ANTHROPOLOGY, INEQUALITY, AND DISEASE: A Review

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Abstract Anthropological approaches broaden and deepen our understanding of the finding that high levels of socioeconomic inequality correlate with worsened health outcomes across an entire society. Social scientists have debated whether such societies are unhealthy because of diminished social cohesion, psychobiological pathways, or the material environment. Anthropologists have questioned these mechanisms, emphasizing that fine-grained ethnographic studies reveal that social cohesion is locally and historically produced; psychobiological pathways involve complex, longitudinal biosocial dynamics suggesting causation cannot be viewed in purely biological terms; and material factors in health care need to be firmly situated within a broad geopolitical analysis. As a result, anthropological scholarship argues that this finding should be understood within a theoretical framework that avoids the pitfalls of methodological individualism, assumed universalism, and unidirectional causation. Rather, affliction must be understood as the embodiment of social hierarchy, a form of violence that for modern bodies is increasingly sublimated into differential disease rates and can be measured in terms of variances in morbidity and mortality between social groups. Ethnographies on the terrain of this neoliberal global health economy suggest that the violence of this inequality will continue to spiral as the exclusion of poorer societies from the global economy worsens their health—an illness poverty trap that, with few exceptions, has been greeted by a culture of indifference that is the hallmark of situations of extreme violence and terror. Studies of biocommodities and biomarkets index the processes by which those who are less well off trade in their long-term health for short-term gain, to the benefit of the long-term health of better-off individuals. Paradoxically, new biomedical technologies have served to heighten the commodification of the body, driving this trade in biological futures as well as organs and body parts.
INTRODUCTION: INEQUALITY AND DISEASE

This review examines how the relationship between social inequality and health has been opened up to anthropological investigation. Epidemiological evidence claims a robust relationship between socioeconomic inequality and health outcomes, although the mechanisms by which this relationship occurs remain poorly understood. Drawing on cross-cultural work on the body and affliction, this article examines how anthropologists through the prism of embodiment have viewed the impact of inequality on health. This review starts with the standard definitions of inequality and health, understood as the socioeconomic disparities captured in quantitative population surveys and the biological outcomes measured in epidemiological research respectively, to explore how anthropological research can generate insight into the relationship between the two by recasting them within anthropological considerations of how the body is fashioned by cultural, political, and historical processes (Diamond 1997). Understanding the body as deeply historicized and socialized enables a cross-cultural framework for understanding how social relations condition disease patterns and, more broadly, states of individual and collective affliction. For anthropologists, the inequality/disease relationship is a form of violence enacted through cultures and rationalities. A distinction has been made between social relations, where the violence of inequality is most often expressed in ritualized form, leaving visible traces on the body, and those where the violence of inequality is transcribed into the body as biological difference and expressed as “risk” to be managed through techniques of government. This distinction differentiates “modern” political spaces of health, where misfortune is managed through specialized therapeutic institutions and violence is sublimated into hierarchies of disease; “pre-modern” spaces of therapy, where anthropologists have classically operated, producing of witchcraft, spirit possession, and other “traditional” medical systems; and “a-modern” (Latour 1993) spaces, where the lines between therapeutic and political power are once again blurred.

More contemporary anthropological work on health and disease points to an increasingly a-modern therapeutic economy, where competing powers and therapeutic claims vie for legitimacy and the right to manage misfortune. The massive global scaling-back of public health in a neoliberal economic climate has conjugated with globalization to magnify the health impact of transnational inequalities and the way these are manifested and administered (Kelley 2003). From this conjuncture a new political configuration of health has emerged that marshals nongovernmental organizations (NGOs) and humanitarian governmentalities, biomedical discourses and technologies, and diseased bodies on an increasingly conflict-ridden terrain (Elyachar 2002). These extreme health inequalities constitute a form of structural violence that has come under increased ethnographic scrutiny. This research has described a striking culture of indifference to affliction present in areas of extreme inequality and expressed through the rationalities used to manage it. This culture of inequality facilitates a pathogenic biosocial spiral of socioeconomic exclusion and deteriorating health. Growing attention has been paid by anthropologists to
how biomedical technologies conjugate with material inequalities to create novel markets that have intensified and accelerated the commodification of the body and its futures, a phenomena of which the organ trade is only the most visible element. These markets are emblematic of the processes by which the poor trade in their long-term health for survival while the rich, although increasingly shielded from most disease threats, are able to purchase better health.

SOCIAL DETERMINANTS OF HEALTH

The relationship between poverty and ill health is well established. The nefarious effects of poverty on health, as historically demonstrated by the McKeown thesis—which showed that improvements in health were due to decreases in poverty in England and had little to do with improved medical care—have been widely confirmed and reviewed (Subramanian et al. 2002, Wagstaff 2002), validating the common view that poverty is the only robust social determinant of health. The mechanisms by which poverty causes disease are, by now, well understood. They include weakened immunity and neurophysiological development because of malnutrition, ease of spread of pathogens because of insalubrious living conditions, and the precariousness of social support networks. More recently, the role of increased exposure to environmental pollutants, to which the poor may be more exposed, has been implicated (Evans & Kantrowitz 2002, Faber & Krieg 2002, Woodward & Boffetta 1997). It is the material deprivation poverty entails that is unhealthy. For epidemiologists, the first hint that the deleterious effects of poverty might not be due to material deprivation alone came from a now landmark study, the Whitehall study (Marmot 1986). It was found that life expectancy among British civil servants increased with their rank, even when standard factors influencing the risk of death—such as smoking, lack of exercise, and so on—were factored in. This finding held even between those with very similar ranks who would have had the same kinds of jobs in adjacent offices and lived in the same neighborhoods and had the same leisure activities; in other words, the finding could not be ascribed to differences in working conditions such as those that might be found between laborers and managers, nor could it be attributed to cultural or class differences in lifestyle. The observation of this hierarchy effect suggested that poverty could not be the sole social factor accounting for adverse health outcomes.

A growing body of epidemiological research now indicates that social inequality contributes to ill health independently of income level, providing evidence that hierarchy effects can act across large populations and not just within discrete groups. This gradient effect means that, at the same absolute level of income, an individual in a more-egalitarian society will be healthier than one in a less-egalitarian society. This gradient effect not only affects those who are lower, or poorer, in the social hierarchy but also impacts health across all income levels (Donohoe 2003, Kawachi et al. 1999). This observation suggests that the concept of social class, although a
conceptually robust first approximation of social inequality, is too blunt an instrument to capture the fine-grained differences that occur within groups that share the same material conditions of reproduction (such as British civil servants), nor does it adequately account for spread within and between classes. Finally, class-based analyses may not be completely transposable across societies with different degrees of industrialization and, therefore, different historical trajectories of class formation (Forbes & Wainwright 2001).

