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Article

The relationship between relative deprivation and self-rated health among Palestinian women in refugee camps in Lebanon

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ABSTRACT

Background: Relative deprivation (RD) has been advanced as a theory to explain the relationship between income inequality and health in high-income countries. In this study, we tested the theory in a low-income protracted refugee setting in a middle-income country.

Methods: Using data from the 2010 Socioeconomic Survey of Palestine Refugees in Lebanon, we examined the relationship between RD and health among a representative sample of Palestinian refugee women ($N=1047$). Data were gathered utilizing a household questionnaire with information on socio-demographics and an individual-level questionnaire with information on the health of each respondent. We examined self-rated health (SRH) as the main health measure but also checked the sensitivity of our results using self-reported chronic conditions. We used two measures for absolute SES: total household monthly expenditures on non-food goods and services and total household monthly expenditures on non-health goods and services. With refugee camp as a reference group, we measured a household's RD as a household's rank of absolute SES within the reference group, multiplied by the distance between its absolute SES and the average absolute SES of all households ranked above it. We investigated the robustness of the RD–SRH relationship using these two alternative measures of absolute SES.

Results: Our findings show that, controlling for absolute SES and other possible confounders, women report significantly poorer health when they live in households with a higher score on our RD measure (because of either lower relative rank or lower relative SES compared to households better off in the reference group which we take to be the refugee camp). While RD is always significant as a determinant of SRH under a variety of specifications, absolute SES is not consistently significant. These findings persist when we use self-reported chronic conditions as our measure of health instead of SRH, suggesting that the relationship between health and RD may be operating through a psychosocial mechanism.

Discussion: Our findings underscore the importance of examining RD under conditions of poverty and in diverse socio-cultural contexts. They also highlight that public health approaches should be concerned with reducing social inequalities in low-income settings in addition to alleviating poverty.

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Background

Epidemiological studies have shown a consistent and strong association between absolute socioeconomic status (SES), measured by occupation, education, expenditures, or income, and health. Furthermore, considerable evidence has shown that health is also determined by the distribution of socioeconomic resources in an individual's context (Wilkinson & Pickett, 2006, 2007). In high-income settings, where basic material needs are satisfied and absolute income is above a certain threshold, health is associated

with inequality as well as poverty (Deaton, 2003; Kawachi & Kennedy, 1999; Lynch & Kaplan, 1997).

Income inequality links with health through a number of macro- and micro-level pathways. At the macro-level, income inequality is purported to lead to under-investments in public goods and services (Kawachi & Kennedy, 1999; Lynch & Kaplan, 1997). With increasing inequality, the interests of the more powerful and well-off classes – i.e., lowering taxes and reducing social spending – translate into under-investments in public goods and services and lower opportunities for the poor. Income inequality may also affect health negatively through the erosion of social cohesion and trust in a society. Kawachi and Kennedy found that states in the United States (U.S.) with higher income inequality

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exhibit lower trust and volunteerism, and lower self-reported health status (Kawachi & Kennedy, 1997).

Income inequality also exerts an effect on health through an individual-level psychosocial mechanism, of which relative deprivation (RD) is one explanatory variable (Kawachi & Kennedy, 1999, 2006). When individuals compare themselves to those positioned higher on the social hierarchy, feelings of RD ensue and activate stress mechanisms that negatively affect health. Thus, RD belongs to the family of psychosocial theories and advances that inequalities cause repeated exposures to stress that exerts wear and tear on metabolic, cardiovascular, and immune systems, thereby increasing susceptibility to illness (Deaton, 2001; Krieger, 2001; Marmot & Wilkinson, 2001). Supporting evidence for RD comes from research on primates that has shown an association between rank, stress, and mortality (Deaton, 2001). Early epidemiological evidence on the RD psychosocial pathway is based primarily on studies in high-income settings (Runciman, 1967; Townsend, 1979; Walker & Smith, 2002).

Empirically, RD is operationalized as a function of both absolute SES and a measure of the distribution of SES in the reference group (Wagstaff & van Doorslaer, 2000). There is no consensus, however, on what constitutes a reference and researchers have generally used the average SES in a demographic or geographic group as a reference (Yngwe, Fritzell, Lundberg, Diderichsen, & Burström, 2003). In some cases, researchers conduct a set of analyses using different reference groups and test which one provides the strongest association with poor health (Kondo, Kawachi, Subramanian, Takeda, & Yamagata, 2008).

