

The impact of income inequality on self-rated general health: Evidence from a cross-national study

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Abstract

Previous studies report a strong negative association between income inequality and population health at the aggregate level. However, it is still in hot debate whether this ecological association indicates a genuine, causal effect of income inequality on health, as asserted by the Wilkinson hypothesis, or it simply reflects a nonlinear effect of individual income on health, as suggested by the absolute income hypothesis. Drawing data from the 2005 round of the World Values Survey, I analyze the relationship between individual income, income inequality, and self-rated general health in a multilevel framework. Results show no independent detrimental effect of country income inequality on individual self-rated general health. In contrast, self-rated general health is strongly associated with absolute material conditions both at the individual and at the country level. Therefore, this study gives more evidence to the absolute income hypothesis, i.e., the strong ecological association between income inequality and population health is more likely a reflection of the nonlinear effect of individual income on health rather than a genuine effect of income inequality.

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1. Introduction

Health inequality, both between and within societies, has become a major concern among studies of social inequality in recent decades. It is well documented that within almost all societies, there is a socioeconomic gradient with respect to health, and higher socioeconomic status (SES) is always associated with better health status (Feinstein, 1993; Robert & House, 2000). In fact, not only do people at the top of the SES gradient enjoy better health than those at the bottom, but also health deteriorates continuously as the ladder of the SES hierarchy

goes lower for all levels of SES (Marmot, 2003; Robert & House, 2000).

Despite the persistent SES-health gradient within societies, international inequality of health is only weakly associated with the level of economic development, especially among developed countries (Preston, 1975; Wilkinson, 1992, 1996). In contrast to the weak association between population health and national wealth, a substantial number of ecological studies show that country life expectancy is negatively associated with societal income inequality, even after controlling for the level of per capita income (De Vogli, Mistry, Gtnesotto, & Cornia, 2005; Flegg, 1982; Ram, 2006; Rodgers, 1979; Wilkinson, 1992, 1996). Specifically, life expectancy in more unequal societies is shorter than in more egalitarian societies. In addition to life expectancy, similar associations are also found between

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income inequality and other indicators of population health, such as infant mortality, age- and cause-specific mortality, mean age at death, self-rated health, population height, and the homicide rate (Flegg, 1982; Hsieh & Pugh, 1993; Qi, 2011; Rodgers, 1979; Waldman, 1992; Wilkinson, 1996). Moreover, the association between income inequality and health has also been observed in certain within-country studies, such as between states and metropolitan areas in the United States (Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Kawachi & Kennedy, 1997; Kennedy, Kawachi, & Prothrow-Stith, 1996; Wolfson, Kaplan, Lynch, Ross, & Backlund, 1999).

The observation of an ecological negative correlation between income inequality and population health has attracted a lot of attention from various disciplines of social sciences over the last two decades, and it still remains one of the most controversial topics in social studies of health (Lynch et al., 2004; Mackenbach, 2002; Wilkinson, 2002; Wilkinson & Pickett, 2006). Two competing theories dominate the debate on explaining the ecological association between income inequality and population health: The Wilkinson hypothesis claiming that income inequality has a genuine detrimental impact on health, and the absolute income hypothesis that emphasizes a nonlinear effect of individual income on health and argues in favor of an instance of ecological fallacy. Nevertheless, these two hypotheses cannot be adequately evaluated by ecological studies, and the debate calls for an examination of the independent effect of income inequality on health by controlling for individual SES markers simultaneously in a multilevel framework.

Drawing data from a large cross-national study project, the 2005 round of the World Values Survey (WVS), this study aims to examine the “income inequality-health” association and test these alternative hypotheses. Compared with previous studies of this kind, the current study fills the gap of the existing literature in several key aspects: First, although there are a large number of within-country studies that have taken the multilevel approach, cross-national studies that are cognizant of this point are still limited. Second, in the existing international multilevel studies, with a few exceptions (Jen, Jones, & Johnston, 2009; Mansyur, Amick, Harrist, & Franzini, 2008), the number of countries included is usually very small and only restricted to a subset of the European countries, hence calling for further investigations with a much larger and diverse sample of countries. Third, for the two available studies with a large number of countries ($N > 30$), the findings are puzzling. Both Mansyur et al. (2008)

and Jen, Jones, and Johnston (2009) report a significantly positive effect of income inequality on individual self-rated health, which is not in line with any known explanations. And finally, international comparability of both income inequality measures and self-rated health is crucial for a valid empirical assessment of the relationship between income inequality and health, but has been largely overlooked in previous studies. This study uses an adjusted income inequality measure that is more comparable, and the two appendices (Appendices B and C) discuss these problems in further detail.

2. Theoretical debates on income inequality and population health

2.1. *The Wilkinson hypothesis*

In a series of publications, Wilkinson (1992, 1996, 1997, 2005) asserts that income inequality has a genuine, harmful effect on population health through psychosocial pathways. His assertion has been echoed and strengthened by other researchers in this field (Kawachi & Kennedy, 1997, 1999; Kristenson, Eriksen, Sluiter, Starke, & Ursin, 2004; Marmot, 2003; Marmot & Wilkinson, 2001; Wilkinson & Pickett, 2006).

Wilkinson (1996, 1997, 2005) argues that for societies that passed the epidemiologic transition, chronic diseases instead of infectious diseases have been the major causes of deaths. For a wide range of chronic diseases, it is the relative income/position rather than the absolute material standard that plays a more important role in determining individual's health status. In addition, in developed countries, the so-called “diseases of affluence” such as obesity, stroke, hypertension, coronary heart disease, are becoming more common among the poor people, indicating that the living standard for the majority of the population has been improved greatly and absolute deprivation becomes a lesser threat to health today. In contrast, even within the most advanced societies, relative deprivation can still be a threat to public health given the existence of social hierarchy. If income inequality is a good proxy of the level of hierarchy in a society, a negative correlation between income inequality and population health is expected. It is argued that in more hierarchical societies the social milieu is more aggressive, hostile and stressful, and continuous exposure to chronic stressors is a major risk factor for many cardiovascular and other chronic diseases. This has been supported by both animal studies and the literature of “job strain”. For example, Sapolsky (2005) shows that social rank is an important factor affecting the quality of life and health for many nonhuman primate species. Low

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