Criticisms that the observation is spurious, merely a statistical aberration or an artefact of measurement, appear to be unfounded (Wolfson et al. 1999). The observation that there is a correlation between socioeconomic inequality and health has proven to be robust and is, therefore, a novel finding of major significance. Previously, it had been thought that absolute poverty, rather than relative poverty, was the only robust social determinant of ill health and that this effect was unidirectional, affecting only those lower on the social ladder. That health outcomes in those who live in inegalitarian societies are inferior to those who live in more egalitarian societies has led to the observation that some societies are, indeed, “unhealthy” (Kawachi & Kennedy 2002, Wilkinson 1996). Globalization, increasing evidence of heightened inequalities, increasing poverty and ill health in many parts of the world, and emerging transnational threats to health invite talk of an “unhealthy planet” and have focused considerable attention most recently on how health equity is to be achieved globally today (Whitehead & Evans 2001).

WHAT MAKES INEQUALITY UNHEALTHY:
THREE HYPOTHESES

This finding has major implications for social policy and public health; as a result considerable energy has been spent on identifying the mechanisms responsible. A significant body of research that details this finding and explores possible mechanisms to explain it has emerged in the field of public health. However, the underlying mechanism for the inequality/disease relationship remains poorly understood. Anthropologists can contribute to advancing attempts to understand the mechanisms through which hierarchy is translated into disease and to inscribe this relationship into a broader historical and sociocultural framework. Considerable attention has been paid to identifying the mechanisms responsible. The elucidation of the pathways—neurodevelopmental, physiological, and behavioral—by which social inequality produces adverse health outcomes has stimulated considerable interest among researchers in these sciences (Evans et al. 1994, Graham 2002). A principal methodological difficulty in examining the inequality/disease relationship has been isolating the adverse impact of inequality, per se, from poverty (Clarke et al. 2002). For instance, how can we know whether worsening health outcomes in a situation of deepening inequality are not just due to the fact that there are more people who are poor? Epidemiologists rely on quantitative methods to tease out the contribution of inequality, or relative poverty, from absolute poverty.
Yet these methods are limited in their ability to segregate the relative contribution of environmental, biological, and social factors to the mechanisms by which inequality exerts its unhealthy effects. Although no clear mechanism for explaining how inequality translates into ill health has emerged, consensus exists around three broad hypotheses.

The role of social cohesion has been emphasized, building on a body of clinical epidemiologic studies (Kawachi et al. 1997, Lomas 1998, Wilkinson 1996). Although lacking a singular definition, these studies point out that the density of social networks correlates with better disease outcomes and decreased mortality, a finding that is understandable in settings of poverty where social ties can be called upon to weather ill health but is more difficult to explain in more affluent surroundings. This observation has triggered a search for a quantifiable proxy for the density of social ties and the presumed correlate, social cohesion. Considerable attention has focused on social capital, a term first advanced in this sense by Jacobs (1961) and that has received considerable interest from epidemiologists, sociologists, and economists (Anheier & Kendall 2002, Cattell 2001, Campbell & McLean 2002, Pearce & Smith 2003, Putnam 1995) as both a potentially quantifiable measure of social cohesion and a goal of policy initiatives.

A host of psychosocial mechanisms have been implicated to account for how hierarchy exerts deleterious effects on the health of populations and individuals. Research has attempted to link psychosocial factors to biological pathways that explain how greater inequality can lead to negative developmental and physiological effects. The emerging field of the biology of inequality is centrally concerned with this hypothesis (Brunner 1997). Stress has emerged as the common psychosocial entry point or trigger for these biological pathways. For instance, stressed mothers have lower-birth-weight babies who are, in turn, at higher risk for adverse health outcomes in adulthood (Mullings & Wali 2001). In adulthood, chronic stress elevates cortisol levels, which decreases resistance to infectious insults (Evans 1994). The initial and persistent emphasis on stress as a determinant subsequently led to cognitivist notions of self-efficacy as well as to approaches that draw on the sociology of emotion, which seeks to complexify the psychosocial triggering of biological pathways (Elstad 1998). These pathways may allow biological effects to be exerted much later on in life, generating cohort or generational effects that make epidemiological ascertainment of cause difficult, as historical events may lead to later biological effects through complex pathways that entangle biology, culture, and environment, pointing to the need for life-course approaches (Graham 2002).

Neomaterialists have countered that material factors can explain the observed gradient effect on ill health. Their reasoning is such that in inegalitarian societies the poor are more deprived than in comparatively egalitarian societies because fewer investments are made in infrastructure and social services (Navarro & Shi 2001). These material investments, which are not captured by aggregate data on income, help to shield those lower on the social ladder from a broad range of environmental, behavioral, and social risks—from environmental toxins to endemic
violence (Wilkinson et al. 1998, Galea et al. 2002)—that would otherwise compromise their health outcomes. Moreover, material deprivation in childhood, which is more prevalent in inequalitarian societies, has been shown to perpetuate “unhealthy” behavior later on in life, leading to worse health outcomes that persist even as individuals climb the social ladder (Lynch 1997).

ANTHROPOLOGICAL PERSPECTIVES ON THE THREE HYPOTHESES

Anthropological research contributes to greater understanding of the complex, multifactorial mechanisms by which inequality leads to ill health. The strength of this research has been its ability to investigate, from the ground up, both the effects of inequality and the way in which it is perceived and acted upon. What has this research contributed to furthering the three hypotheses?

The notion of social capital has been drawn upon extensively to attempt to explain what makes a society “healthy.” However, closer examination shows that the concept of social capital has been lacking analytic clarity. Definitions have ranged from trust to density of social ties. Surveying the uses of social capital in the literature on health inequality and disease, it is difficult to avoid a nagging suspicion that this lack of analytic clarity leads to a tautology: Societies are healthy because they are trusting, and there is a lot of trust because societies are healthy. Although part of the confusion stems from different usages of the term by economists and sociologists, conceptual clarity will not necessarily be helpful in the absence of research that can place social capital within local, historical dynamics and understandings of trust (Anheir & Kendall 2001, Kunitz 2001). The plea for local context questions the idea of social capital as a historical and cultural essence, arguing instead for understanding how social ties are produced in historically and culturally conditioned networks of reciprocity and exchange, result from asymmetrical relations of power that are highly hierarchized (Elkana et al. 2002), or may simply be artefacts of bodily practice.

