancy dropped significantly in nearly all of the countries in the former Soviet Union.[36] The declines were stunning, such as a life expectancy reduction of nine years for men and four for women in Russia.[37] Explanations for the declines were widely debated, but massive increases in inequality seemed to have played a major role. Even today the declines have not stabilized: In Russia, life expectancy for men continues to decline.[38] To date, the toll on human lives from this experiment certainly exceeds 10 million and may be closer to 20 million for the whole region.[39] This staggering number of deaths, which has received comparatively little attention, is comparable to the Soviet famines of the 1930s under Stalin.

Encouraging Examples

In a handful of developing countries, a commitment to equity has produced healthy populations. For example, the state of Kerala in India, as well as Cuba, Sri Lanka, and Costa Rica and some of the formerly communist states of Eastern Europe, have significantly lower infant and child mortality rates than other poor countries.[40] Equity-oriented policies in Kerala, one of the poorest states in India, include subsidized food distribution, effective land redistribution, a focus on universal primary education and health care services, and, finally, a vibrant public political consciousness that elects socialist governments and rarely re-elects the incumbent.[41] Health policy in

Kerala, which supports health and nutrition services equally across the entire population, contrasts sharply with that of other states in India where the wealthier population benefits proportionately more from state services than the poor. As a result, the infant death rate in Kerala is close to that of the US.[42]

A few developed countries also provide examples of successful equity-oriented health-promoting policies. Although the income gap has widened in Canada since the mid-1980s, taxation has helped to level the differences. Income redistribution takes the form of improved models of unemployment insurance and social assistance, and universal access to health care and education. These equity-promoting policies allow Canada to have one of the highest life expectancies in the world.[43] Sweden and other Scandinavian countries are even better at using fiscal policies to limit poverty. Various private, universal, and social transfers—as well as taxes and social assistance—reduce poverty rates by 19 percent in the US, 40 percent in Canada, and almost 82 percent in Sweden.[44]

Before World War II, Japan—now the country with the longest life expectancy and lowest infant mortality rates in the world—ranked poorly in these areas.[45] After World War II, Japan was compelled by American occupiers to demilitarize, democratize, and decentralize wealth and power. The army was abolished and spending on the military was drastically reduced. Corporate conglomerates were also broken up. (American politicians decided that these conglomerates, which dominated three quarters of Japan's industrial and commercial activities, were the architects of Japan's irresponsible government and they had to be dismantled.)[46] The Japanese government also instituted a successful land reform program. Landlords, who had been village elites, were replaced by a broad class of independent farmers.

Finally, the constitution was revised to give more power to citizens, separate Shintoism and the state, and include a very meaningful peace clause requiring that "the Japanese people forever renounce war as a sovereign right of the nation and the threat or use of force as a means of settling international disputes." More progressive than the American constitution, the Japanese constitution provided for free universal education, the promotion of public health and social security, the right of workers to organize and bargain collectively, and the right of everyone "to maintain the minimum standards of wholesome and cultured living."[47]

Obviously, Japan is a major economic power today, and shares the interests of other wealthy countries. However, the history of the country's reconstruction may be provocative, if not encouraging, to those seeking to improve global health through political and economic policies.

Conclusion

Unbridled economic growth and trade (or corporate-centered globalization) has contributed to economic inequality, and as we have seen, inequality suppresses the health and well-being of poor people all over the world. If improved human health in this globalizing world is a goal, then we must create and support economic and social policies that will positively affect health. When he received his Nobel Peace Prize in 2002, Jimmy Carter said,

> I was asked to discuss...the greatest challenge that the world faces. I decided that the most serious and universal problem is the growing chasm between the richest and poorest people on earth. The results of this disparity are root causes of most of the world's unresolved problems, including starvation, illiteracy, environmental degradation, violent conflict and unnecessary illnesses that range from Guinea worm to HIV/AIDS.[48]

As long as these extreme disparities persist, inequities in health outcomes, such as life expectancy and infant mortality, will persist. Clearly, achieving equity in health requires us to work well beyond the borders of the health care sector and secure safe food and water, decent housing, education, and reliable and reasonable incomes for the most vulnerable. These goals will only be accomplished through major social changes that will decrease inequality. Besides bringing those at the bottom up, it will also require those at the top to share wealth, resources, and power.