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Democracy and growth in divided societies: A health-inequality trap?

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ABSTRACT

Despite a tremendous increase in financial resources, many countries are not on track to achieve the child and maternal mortality targets set out in the Millennium Development Goals 4 and 5. It is commonly argued that two main social factors – improved democratic governance and aggregate income – will ultimately lead to progress in reducing child and maternal mortality. However, these two factors alone may be insufficient to achieve progress in settings where there is a high level of social division. To test the effects of growth and democratisation, and their interaction with social inequalities, we regressed data on child and maternal mortality rates for 192 countries against internationally used indexes of income, democracy, and population inequality (including income, ethnic, linguistic, and religious divisions) covering the period 1970–2007. We found that a higher degree of social division, especially ethnic and linguistic fractionalisation, was significantly associated with greater child and maternal mortality rates. We further found that, even in democratic states, greater social division was associated with lower overall population access to healthcare and lesser expansion of health system infrastructure. Perversely, while greater democratisation and aggregate income were associated with reduced maternal and child mortality overall, in regions with high levels of ethnic fragmentation the health benefits of democratisation and rising income were undermined and, at high levels of inequality reversed, so that democracy and growth were adversely related to child and maternal mortality. These findings are consistent with literature suggesting that high degrees of social division in the context of democratisation can strengthen the power of dominant elite and ethnic groups in political decision-making, resulting in health and welfare policies that deprive minority groups (a health-inequality trap). Thus, we show that improving economic growth and democratic governance are insufficient to achieve child and maternal health targets in communities with high levels of persistent social inequality. To reduce child and maternal mortality in highly divided societies, it will be necessary not only to increase growth and promote democratic elections, but also empower disenfranchised communities.

Introduction

In 2001 the member states of the United Nations agreed a series of Millennium Development Goals (MDGs) to be achieved by 2015. Among them, three related specifically to health. These are to reduce child mortality rates by two-thirds (MDG 4), maternal mortality ratios by three-quarters (MDG 5), and to halt and reverse the spread of HIV, tuberculosis, and malaria by 2015 (MDG 6). Despite some signs of reduced maternal (Hogan, Foreman, & Naghavi, 2010) and child mortality (Rajaratnam, Marcus, & Flaxman, 2010), progress towards these health MDGs has in many respects been disappointing (WHO, 2010). While most of the world's regions have made notable progress in both child and maternal mortality rate, regional averages conceal marked variation among individual countries, some of which have experienced substantial gains while others have lagged behind or worsened. For example, a recent assessment of progress towards the MDGs in Africa reported large reductions between 1990 and 2005 in under-5 mortality in, among others, Eritrea, Ethiopia, Madagascar, Malawi, Niger and Tanzania, while the situation worsened considerably in Botswana, Zimbabwe, Swaziland, Cote d'Ivoire, and Kenya (UN, 2008). An understanding of these differences is aided by the now extensive literature on the determinants of adverse health

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outcomes, in particular the importance of specific health interventions such as access to skilled birth attendants, as well as underlying socioeconomic factors, such as poverty and female literacy (Alvarez, Gil, Hernandez, & Gil, 2009; Rajaratnam et al., 2010; Schell, Reilly, Rosling, Peterson, & Ekstrom, 2007). More recently, economic consequences of chronic disease and HIV, with the resultant impoverishment of families, have been implicated in slowing progress towards the MDGs (Stuckler, Basu, & McKee, 2010a). In some countries, the effects of natural disasters, such as tsunamis or earthquakes, or human-produced crises, such as food price bubbles, financial crisis, or wars, have affected child and maternal mortality rates significantly (EU, 2009; Gakusi & Garenne, 2007; Lock, Stuckler, Charlesworth, & McKee, 2009).