A theoretically important critique of the biology-of-inequality hypothesis has been advanced by medical anthropologists. Several important studies question the universality of the biology that is assumed to express the pathways through which inequality exercises biological effects. Rather than deny the relevance of biology to understanding social phenomena, these studies, which take biology very seriously, point out that biology—from the genetic to the ecological—is more plastic than otherwise acknowledged and is extraordinarily permeable to social events (Lock 1995, Lewontin 2000). An important caveat, these studies tell us, is not to confuse cause and effect: For example, biological differences between populations may not so much be the cause of observed social differences as their effect. These studies indicate that rigid notions of causality—such as that implied by terms like social determinants—may oversimplify what are highly complex biosocial interactions between environment, culture, diet, and history and may endorse longitudinal or
life-course approaches that take into account how individuals shape their environments based on the ways in which they understand their positions in the world. These life-course approaches provide a glimpse into how history is embodied; they point to how complex social, historical, and physiological interactions are overly simplified by reducing them to uniquely biological phenomena. Such biologizing, and by extension medicalizing, of social ills can be a form of social control and, perhaps more dangerously, paves the way for attempts at “magic bullet” solutions to these complex problems, with potentially deleterious results (Conrad 1992, Illich 1977, Zola 1972).

Medical anthropologists are largely sympathetic to the neomaterialist hypothesis, adding to it a more overtly political perspective by seeking to link local inequalities to a broad range of large-scale social forces by working “up” from field sites. Building on the social epidemiology that sought to track the hidden injuries of class in the 1970s (Baer 1996, Turshen 1984, Waitzkin 1981), the impact on health of social policy and, furthermore, of the broader political economy has received renewed attention, with a focus on how contemporary changes in macroeconomic policy and the role of the state impact the health of populations in general and the poor in particular (Kim et al. 2000, Navarro 2002). Here, by using social theory to provide the crucial link between large-scale social change and the lives of individuals, medical anthropologists have joined forces with critical scholars of public health to more sharply politicize the materialist hypothesis. Increasing attention has been paid to linking material “determinants” of health to social policy, how social policy is translated into material action, and, more generally, to the ideological and political commitments that shape the environments within which policy is formulated (Coburn 2000).

In summary, anthropological perspectives on the three hypotheses advanced to explain the inequality/disease correlation call for an approach that links local context to broader analysis. This approach requires that materialist factors be placed within a broader geopolitical context (Coburn 2000, Popay et al. 1998), that discussions of biological or social determinants be opened up to include exploration of the full complexity of biosocial interactions, and that analytically robust definitions of social capital be developed from fine-grained empirical studies that examine the historical and cultural coproduction of social cohesion and inclusiveness.

THE EMBODIMENT OF INEQUALITY:
A THEORETICAL FRAMEWORK

Anthropologists may work within an epidemiological framework to integrate sociocultural and historical approaches with the research agenda, as is the case with research that examines why inequality leads to the poor health outcomes measured in epidemiological surveys. The epidemiological framework relies on quantitative understandings of inequality and health: respectively, income distribution and biomedically measurable morbidity and mortality events. Outside of the
epidemiological framework, anthropologists have more broadly conceived the inequality/health relationship as being one between the body and society and fleshed out by ethnographically driven approaches. Before exploring the implications of ethnographically driven work on inequality and disease, this section first examines how theoretically driven approaches have enlarged epidemiological notions of health and inequality to allow for consideration of the processes that produce and legitimate inequalities both in societies and in bodies.

Medical anthropologists have long argued that biomedical and epidemiological categories are socially constructed rather than naturally given. The social construction of biomedical facts—that is, their production through different combinations of institutional, technical, social, cultural, and political operations—does not mean they are not real; rather, it is through these very operations that the biological world becomes real and available for intervention (Cambrosio & Keating 1992, Latour 1993). As a result, the categories through which the biological world is understood and acted upon may reflect and perpetuate existing inequalities (Adas 1989, Lippman 1991, Sharp 2002, Wright & Treacher 1982). A complementary tradition within anthropology more generally has rejected the biomedical definition of disease (seeing it as too narrow, even ethnocentric) in order to better study the forms affliction takes across cultures—from witchcraft and spirit possession to infestation by various nonhuman agents (Lewis 1991, Samuelson 2001, Geissler 1998). The evidence that biological categories—biomedical nosologies—do not adequately cover the spectrum of afflictions present across the world has prompted anthropologists to seek more inclusive definitions of affliction and, therefore, a fuller picture of how inequality translates into affliction. More recent work informed by social studies of science has problematized the social and technical processes through which disease entities are constructed and embodied.

Within medical anthropology, a phenomenological school sees the biomedical inscription of disease as one cultural elaboration among many of a precultural, existential form of suffering that is considered defining of the human condition (Good 1993). In this view, while biomedicine shares with Christian religions a soteriological structure, it offers treatment without salvation. An engaged anthropological critique of social suffering has joined forces with critics of medicalization to denounce the depoliticization of health and to mount a powerful critique of the social forces that shorten the lives of the poor (Farmer 1997). However, the notion of a precultural existential ground of suffering does not offer firm theoretical purchase on how affliction is to be historicized—according to this view, it is the enculturation of suffering that is historicized, not affliction. Social suffering approaches also foreclose the possibility that what is at stake in anthropological considerations of the body may include issues other than affliction. Medical systems are not only preoccupied with pain and suffering, it is argued, but also are intimately concerned with pleasures and passions (Farquhar 1994a).

Eschewing the search for a transcendental theory of suffering and soteriological approaches to biomedical systems, other medical anthropologists have instead focused on the materiality of the body, drawing on a tradition of scholarship on the
anthropology of the body that has shown how social relations invest and express
the body, either as inscription (Turner 1980), experience and its embodiment as
traces in the body (Pandolfi 1990), or practice, sedimented into what Bourdieu has
called habitus (Farquhar 1994b). This social dimension makes for a politics of the
body, visible in the political economy of the body (Goodman & Leatherman 1998)
or through the scrutiny of the processes through which the body may express resis-
tance to dominant political forms (Comaroff 1985). By focusing on how the body
is located within historical and social relations, this literature provides an impor-
tant theoretical stepping stone to formulating an anthropological problematic that
is more sharply focused on the relationship between social inequality and disease.

A phenomenon of such great significance as the disease/inequality relationship
calls for examination in cross-cultural and translocal perspectives—whether this
is to validate the findings or to challenge and sharpen the hypotheses it raises. The
anthropology of the body offers a theoretical framework that allows comparative
research into how social processes and local meaning inform and produce affliction
(Lock 1993). Quantitative measures such as income spread, gini coefficients, and
so on are invaluable for generating hypotheses, providing comparative markers,
and indicating new avenues for research. However, the rich tradition of anthro-
pological scholarship reviewed in this volume indicates that understanding what
makes a society inequalitarian requires qualitative research for understanding how
local actors understand, enact, and respond to inequalities and, as a result, how
these translate into embodied effects.

