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Angus Deaton on Health and Inequality

David Edmonds: *The media is full of bad news. This includes bad news about our health, crises in hospitals, cancer scares. But this marks a far more important development: the incredible improvement in human health. Mind you, the picture is sketchy; some parts of the world lag far behind others. What should be done about this inequality? Angus Deaton is a social scientist and the author of *The Great Escape: Health, Wealth and the Origins of Inequality*. His Princeton colleague, the philosopher Peter Singer, argues that aid is vital to combat the terrible mortality rates in some countries. Angus Deaton disagrees.*

Nigel Warburton: *Angus Deaton, welcome to Social Science Bites*

Angus Deaton: Thank you very much. I'm delighted to be talking to you.

NW: *The topic we're going to focus on is 'Health and Inequality.' I wonder if we could begin by talking about the long history of health. There's been a remarkable change in health in the last couple of hundred years.*

AD: Yes, and that's the foundations for where we are today. I mean, we don't expect to die as children or our parents don't expect us to die as children. And, by and large, we don't. And then we're making substantial progress on not dying as adults or as elderly as we beat back cardiovascular disease and most recently some of the cancers too.

NW: *When you say 'we', we're talking about 'we Americans?' 'We – Europeans?'*

AD: Well this sort of started in North---West Europe, like the Industrial Revolution started in North---West Europe, and then sort of spread out: first, to the colonies – as it were – Australia, New Zealand, the United States (I mean, I don't think of it as a colony), but the offshoots of North---West Europe, and then, sort of, Southern and Eastern Europe and then, really after the Second World War, widely to the poor countries of the world...and it's certainly not complete there.

NW: *In terms of longevity, is there any statistic on that?*

AD: One of them that's pretty amazing is that we're getting about three or four years every decade of additional life expectancy. And then, if you want to look at some poor countries --- for instance, immediately after the War when they started taking antibiotics; the germ theory of disease; spraying against mosquitoes --- there were some poor countries like Mauritius where life expectancy was increasing at three/four years every year – at least for a while.

NW: *But there have been setbacks along the way. Obviously, the Spanish influenza outbreak after the First World War had tremendous impact.*

AD: Yes, and two of the ones I talk about in the book are the Great Chinese Famine of 1958---1960 which was a great political catastrophe (and I think recent scholarship has shown that there were no weather---related events or any real reason why there should have been a famine and that it was a politically driven famine; and a tremendous amount of responsibility rests on the shoulders of Chairman Mao); the other great disaster, of course, more recently, is the HIV/AIDS epidemic.

NW: *So, this overall progress despite the occasional blip, as it were --- large---scale blip – is due entirely to medical advance, is it?*

AD: I don't think so. I think medical advance has been very important but, especially in the early years, a lot of it was more like basic knowledge: cleaning up water supplies, for instance; more public health. I mean, it's all medical knowledge; on the other hand, the way we often think about it is that physician---assisted healthcare system and that has very little to do with what we think of as public health – like water supply, clean water...also, smoking nowadays which is a very very important, determinant of mortality in rich countries today.

NW: *So do you see this as a trajectory that's going to continue --- t can't continue forever, presumably --- but we're going to see increased longevity as the years go by?*

AD: One could hope so. And there's some scholarship which suggests that the biggest increases in life expectancy or the biggest declines in mortality are happening among very old people so that there are gains even at that end of the thing, you know. So you can expect more and more people to live to be a hundred years old. I mean, one of the things I say in the book is that a young upper class girl born in an upper---middle class family in the United States today probably has about a 50/50 chance of making it to a hundred, and, given the declines in disability and so on too, she'll probably dance at the party! So, that's the optimistic view. The more pessimistic view is that 250 years is not such a long time in human history; there were great episodes of economic growth in China in the 11th century and been scattered around the world and all have come to an end. I mean, none of them lasted for 250 years. But it could be, a thousand years from now, we'll look back at this as a flash in the pan and we'll be sort of back to the horrors of the past.

NW: *Well, you mentioned economic growth there and until now we've talked about medicine and increases in hygiene and so on. So obviously there is a connection between economic flourishing and health. But how do you tease that out?*

AD: I think it's very hard. So, some people will argue that economic health is the precursor for all health progress too and that without the growth you're not going to
www.socialsciencebites.com Deaton December/2012

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get much health progress. Other people argue that without the health first, you're not going to get much economic growth because people have to be healthy to take benefit of it. I'm more on that side but it's clear that this is very historically specific and contingent, so it depends on what sort of health improvement you're talking about. Improving health for babies is not the same and does not have the same economic consequences as improving the health for fifty yearold males who might be dying of heart attacks. So you've got to be more specific about what's happening here.