Studies examining the link between income inequality and health, for which RD is one explanatory pathway, have shown mixed results. Whereas U.S.-based studies utilizing self-rated health (SRH) as the outcome measure provided supportive evidence (Kennedy, Kawachi, Glass, & Prothrow-Stith, 1998; Subramanyam, Kawachi, Berkman, & Subramanian, 2009), initial findings from European studies focusing on other health measures (i.e., mortality) did not (Mackenbach, 2002; Osler et al., 2002). On the one hand, the null findings in Europe suggest that the relationship between income inequality and mortality may be specific to the highly unequal context in the U.S., purportedly because European welfare benefits buffer the negative effects of income inequality on health. On the other hand, the divergent findings may be due to the nature of the health outcome itself, as subjective health may be more sensitive to inequality than an objective health measure such as mortality. In more recent cross-country analyses of European data, income inequality was found to weakly predict poor SRH in general, though the association was relatively strong in Eastern European countries due to causes of death related to smoking and alcohol use (Mackenbach et al., 2008). In Western Europe (i.e., the United Kingdom), absolute income remained more strongly predictive of SRH even after the inclusion of measures of RD (Jones & Wildman, 2008).

Only a handful of studies examined the RD-health association outside the U.S. and Europe; all revealed strong evidence that, above and beyond absolute income, RD is an important predictor. In research using a large probability sample of Japanese men and women, RD measured by the Yitzhaki Index was found to associate with poor SRH independently of absolute income (Kondo et al., 2008). Further, a study based on a nationally representative cohort of Costa Rican individuals aged 30 and over found a positive association between RD, measured by area-level Gini Coefficients, and mortality. Modrek, Dow, and Rosero-Bixby (2012) In South Africa, research linking income and mortality data between 1993 and 1998 has shown that multiple measures of RD significantly predicted mortality after adjustment for absolute income (Salti, 2010). Finally, research linking RD to adult nutritional status in rural Zambia found that a lower subjective perception of SES is

associated with a significantly lower body mass index (Cole, 2012). The results of these studies combined suggest that RD is an important predictor of health, sometimes independent of absolute income, outside the context of the U.S. and Europe.

RD presumably operates in societies where material living standards are adequate but where social inequalities exist. The theory has rarely been tested in low-income contexts despite accumulating evidence that income inequality is widening globally and threatening to block efforts to reduce poverty. As the detrimental effects of RD on health co-exist with the effects of poverty, it no longer suffices to promote poverty reduction alone as a policy to improve health. Reducing income inequality then is an important social policy approach to population health.

In this paper, we investigated RD as a pathway between income inequality and health in the low-income setting of Palestinian refugee camps in Lebanon. We examined self-rated health (SRH) as the main health measure but also checked the sensitivity of our results using self-reported chronic conditions. With the exception of a few studies investigating the pathways between social inequalities and health among Palestinians in Israel (Daoud, Soklone, & Manor, 2009a, 2009b), very few have specifically examined social inequalities within Palestinian refugee communities. Though the World Bank classifies Lebanon as an upper middle-income country, Palestinian refugee camps on Lebanese territory constitute pockets of poverty (Ramadan, 2013). Palestinians arrived to Lebanon as refugees in 1948 after the creation of the State of Israel; they currently number 450,000 according to the records of the United Nations Relief and Works Agency, UNRWA (UNRWA, 2013). For more than six decades, they have faced exclusionary policies that restrict their employment, property ownership, and other civil rights (Abdulrahim & Khawaja, 2011; Chaaban et al., 2010). More than 50 percent of Palestinians in Lebanon reside in twelve recognized refugee camps under conditions of poverty and overcrowding; the rest reside in “unofficial gatherings”, some of which have worse infrastructure than official camps.

UNRWA’s mandate is the provision of education, health care services, and relief to Palestinian refugees, but not legal protections, which are usually provided by the United Nations High Commissioner for Refugees (Knudsen, 2009). Palestinian refugees in Lebanon exhibit a low rate of secondary school completion and are banned from participating in syndicated professions such as engineering, law, and nursing. As such, most Palestinians are economically and spatially segregated from the rest of Lebanese society; those who work do so in the informal labor sector and half earn less than the Lebanese minimum wage (Garrity, Somes, & Marx, 1978). Palestinian women experience more disadvantage than Palestinian men due to the intersection of gender and ethnic exclusion; women who work are primarily segregated in jobs inside the camp and earn lower wages compared to men (Abdulrahim & Khawaja, 2011).

In this context of segregation, RD deserves examination as a potential explanation for health inequalities within the Palestinian refugee community in Lebanon. Moreover, as Palestinian refugees have universal access to primary health care through UNRWA’s clinics, they present a unique case for testing the RD theory, which proposes that the social inequality-health relationship cannot be explained by differential access to health care. Utilizing data gathered in 2010, we examined the relationship between the health of Palestinian women residing in refugee camps and two alternative measures of RD, each calculated using a different proxy measure of absolute SES (household non-health expenditures per capita, and household non-food expenditures per capita), with camp of residence as the reference group. To investigate the contribution of RD as a determinant of health, we added a measure of RD to standard determinants of health, which include age, chronic conditions (Garrity et al., 1978), household size (Wu & Li, 2012),

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