Whether the classical object of anthropological research is taken to be culture or
society, recent work has reread both in light of the opening up of field sites to develop-
ment, globalization, technoscience, and new social movements (Haraway 1996,
places (Tsing 1994) and in a plethora of new field sites closer to home has moved
beyond debates concerning structure, agency, and meaning to reposition culture
firmly within the nexus of power, history, and subjectification. Whether one sub-
scribes to a modernist or postmodernist program, common new social forms have
become available to ethnographic scrutiny. Although these new objects of study
have not been viewed through the lens of inequality, their focus on the processes
of social change means that they have either addressed new forms of inequality
or their consequences. Studies of new social movements that respond to these in-
equalities, especially NGOs and the humanitarian industry (Pandolfi 2001), can be
cited alongside those of various urban subcultures, violent conflicts (Ellis 1999),
displaced populations (Malkki 1995), emerging and resurgent infectious threats to
human health (Farmer 1999), and “natural” catastrophes (Steinberg 2000). As can
be seen from the ethnographic spread of this work, the challenge is to integrate
a scattered body of empirical work within a cohesive theoretical paradigm that
allows the disease/inequality relationship to be ethnographically fleshed out.

The insistent presence of the suffering body in medical anthropology (Butt
2002a) means that the question of power—the power to wound, to heal, or to
prevent injury—is more acute than in other domains of anthropological inquiry.
Power offers a compelling framework for opening up consideration of inequality to include historical and cultural processes, rather than reifying it in terms of social structure or cultural essence or individualizing it in terms of human agency. As a result, a political anthropology of health offers an appealing theoretical project for reconciling culture, inequality, and disease. Fassin (1996) has developed a genealogical model to bring anthropological scholarship on “traditional” societies into a dialogue with more contemporary work. This model represents the most definitive statement of the form such a political anthropology should take. Rather than being a comparative enterprise framed by a structuralist understanding of society, or a humanist notion of agency, this model draws on the Foucaultian distinction between premodern and modern political societies. This opposition can be used to delineate contrasting political spaces of health, constituted along three axes: the ways in which inequalities are embodied, therapeutic power is legitimated, and collectivities respond to misfortune. This genealogical approach identifies the outlines of a political regime of health that articulates affliction, therapeutic power, and collective management of misfortune in contingent ways. Rather than advocating a teleological or evolutionary view of “progress” toward a modern medicalized society, this approach permits the identification of ruptures as well as the tracing of continuities between premodern political health apparatuses, such as witchcraft and spirit possession, and their equivalents in the modern world (Fassin 1996).

THE VIOLENCE OF INEQUALITY

Social inequality is manifest in the body; however, it is not limited to biomedical manifestations (i.e., disease). Rather than proceeding from a strictly biomedical definition of disease and correlating it with social inequalities, anthropological approaches to the body invite us to compare how inequality is embodied across societies and times. Rites and social procedures that mark the body and place it in a social order are a paradigmatic example of this phenomenon (Maertens 1978, Turner 1980). Similarly, various forms of initiation, spirit possession, and witchcraft can be viewed as manifestations that express and enact social hierarchy, fixing them in a fluctuating social world. However, these examples show us that the body is not merely a passive recipient of social inscriptions; indeed, the body can serve as a site for organizing forms of resistance to dominant social inscriptions, such as those exercised by patriarchy (Boddy 1989), capital (Ong 1987), the state (Arnold 1993), or colonialism (White 2000). Resistance operates through diverse mechanisms, either by furnishing counter-hegemonic meanings (Hebdige 1979), constituting therapeutic communities whose historical infrastructure conditions the rise of political movements (Comaroff 1985), or producing dissident subjectivities (Nguyen 2002). However, subjects often deploy, modify, or enact their bodies not as acts of resistance but simply as a form of pragmatic action (Lock 1998).

Modern bodies can be differentiated from premodern ones. The argument that contemporary forms of scarification express a return to tribal forms of belonging
ANTHROPOLOGY, INEQUALITY, AND DISEASE

(Maffesoli 1995) glosses significant divergences between premodern and modern practices (notably, that moderns elect to modify their bodies to signify particular social identities, in contrast to traditional societies where bodily modification is assigned). However, this argument does have the merit of pointing to how the body is treated as a social medium even in highly individualistic societies (Mascia-Lees & Sharpe 1992). Fassin shows how in premodern society the embodiment of inequality was limited to modifications of the body through ritual, a form of violence that did not significantly translate into differences in morbidity or mortality between groups at different positions on the social ladder (Fassin 1996). In modern society, inequality becomes embodied biologically, as those lower on the ladder suffer higher morbidity and mortality rates. This lends credence to the Foucaultian thesis that in modernity violence is sublimated, echoing Foucault’s observation of how the spectacular nature of premodern punishment is transformed into a more insidious and pervasive ordering of bodies through institutional practices. Fassin shows how this disciplinary turn registers at the biological level and makes a convincing and important argument that in modern societies inequality is biologized (transcribed into the body) rather than ritualized (inscribed onto the body).

BLAME, RISK, AND THE VIOLENCE OF POSTMODERNITY

For moderns, risk is the primary mechanism through which social inequality is embodied and is visible in different prevalences of diseases and outcomes between different social groups. Risk, then, can be said to be a measure of social violence, capturing how power distributes unevenly down the social ladder. This echoes findings from anthropological work on AIDS that demonstrated that the HIV epidemic “tracks along social fault lines,” (Farmer 1999) affecting those whose poverty and social exclusion have made them the most vulnerable to infection (Parker 2002). Marked differences in morbidity and mortality from HIV and other preventable and treatable diseases, such as tuberculosis and malaria, thus indicate a situation of structural violence (Farmer 1997). Structural violence is visible in the steep gradients of social inequality that, by producing indecent poverty in an era of increasing wealth, expose the poor to fatal diseases. The health impacts of structural violence are compounded by lack of access to effective care for the powerless (Farmer 1999). The existence of a gradient of access to biomedicine is best seen in studies of patterns of resort (Fassin 1992) and indicates that biomedicine has, by virtue of its efficacy, become an unwitting accomplice to biological inscription of social hierarchies.

Medical anthropologists have also focused on the way discourses of risk are used to label and manage particular populations, drawing on Foucault’s notion of governmentality (Burchell et al. 1991) to explore how risk has become a technique for governing populations and producing particular kinds of subjects (Dean 1999, Novas & Rose 2000). Modern administration of risk involves identifying and targeting at-risk populations for preventive intervention (Lupton 1999). This
practice draws its origins in the control of epidemics through the identification, isolation, and treatment of infectious cases. Although the efficacy of this strategy is established, it subjects individuals and social groups to forms of discrimination. In public health discourse and intervention, risk serves to differentiate populations variably across the social ladder, performing finely grained distinctions between social groups within populations. Risk is used to constitute specific populations—the teen drop-out (Hutson & Liddiard 1994, Bridgman 2001), the homeless (Desjarlais 1993, Lyon-Callo 2000), welfare recipients (Churchill 1995), single mothers (Coffield 2000), the poor (Newman 2001), and so on—as targets for intervention. This targeting may produce collateral damage, legitimating stereotypes and providing fodder for stigma (Hacking 2000).