There is a growing recognition of the importance of looking at what have been termed the "causes of the causes"(Marmot, Friel, Bell, Howeling, & Taylor, 2008), by which is meant the underlying social and economic determinants of health, such as income, education, employment, housing, and social inclusion (Stuckler, Basu, & McKee, 2010c). This has focused on the role of economic development and income inequality; richer, more equal countries have generally achieved better overall health outcomes (Frey & Field, 2000; Houweling & Kunst, 2010; Pritchett & Summers, 1996), while the benefits of greater aggregate income may be greatly reduced in unequal communities as it fails to improve the material conditions of deprived groups and inequalities impede the expansion of public welfare systems (Biggs, Basu, King, & Stuckler, 2010; Wilkinson, 1992; Wilkinson & Pickett, 2006). It is well recognised that economic growth is a precondition for improved health and basic capabilities but realising this potential is dependent on democratic governments channelling some of the resources generated into social interventions (Ahmad, Dreze, & Sen, 1991). Democratic governance is also thought to be an 'upstream' determinant of health outcomes, by affecting the accountability and responsiveness of governments to people's health, and by permitting better representation of the poorest members of a state who are generally the sickest (although there are contrary views) (Mulligan, Gil, & Sala-i-Martin, 2004). Greater levels of democracy are associated with lower infant mortality (Lena & London, 1993; Navia & Zweifel, 2003). Children in Africa born to the same mother before and after political changes have been noted to have disparate health outcomes; infant mortality falls when multi-party elections lead to a change of leader, but not where the incumbent wins or when the change of leadership is undemocratic (Kudamatsu, 2006). The analysis further identified that improvements in public health service delivery, rather than wealth, were the key mechanism by which democracy reduced infant mortality. There is also evidence, however, that the health benefits of democracy are mediated by the way that a country responds to external socioeconomic risks. Infant mortality is increased by the level of both multilateral corporate penetration of the economy and conditionalities from the International Monetary Fund, independent of other mediating factors, but democratic governance appears to mitigate these effects (Shandra, Nobles, London, & Williamson, 2004). These findings have contributed to a general belief among the global health community that the transition to democratic rule (democratisation) (Geddes, 1999) and economic growth are sufficient to create the socioeconomic conditions for improvements in health outcomes (Kim, Millen, Irwin, & Gershman, 2000; Pritchett & Summers, 1996).

However, the literature in anthropology and sociology has found this theory controversial; ethnographic analyses suggest that the process of democratisation and poverty-reduction (including aid programmes) are often so significantly destabilised by local political processes as to sometimes worsen health outcomes (Ferguson, 2001). The composition of the population in a country is thought to be a major determinant of how poverty and democratic governance will affect health. A number of countries that have failed to make progress on the MDGs have been characterised by inter-ethnic or religious tensions. Examples include Kenya and Cote d'Ivoire. It is plausible that, in a country where the population is heterogeneous, those in power may see themselves as having little in common with those facing a disease outbreak or persistent illness. This heterogeneity is often termed social 'fractionalisation' (Alesina & La Ferrara, 2005). Such analysis extends the work of Wilkinson and Pickett in the public health literature, which mainly focuses on income inequality as one important and intermediary component of the processes of overall social stratification and division (Wilkinson, 1992; Wilkinson & Pickett, 2006).

In circumstances of high fractionalisation, elites may be less willing to invest in public goods that benefit the entire population. Ethnically diverse countries have achieved lower rates of economic growth and worse educational outcomes as well as reduced investment in infrastructure when compared with countries that are ethnically homogenous (Easterly & Levine, 1997). Subsequent studies corroborated these findings with regard to health outcomes (Alesina & Spolaore, 2003; La Porta, Lopez-de-Silanes, Shleifer, & Vishny, 1999), although additional determinants also emerged, including a country's colonial history, legal infrastructure, and political persuasion (Lena & London, 1993). Public transfers are lower in more fractionalised countries (Alesina, Glaeser, & Sacerdote, 2001). Communities that are more divided are also less likely to produce public goods (Alesina, Baqir, & Easterly, 1999; Miguel & Gugerty, 2005), while, within the USA, states that are more racially divided have less generous welfare regimes (Alesina & Glaeser, 2004). Individuals living in more racially divided communities appear less likely to support redistributive policies, (Luttmer, 2001) although it is necessary to look separately at ethnic, religious and linguistic fractionalisation as they are poorly correlated to one another and show different associations with social outcomes (Alesina & La Ferrara, 2005).

Fractionalisation has been observed to exert the greatest adverse effect on economic growth where regimes are non-democratic (Collier, 2000), although this effect is mitigated by the existence of strong legal and political institutions (Easterly, 2001). Therefore, it could be argued that improved economic growth and democracy could overcome any negative effects of ethnic fractionalisation on healthcare distribution or the distribution of capital for expenses related to child and maternal mortality.

For these reasons, it remains controversial whether development agencies should push forth with a narrow agenda on democratisation and economic growth, or whether they should recognise explicitly the level of fractionalisation in countries when designing programmes to assist towards the health MDGs. Is promoting economic growth and democratic elections sufficient, or because of social inequalities should preferential treatment be given to those most disadvantaged? There is evidence that one reason why countries fail to improve is the exclusion of the disadvantaged groups (Gwatkin, 2005; Moser, Leon, & Gwatkin, 2005). However, if such fractionalisation does play a role, this may vary according to different levels of economic development and democratisation, or be inconsequential where there is sufficient growth and democracy, as some have argued (Pritchett & Summers, 1996).

In this paper we test the following hypotheses that:

a) Because fractionalisation can erode state capacity, the benefits of democracy in achieving improved social welfare programs to reduce maternal and child mortality are undermined by