NW: *Well, let's be a bit more specific. What would you say are the precursors of a flourishing economy in terms of health? Should we be targeting the very young work--aged males or work---aged females? What is the target group and what sort of mechanisms can be used to influence outcomes there?*

AD: I resist a little bit the notion of targeting, because saving lives is a good thing wherever it happens. We don't have to justify improving health in terms of economic growth. If it has no effect on economic growth, it is still a damn good thing to do. There was a huge reduction in mortality amongst babies in the Third World – say – after 1945 and through into the sixties and seventies and still going on. That produced a lot of kids, who would have otherwise died, who are now there. They are mouths without any hands – as it were – they have hands but they're not workers and it's going to be a while before they're workers. So you do get a situation for a period of twenty or thirty years with a lot of extra dependents who wouldn't have otherwise been there. And you wouldn't expect them to do very much for economic growth *then*, even though, they'll do a lot for economic growth later. So, it's a complicated question and I'm not sure you'd want to target some particular group.

NW: *I know you've got a special interest in India. Could you say a little bit about your research there?*

AD: Well, I mean, India is a fascinating place because there's been this extraordinary economic growth over the last twenty or thirty years. And there are enormous disputes about who benefited from that and who didn't benefit from that and whether this has opened up enormous gaps. I mean, it clearly has to some extent because there are billionaires in India. Very rich people live in gated communities and are basically living a lifestyle that's no different from if they were living here in London or in New York. On the other hand, if you go to the rural villages in Rajasthan, for instance – where I worked – there's not that much visible progress. I mean, there's some but it's certainly none of this wealth seems to be being shared there. One of the most extraordinary things about India is that, in spite of this economic growth and in spite of it being classed by the World Bank as a middle---lane country, it's not a poor country anymore. Almost a half of all Indian children are severely malnourished, meaning they're way off their growth charts in the negative direction.

And we don't really know what that is. I mean some of it is that the growth has not been widely shared. Some of it is it may take generations to catch up once people start becoming richer. My guess is that at least some of it is the fact that the reason you could get so many people living in the Gangetic plain over hundreds and hundreds of years is that they had to become very small and they all had to be vegetarians essentially because that's the only way you could support a large number of people. I think it'll probably take three or four generations for that to unwind. So, my guess is, given another fifty years, Indians will not be nearly as short as they are now. But on the inequalities, I don't think – in a general, at least, income sense – India's quite so unequal as many other places around the world. And the other thing that's worth remembering is the biggest inequalities in the world are *between* countries – not within them. So they're just the huge income differences between the United States, Japan and Western Europe and places in Africa, just unimaginably large.

NW: *So there are these inequalities between countries in relation to health. Does it matter?*

AD: Yes. It does matter, though, what it leads you to want to do is much more controversial. You know, these big health inequalities are largely to do with the fact that you have a pretty high chance of dying before your fifth birthday, if you're born in the wrong place. If you're born in Britain or you're born in the United States, you're almost certainly going to make your fifth birthday. If you're born in Sierra Leone or you're born in Mali, then that's much less so. And it's not very long ago, in places like Mali, where half of all kids didn't make their fifth birthday. So the first thing you have to ask yourself is "What are these kids dying of?" Well, some people might think: "Well, there's dying of these weird, exotic diseases that come out of the jungle that you read about in bestsellers. You know, where some animal comes out and bites you and then everybody starts dying in an explosion of blood and all the villagers run." It's not like that at all. They're dying of things that we've known how to fix for the better part of a hundred years. I mean they're dying of diarrhoea; I mean they're dying on pneumonia and so on. So this, in some sense, is just an outrageous scandal that these kids are dying from things that we've known how to fix a really really long time ago. And in some countries, like India and Brazil, there are great modern hospitals that look like the hospitals in London, where the rich people go when there are kids dying on the streets not very far away. So these inequalities just seem absolutely outrageous. They're something where you ought to do something about. The question is what.

NW: *Do you have a take on what might work in that situation?*

AD: Well, one of the things I write in the book is that I'm sceptical as to whether foreign aid – aid from outside – is very effective in doing very much about this. And

it's not that it's not effective on the health side. In fact, one of the great triumphs of foreign aid today – I've been talking about babies but let me switch to adults – is there are large numbers of people who would be dead from HIV/AIDS who are alive because of antiretrovirals that were provided by the Global Fund or by PEPFAR from the United States and so on. And that's just terrific. The down side of that, as with all aid, is that in the end you have to have your own indigenous health service which is actually run by the people according to their needs. I mean, if someone else is running your health service and you have an election in some foreign country where someone decides "We're not going to do HIV/AIDS anymore, we're going to do maternal health" so all these people get to die whilst they start refocusing. I mean, that shouldn't happen; I mean this should be done within the countries. One of the undesirable consequences of aid, on this side, is that it undermines these local institutions.

NW: *Isn't another major factor the high price of pharmaceutical products that have been patented in the West? And companies want to make a lot of money out of these and they're not prepared to reduce prices to a level where the poorer countries can buy them in sufficient quantities to make a difference.*

AD: That's an issue that one always has to watch out for. And it's been very very controversial but mostly over the HIV/AIDS drugs and that seems to have been largely resolved which means that people in poor countries are getting those things and the pharmaceutical companies are relatively happy. You'll find different opinions about other drugs as to whether that's an issue. I mean, the WHO has a list of essential medicines which every country has; almost none of those are still patented and they are available for very small sums of money.