The operationalization of discourses of risk into targeted interventions has the effect of refracting inequalities, producing different effects at various positions in the social spectrum. Those lower on the social ladder find themselves blamed for behavior over which they have little effective control and find themselves subject to interventions that medicalize social forms of suffering, even as they are excluded from collective forms of solidarity. Those higher on the social ladder find themselves undergoing ever more biomedical poking, prodding, and testing in a vain attempt to achieve certainty from the amorphous threat of risk of which the biomedicalization of everyday life is symptomatic (Lock 1998, Cussins 1998). Bluntly put, governmental technologies of risk blame the poor and magnify uncertainty for the rich with different embodied consequences.

Risk, by striating the social body into degrees of operability, refracts social inequalities at the level of body modification. This is most obvious in phenomena like plastic surgery where economic access is a primary determinant, but it may also be hypothesized to exist for other surgeries, such as hysterectomy and caesarian section, where rates have been demonstrated to differ markedly between localities (Fabri & Murta 2002). These differences in medical intervention may express variances in idioms of distress in groups at different positions on the social ladder (those to whom a psychological language is most available may have lower rates of biomedical body modification than those for whom distress is primarily a somatic affair) (Kirmayer 1992), different economic circumstances, or different styles of engagement with the state (Cohen 1999).

Although Foucaultian-inspired analyses have pointed out the sublimated violence that incorporates inequality in terms of epidemiological differences in survival, increasing attention is being paid to the public health impact of the proliferation of low-intensity violent conflicts around the world (McGinn 2000, Levy & Siddel 2000). The impact, in terms of mortality and physical and psychological morbidity, is devastating (De Jong 2002, Desjarlais et al. 1995, Jenkins 1998), the dark side to the biopolitical rationalization of violence. In these conflicts, civilians are the primary targets, often not just of killing but also of nonlethal violence that results in life-long debilitation (Summerfield 1998). Violence used in a manner intended to inflict lasting psychological damage (such as torture, rape, amputation, and other violent forms of degradation) is widely reported from across the world. Studies of these conflicts have detailed how a highly inegalitarian and extractive
global economy fuels this kind of violence, facilitated by cheap arms exports and weakened states no longer able to enforce authority over their territories (Ellis 1999).

Despite evidence of the growing impact of violent conflict on world health, the effect of politics on population health has been most widely understood in terms of how particular policies, such as taxation, health insurance, and access to schooling, inflect disease rates. Recasting the relationship between disease and social inequality as the embodiment of social relations adds value to the core epidemiological finding by allowing affliction to be related to prevailing ideologies that inform policy, configurations of social violence, the way misfortune is conceptualized and managed, and how meaning systems influence how individuals interpret their bodily states, seek care, and fashion themselves according to prevailing moral notions. Inequality is more broadly viewed as a form of violence that can be exercised directly on the body or indirectly through risk and blame. This view allows the three epidemiological hypotheses about how inequality results in ill health to be (a) extended to include political processes, (b) sharpened to examine local social pathogenesis, and (c) complexified to take into account biosocial interactions. All three of these insights texture the landscape of affliction in society, focusing the question of power more centrally on the question of how therapeutic power—the power to manage misfortune—is legitimated.

THERAPEUTIC POLITICS AND LEGITIMATION

Medical systems in different cultures and at different historical moments may differ in the methods and technologies used to diagnose the causes of misfortune; the substances, objects, and practices used to alleviate it; and even the goals of therapy (Young & Leslie 1992). However, across times and places therapy retains a political dimension: Therapeutic claims must be justified and practitioners must legitimize their ability to exercise therapeutic power. These therapeutic politics mediate the impact of social inequalities on health.

Therapeutic systems texture the form affliction takes in a society and may therefore exacerbate or alleviate existing inequalities. Anthropological studies of millenarian movements have long shown that, worldwide, these movements are religions of the oppressed; similarly, possession by spirits favors women and, in some settings, effeminate men (Boddy 1994). Classic debates as to whether these therapeutic systems act as pressure valves to maintain political homeostasis and legitimate existing inequalities or, on the contrary, are sources of conflict and fissure, renting communities apart (Marwick 1991), have given way to considerations of how therapeutic systems may exert indirect political effects, for example embodying forms of embodied resistance that may mature into full-fledged political movements (Anderson & Johnson 1995). Regardless of where one sides in this debate, the centrality of therapeutic systems to the political physiology of a society is uncontested. Although the actions of therapeutic systems are “infra-political,” in the sense that they do not register in the arena of state power and struggles to obtain
access to it, increasing attention has been paid to how the idioms of therapy and indeed therapeutic practices have crept into political life. To name a few, studies have been published of infantile citizenship and metaphors of trauma and therapy in American political life (Berlant 1991), the conflation between therapeutic experience and political power in born-again statesmen (Strandjsberg 2000), the manipulation of prophetic acquaintance to imbue politicians with an aura of infallibility (Dozon 1995), or the attribution of political longevity to occult practices (Comaroff & Comaroff 1994).

These studies indicate that the entanglement of the power to heal and the power to rule is the result not just of traffic between the symbolic domains of body and society (Douglas 1996) but also from the material intermingling of therapeutic action with the exercise of rule, as well as the proliferation of resistances to it. This entanglement occurs when the charisma of political power stems from the power to heal or the experience of being healed and when the exercise of political power is crossed with therapeutic rituals. This political/therapeutic tangle challenges Weberian notions drawn on by some scholars to argue that modernity can be characterized by a separation of powers, such that therapeutic power differentiates into a separate domain—biomedicine—from political power, with a residual interface remaining in public health and health policy (Dozon & Fassin 2001).

The therapeutic pluralism at work in the government of collective life puts the legitimation of therapeutic power firmly in the political arena (Brodwin 1997). This is most evident in the struggle for recognition waged by nonbiomedical therapeutic traditions, such as traditional African therapies on that continent or traditional Chinese medicine and its migrant reincarnations in North America (Lau 2000). Different medical traditions define and manage pathology differently; consequently, the therapeutic blend present in a given locality will impact sufferers’ patterns of resort and the embodiment of inequalities (Nichter & Lock 2002). Biomedicine is often the most expensive therapy in developing countries and, as a result, is resorted to only after more accessible (whether for economic, cultural, or geographic reasons) therapeutic options have been exhausted. Fluctuations in the availability of different therapeutic options can impact health outcomes, for instance, when public investments are made in less accessible therapies that may be more effective at an individual level but do not translate into improved health of the general population because most do not have access to them.

Although the impact of biomedicine on population health has been overshadowed by the interest in social pathways through which inequality exerts deleterious effects, differences in access to biomedical care lead to different morbidity and mortality rates for the same disease in different social groups. In industrialized settings, heart disease is underdiagnosed and undertreated in American and British women relative to men, which leads to higher morbidity and mortality rates in women as compared to men (Annandale & Hunt 2000, Ostlin et al. 2002). Similarly, cancer pain is undertreated in African Americans, which results in their suffering greater pain (Dressler 1993). Although these observations suggest gender or racial bias on the part of practitioners, clinical ethnographies advance the hypothesis that biomedical knowledge is itself “biased,” not in the sense of being...
patently false, but rather to the extent that it is partial because it is constructed from prevailing social understandings of the body and society (Casper & Koenig 1996, Clarke & Casper 1996, Hogle 2002, Mol & Berg 1998, Simon 1999, Willems 1998). Evidence that diagnostic categories perform best in privileged groups (the articulate, white, male patient) indicate that an epistemological bias reflects inequalities of access of certain groups to the elaboration of medical knowledge (Aronowitz 2001). For instance, if biological norms and diagnostic tests are standardized on middle-class, white populations, they may not perform accurately in groups who may differ biologically or in the way they report symptoms. Biological difference between populations should not be understood as essential but rather as differences in environment and interactions between heredity, culture, and environment (Szathmary & Farrell 1990). Vegetarians, whether they are middle-class American women or upper-caste Indian men, have lower haemoglobin values and will more often be diagnosed as anaemic.

The embodiment of inequality indexes the diverse ways in which violence translates into affliction. Examination of how the power to wound, to heal, or to prevent injury is legitimated indicates that political entanglements also unfold on an epistemological terrain, and not just in the way violence is embodied. Competing medical systems, as well as different social groups, struggle to legitimate therapeutic power, experiences of suffering, and claims for redress. These struggles refract social inequalities in myriad ways. This is not to imply a kind of epistemological war of all against all. Within society, just as collectivities have evolved political mechanisms to regulate social life, they have also evolved mechanisms to collectively manage misfortune and, in some cases, arbitrate between competing therapeutic systems. Recent anthropological study of these collective mechanisms has drawn on Foucault’s notion of governmentality (Burchell et al. 1991) to develop a critical anthropology of policy, public health, and the forms the government of life has taken in industrialized countries (Petersen & Bunton 1997, Shore & Wright 997). The planetary scope of the HIV epidemic and the institutional response to it is a harbinger of how the government of life will increasingly go global, with the result that health becomes framed by mobile, issue-driven configurations of institutions—what have been called transnational advocacy networks or transnational discourse coalitions (Keck & Sikkink 1998). As the political space of health becomes an increasingly global one, anthropologists are beginning to focus on how local phenomena trace the contours of a global political apparatus of health.

GLOBALIZING THE POLITICAL SPACE OF HEALTH

In an era of accelerating and intensifying movement of capital, technology, and people, however, it is no longer possible to view political regimes for managing health and their therapeutic economies in isolation from each other, and this is having significant impacts on health. Whether or not one subscribes to the view that globalization is a new phenomenon, anthropologists have pointed out that gradients of inequality exist across national borders and will play an increasing
role in shaping the health of populations (Bateman et al. 2001, Bettcher 2000). Transnational social inequalities drive migration for economic survival or therapy (Kangas 2002), as well as the movement of pharmacological agents, biologicals, and organs. The predominantly national nature of the socioeconomic data collected to explore the relationship between socioeconomic inequality and health has imposed constraints on the ability to capture the impact of migration and transnational health gradients, constraints to which ethnographic methods offer an alternative.

Much of the contemporary literature in medical anthropology addresses the relationship between health, biomedicine, and social change. Critical approaches to biomedicine have figured more prominently in studies conducted in industrialized countries than in the third world. This is not surprising because biomedicine’s cultural valence is more readily visible where it is an institutional and industrial heavyweight, as seen in studies of medicalization, clinical ideologies, or micropolitical struggles (Lock & Kaufert 1998). Thus, although the role of biomedicine as a powerful cultural vector, present both in everyday life and in collective representations (Brock & Howard 1984, Lupton 1994), is by now widely accepted in anthropological scholarship on modern society, comparatively little work has investigated its corollary in the postcolonial world, still too often seen as being mired in a “traditional” therapeutic economy. Future studies of transnational health inequalities will need to pay serious attention to how transnational medical traditions, whether biomedicine or others, impact local therapeutic economies, patterns of resort, and distributions of affliction.

ETHNOGRAPHIC APPROACHES TO THE CULTURE OF INEQUALITY

A political anthropology of health offers a compelling theoretical framework for addressing the relationship between inequality and disease because it fulfils the requirement that social change and the forces that drive it be taken into account in consideration of how social inequalities are embodied. This theoretically driven approach has the additional merit of allowing a broad range of ethnographic evidence to be used to shed light on this important question and to trace the contours of social, cultural, and political formations that are too large to be captured within individual ethnographic studies. Ethnographically driven approaches offer a complementary strategy for examining the relationship between disease and inequality from the ground up. These approaches bring together a strong corpus of ethnographic studies of poverty and newer work examining situations of social inequality, structural violence, and social exclusion (Mclean et al. 2003, Pfeiffer 2002, Santana 2002).

Although this research speaks to the notion of a culture of poverty that emerged from earlier ethnographic studies and still finds resonance in today’s ghettos and shantytowns (Bourgois 1996, Schepers-Hughes 1992), it differs in two important respects. First, contemporary ethnographies take pains to detail the historical dynamics that produce inequality: both wealth and poverty. While political economic approaches, drawing on Marxist and World Systems theory, have been a
favored tool for capturing these historical dynamics, these studies have been careful to document how local cultural and spatial dynamics texture the way in which local actors comment on and engage with global processes. Accordingly, the cultural dimensions of poverty are no longer viewed *sui generis* but as local attempts to understand, negotiate, and even resist global political and economic processes. As a result, these studies have been sensitive to how local actors make meaning and draw on a cultural repertoire to fashion tactics in order to allow engagement with a material environment that, if not overtly hostile, offers a considerably diminished horizon of possibility. Furthermore, these studies pay serious attention to translocal and transnational phenomena that shape local worlds and possibilities for action, drawing attention to how globalization increases social inequality and, through global media, awareness of it.