NW: *Were you sceptical just about governmental intervention or about non--governmental organisations as well?*

AD: I think it's easy to feel that it's the governments that are the problem and the NGOs are good guys. That's much too simple. I mean, there are a lot of really bad NGOs out there. I mean, when you think of NGOs, you think of Oxfam but there are also fundamentalist religious groups or crazy people out there of various sorts who are coming in to help people according to their light. The National Rifle Organisation is an NGO just as Oxfam is an NGO. So it's not entirely clear that you can lump all these NGOs together. But, I mean, NGOs have some of the same problems. You know, what the government spends is sort of fungible. So if NGOs are doing the jobs that governments need to do, it's taking the pressure of the government to provide these things. And it's also stopping the political agitation that needs to take place by people in the countries to get their government to do these things because someone else is doing it for them.

NW: *This sounds almost like Buridan's Ass. There's this donkey between two bales of straw and equidistant between them and can't get to either one because he can't make up his mind between the two of them. Here, we can't get the funding from the local government because they're not very efficient but if we were to put it in from outside, that's not going to work either because then the government certainly wouldn't give you any money. So the poor ass – the poor person – starves.*

AD: Right. We don't want the donkey to starve. But here's a practical way of dealing with that: let's tell the HIV/AIDS or the health services that are being provided broader that we will do this for ten years. And at the end of the ten years we're done. So, you've got time to do something about this and also the people who are getting these services have time to agitate and come back and say "Look, you've got to do this for us or we'll vote you out or we'll come and kill you or we'll burn down your house" or things like that.

NW: *Isn't this slightly dangerous as a message? I could think of somebody listening to this now having a very good rationalisation for not giving money to a charity that works in a different way that doesn't present licensed help but actually presents long-term help.*

AD: One of the things that happens to me all the time is, Princeton has some very very good, very dedicated students and they'll come to see and say "What do you want us to do? You know, you've sort of persuaded us or maybe you've persuaded us but we go to Peter Singer's class and Peter Singer tells us, you know, we've got to hand over everything we have. What should we do?" and I say well there's something you really can do which is really important. We're doing a lot to seriously hurt developing countries right now by our trade policies, by our commercial policies. You talked about the licencing policies for pharmaceutical drugs, for instance. When the US does a bilateral trade deal with Honduras or with some small country, there's a battalion of lawyers from the pharmaceutical companies in the room. Whereas, the poor developing country, that's signing this treaty, has one guy with a Masters degree from Leeds or something – you know – who's the lead negotiator on that. Now, that's outrageous, right? And if the US really wanted to help these countries, it'd help them staff up their delegations so they'd get a more reasonable playing field for this deal. Of course, the US is not about to do that because the pharmaceutical companies own the government --- well, that's maybe a *little* too strong but you can see the problem. And you can become a little cynical about this, in the end, which is you believe the US will do anything to help people provided it doesn't hurt it in any way at all. And, I think we have to face up to that. I mean, we're selling arms all over the Third World. What sense does it make to say we really care about health in the Third World when we're selling arms to them all the time? So there's a lot of things my smart kids can go do in Washington where they have a standing and a legitimacy to speak and go and say "Stop this!" you know, "We're really doing harm there."

NW: *Now, your work crosses disciplines to some degree but would you say you're broadly within the Social Sciences?*

AD: Yes, I think so. I think one of the best things that has happened in recent years, and it happens a lot where I sit, is a much greater broadening of Social Sciences and much more inclusive view of Social Science. I've been lucky: I mean, I teach in a Public Policy school as well as the Economics department where we have people from many different disciplines. For five years, I had the office next to Danny Kahneman – I mean that was a very opening experience for me and maybe for him too. I mean, we wrote one paper together; we argued a lot. And there are terrific practical philosophers like Peter Singer but many others at Princeton. There are very good political scientists who are working on issues like inequality and so on. So, it's actually very easy to spread out and get high quality help across that discipline. The Demography for me was a little harder. A lot of the health and Demography stuff – we don't have a school of Public Health or a Medical school at Princeton.

NW: *So that's really interesting because it suggests that the way a university is organised, in terms of departments and faculties, can affect the ease with which certain subjects/topics can be investigated.*

AD: Absolutely. I think that's not widely recognised but it's very very important. Academic departments should not be cast in stone for generations: they get turned in on their own problems and it's important to shuffle them around. I've always argued that all the offices ought to be shaken around like a saltshaker every five or six years so you get to sit with a different set of people – maybe not nuclear physicists or quantum theorists, but something where there's some synergy and where you talk to each other and things happen. I mean the other thing that's been very important in economics is a much closer link with psychology so I work mostly with psychologists nowadays and that's been a big change for me and opened up all sorts of interesting frontiers.

NW: *Angus Deaton, thank you very much.* **AD:** Thank you. It's been a real pleasure talking to you. [ends]