This literature goes beyond ethnographies of poverty to sketch the contours of the cultural formations that emerge in settings of extreme inequality and structural violence. A range of ethnographies conducted in settings of cheek-to-jowl inequality—the urban ghettos of inner-city America (Bourgois 1996, Broughton 2001), the bleak *cités* that ring French cities (Bourdieu 1998, Leclerc 2001), refugee camps (Malkki 1995), and rapidly growing urban metropolises in developing countries (Caldeira 1996)—have identified characteristics that are present across different geographical and social sites. Most striking has been the ethnographic rebuttal of the common-sense view that situations of distress, extreme poverty, or endemic violence are rife with psychosocial stress, social breakdown, and a feeling of emergency. This does not appear to be the case, however—indeed, these situations are remarkable for the apparent normalcy that reigns. Echoing Arendt’s arguments about the banality of evil (Osiel 2001), Benjamin’s notion of the “state of emergency” (Benjamin 1969), and, more recently, Agamben’s theorization of the state of sovereign exception and “bare life” (Agamben 1998), anthropologists have reported situations where exceptional events—disappearances, murders, violence—are routinized. Taking up work on the culture of poverty, and drawing on Taussig’s notion of a “culture of terror” (Taussig 1992), we might tentatively advance that anthropologists working in these diverse situations have been studying a culture of inequality (Lewis 1978). How do these cultures of inequality play a role in generating “unhealthy” societies?

**THE SOCIAL INEQUALITY/DISEASE TRAP: A PATHOGENIC SOCIAL SPIRAL**

Strikingly present across these studies is the observation that the adverse health impact of contemporary social health inequalities exacerbates those very inequalities, resulting in a spiral from which it is difficult to emerge. This is the social corollary of the “illness poverty trap” (Whitehead et al. 2001), whereby poverty produces ill health which then worsens poverty. Extensive evidence exists that new forms of social inequality erode preexisting social hierarchies. These often fulfill a public health role by assisting collectivities to weather health crises through ensuring
rational distribution of resources (Sen 1981); new inequalities upset a delicate ecology of entitlements with, at times, disastrous results. This upset has already been extensively documented in colonial settings in Africa, where capitalist encroachment led to widespread famines as cash crops and indentured labor, driven by poll taxes, replaced traditional forms of agriculture (Moore & Vaughan 1994). The epidemics that raged across the continent in the interwar period have been attributed to the breakdown of indigenous public health systems—for instance the cultural systems that prevented the spread of sleeping sickness by segregating cattle from human settlements in Eastern Africa—brought about by these social changes (Lyons 1992). Migrant labor was often housed in insalubrious conditions, fulfilling the prophecy of the diseased native (Packard 1989). Even modern forms of solidarity are not immune to the impact of deepening social inequality. As the ability of states to deliver effective public health programs is compromised in an increasingly neoliberal political economy (Coburn 2000, Maskovsky 2000), the wealthier are able to maintain access to health capital—clean water, good food, medical care, salubrious living conditions—while the vulnerability of the poor increases (Bond 2000). The wealthier are thus better able to shield themselves from unhealthy environments, whereas the poor are increasingly vulnerable. Migration remains an important element of the equation because it not only contributes to erosion of existent forms of solidarity as people move further afield in search of work but also facilitates the spread of infectious diseases. These elements, and likely many others, conjugate to form a pathogenic social spiral from which it is increasingly difficult to emerge—as the poorer get sicker, and poorer, the cost of mitigating the social consequences rises, triggering a defensive reaction on the part of the rich, who do not want to shoulder the medical cost of inequality.

What is most striking about this pathogenic social spiral is the complacency that greets it. Historical studies have identified the cultural formations that conditioned the indifference of colonial elites to the plight of natives (Dozon 1991), under such terms as the sanitation syndrome (Swanson 1977) and heterophobia (Le Pape 1997). Relatively little contemporary work, particularly among international decision makers and within powerful agencies, has focused on the culture of indifference that surrounds growing evidence of a worsening “sanitary apartheid” (Bulard 2000). Exceptions include critiques of the tendency to invoke a version of cultural relativism to explain why certain health outcomes may be more acceptable to certain groups than to others (Farmer 1999). Equally criticized has been the deployment of cost-effectiveness arguments to justify inequalities in access to biomedical care. The argument that health is a human right is often used as the cornerstone for these critiques of indifference in the face of health inequalities (Kim et al. 2000, Mann et al. 1999). An important polemic, however (Irwin et al. 2002), has developed between proponents of human rights arguments, and the humanitarian appeal that underlies them, and critics of development and humanitarian intervention, who see in such appeals a commodification of suffering, a dismissal of local politics, and a disguised imperialism masking as a universal notion of human rights (Adams 1998, Butt 2002a, Cheang 1997, Malkki 1998,
Negri & Hardt 2001, Rabinow 2002). This points to the need for more empirical study of just how human rights and humanitarian intervention are operationalized in different localities and through different issues around the world (Butt 2002b, Pandolfi 2001). The issue of whether cultures of indifference and humanitarian cultures of empathy are part of a global formation that perpetuates inequality, or are simply local perversions, needs to be resolved.

**MATERIALISM OF INEQUALITY: INTENSIFYING THE COMMODIFICATION OF THE BODY**

Situations of extreme inequality conjugate relative deprivation with fleeting access to the world of the wealthy. Lack of access to education, capital, and other resources that would otherwise permit upward mobility in a capitalist economy limits options for survival and advancement for those who are both deprived of, and exposed to, the world of wealth. The Marxist theory of labor remains the cornerstone of theories of commodification of the body. Although debate still remains as to whether sex work represents a form of commodification, it does appear that increased inequality facilitates exchange of sex for access to economic resources (Schoepf 1998, Sobo 1995), providing increased opportunity for the spread of sexually transmitted infections such as HIV. The commodification of health was initially most visible in the increasing adoption of market mechanisms to deliver health care (Maskovsky 2000, Peterson 1998), so-called managed inequality (Rylko-Bauer & Farmer 2002). However, new markets and new biomedical technologies condition new forms of extraction (Cohen 1999), in effect intensifying the commodification of the body and its futures. The result has been a brisk trade in organs (Sharp 2001), cell lines, genetic material, biologicals, and reproduction, whether through surrogate motherhood or transnational adoption (Ragoné 1999).

Anthropologists have begun to examine the organ trade as a form of body commodification facilitated by inequality and the constitution of global markets for organs through the dissemination of biomedical technologies (Cohen 1999, Marshall & Daar 2000, Scheper-Hughes 2001). Study of illicit trade is notoriously difficult (MacGaffey & Bazenguissa-Ganga 2000, Leggett 2002), if not dangerous, explaining why other forms of body trade—such as traffic in women, children, and migrants—remain largely unexamined by anthropologists. Although only a partial view, the studies that have been conducted indicate that, whereas the driving force for such transactions is material, more affective motivations (such as the desire for emotional security, children, or status) embedded in cultural notions of value and the good life also play a role (Lock & Kaufert 1998, Sobo 1995).

These studies call attention to how translocal inequalities juxtapose competing regimes of value (Appadurai 1988), establishing novel markets and economies. Simultaneously, the global dissemination of new biomedical technologies (Lock et al. 2000) works to give populations access to biomedical technologies that were previously unavailable.
The description of capital’s extractive power in venous terms, as something that, via the alienation of labor, bleeds subaltern classes until they are too weak to resist the vicissitudes of life in poverty, dates to the Industrial Revolution (Marx 2000 [1873]). This metaphor persists in the political economy approach to health inequalities, an approach that insists on unmasking the bland language of epidemiology to indict policies and agencies that perpetuate and exacerbate inequalities (Navarro 2002). The political economy approach, however, has at times overlooked the accelerated and intensified mechanisms by which the very substance of life is extracted from those lower on the social ladder for the benefit of those higher up. Markets for organs and babies are the most dramatic example of just how arterial these processes of extraction have become. These phenomena are only the most lurid examples of processes that dramatically shorten life expectancy of the poor even as that of the rich increases. Biocommodities and biomarkets are often transnational in scope because the inequalities that permit them are difficult to sustain within national borders, although they clearly exist in countries, such as the United States, with sufficiently steep gradients of inequality. Study of biocommodities and biomarkets index the processes by which less-well-off individuals trade in their long-term health for short-term gain, to the benefit of the long-term health of those who are better off.

Intensified commodification is occurring throughout the biological realm, as transnational corporations claim patents over an ever-extending part of the biological realm. This, it has been argued, is nothing short of a fencing off of the intellectual commons, as seen in the reinforcement of international intellectual property law through the trade-related aspects of intellectual property rights (TRIPS) (The Panos Institute 2002, Vercellone 2002). The current struggle over expanding access to antiretroviral drugs highlights how biocommodation compromises public health, particularly in poor countries, and exacerbates health inequalities by raising the cost of treatment—and the cost of developing new treatments (Bierlich 1999, WHO/EDM 1999). The rise of biocapital essentially concentrates therapeutic options in the hands of transnational corporations, subsuming future health to the imperatives of capitalist production (Negri & Hardt 2001).

Public health in most parts of the world has been sacrificed—through structural adjustment programs and a host of other neoliberal incentives foisted on the world’s poorer countries by the implementing agencies of rich donor countries—in order to create more favorable climates for investment (Braveman & Tarimo 2002, Lloyd-Sherlock 2000). The poor disproportionately suffer the consequences, resulting in the illness-poverty trap that has spiraled entire societies into demographic decline as communicable diseases spread unchecked. This finding concurs within observations that the demands of neoliberal globalization imply that the poor are dying for growth (Kim et al. 2000), just as they bled for the industrial revolution in the nineteenth century. This venous language, as strident as it may sound to some, is mild compared to the vernacular of vampire rumors and other references to the occult nature of contemporary capitalism (Ashforth 1999, Comaroff & Comaroff 1999). These authors describe arterial forms of extraction and a cannibalistic social
order, where the poor sell their health to stay alive to benefit those who are better off.

This phenomenon occurs even as the care of the body, particularly in settings of high prevalence of disease, becomes ever central to maintaining life and reproduction. Although in situations of absolute poverty there is no effective access to expensive biomedical care, inequality means that even the poor will mobilize significant resources to access biomedicine (Aymé et al. 2002). Partial access to biomedicines is of particular public health concern in the case of infectious disease, where suboptimal treatment with inadequate doses or courses of antibiotics, or use of substandard antibiotics, can spread drug resistance. Drug resistant epidemics of tuberculosis have now been documented in most parts of the world (Farmer 1997). These epidemics threaten rich and poor alike, an example of a gradient-driven health effect whose consequences stretch across the socioeconomic spectrum.

CONCLUSION

Inequality, or the uneven distribution of power, is universal in any society, as witnessed by the fact that in every society misfortune is selective, affecting some but not others. The embodiment of inequality calls attention to the different forms through which violence is exercised in a given society and the ways in which the body serves as a register for, or a site of, struggle against forms of domination. The deepened inequalities that have emerged under the sign of the global (Tsing 2000) call attention to the increasing commodification of the body and its futures and to the cultures of inequality that breed indifference in the face of a pathogenic social spiral that threatens to unravel social solidarity in the face of the health threats of the new millennium. Ethnography has emerged as a key research strategy not for reciting a pious liturgy on the horrors of the forms human misery takes but for demonstrating the links between policy and everyday life and for carefully scrutinizing the legacy of those who rightfully seek to correct conditions that are all too often beyond their control.

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CONTENTS

Frontispiece—Ward H. Goodenough  xiv

OVERVIEW
In Pursuit of Culture, Ward H. Goodenough  1

ARCHAEOLOGY
Mississippian Chiefdoms: How Complex?, Charles R. Cobb  63
It’s a Material World: History, Artifacts, and Anthropology, Elizabeth M. Brumfiel  205
Hunter-Gatherer Archaeology in South America, Vivian Scheinsohn  339

BIOLOGICAL ANTHROPOLOGY
Developmental Biology and Human Evolution, C. Owen Lovejoy, Melanie A. McCollum, Philip L. Reno, and Burt A. Rosenman  85
Environmental Pollution in Urban Environments and Human Biology, Lawrence M. Schell and Melinda Denham  111
The Neolithic Invasion of Europe, Martin Richards  135
Intergroup Relations in Chimpanzees, Michael L. Wilson and Richard W. Wrangham  363

LINGUISTICS AND COMMUNICATIVE PRACTICES
Context, Culture, and Structuration in the Languages of Australia, Nicholas Evans  13

SOCIOCULTURAL ANTHROPOLOGY
Gender and Inequality in the Global Labor Force, Mary Beth Mills  41
Complex Adaptive Systems, J. Stephen Lansing  183
Urban Violence and Street Gangs, James Diego Vigil  225
Sustainable Governance of Common-Pool Resources: Context, Methods, and Politics, Arun Agrawal  243
Urbanization and the Global Perspective, Alan Smart and Josephine Smart  263
CONTENTS  ix

Resource Wars: The Anthropology of Mining, *Chris Ballard and Glenn Banks* 287


Maddening States, *Begoña Aretxaga* 393

Highlights and Overview of the History of Educational Ethnography, *Daniel A. Yon* 411

Children, Childhoods, and Violence, *Jill E. Korbin* 431

Anthropology, Inequality, and Disease: A Review, *Vinh-Kim Nguyen and Karine Peschard* 447

**THEME I: URBAN WORLDS**

Environmental Pollution in Urban Environments and Human Biology, *Lawrence M. Schell and Melinda Denham* 111

Urban Violence and Street Gangs, *James Diego Vigil* 225

Urbanization and the Global Perspective, *Alan Smart and Josephine Smart* 263


**THEME II: INEQUALITY**

Gender and Inequality in the Global Labor Force, *Mary Beth Mills* 41

Anthropology, Inequality, and Disease: A Review, *Vinh-Kim Nguyen and Karine Peschard* 447

**INDEXES**

Subject Index 475

Cumulative Index of Contributing Authors, Volumes 24–32 485

Cumulative Index of Chapter Titles, Volume 24–32 488

**ERRATA**

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