Questions of Health and Inequality in Mozambique

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Abstract

This paper explores what a focus on inequality rather than poverty might mean for the way we look at the issues of social protection and health in Mozambique. It does not provide fixed answers on the state of health and well-being in Mozambique today, and even less recommend policy interventions. It only attempts to identify some issues that need more research and reflection.

The paper is part of a series of articles resulting from the "seminar on productive social protection action" that IESE's Research Group on Poverty and Social Protection held on May 12, 2010.

Resumo

Este artigo explora o que o foco na desigualdade, ao invés da pobreza, pode significar para a forma como olhamos as questões sobre protecção social e saúde em Moçambique. Não fornece respostas fixas sobre o estado da saúde e bem-estar em Moçambique de hoje, muito menos recomenda intervenções políticas. Apenas tenta identificar algumas questões que precisam de mais investigação e reflexão. O artigo faz parte de um conjunto de artigos resultantes do "seminário sobre acção social produtiva" que o Grupo de Investigação "Pobreza e Protecção Social" do IESE, realizou em 12 Maio de 2010.

Introduction: Social protection, health and inequality

Much of the academic and policy literature on social protection is concerned with addressing the plight of the poor and the particular vulnerabilities of poor people to different kinds of risk. Ill health, whether sudden and transient or chronic, is one of these. Recently, however, some have argued that a policy focus on the health of the poor can be misleading. Wilkinson (1996) has argued that inequality is actually more important than poverty as a cause of ill health; Unequal societies are literally sick societies. This focus on inequality and health has drawn increasing attention in the social policy literature. Even the World Bank has recently published a report on inequality and health (Yazbeck 2009). This paper explores what a focus on inequality rather than poverty might mean for the way we look at the issues of social protection and health in Mozambique. It does not provide fixed answers on the state of health and well-being in Mozambique today, and even less recommend policy interventions. It only attempts to identify some issues that need more research and reflection.

A focus on inequality rather than poverty has analytical implications for those concerned with how to improve the well-being of the poor. A narrow focus on poverty *per se* limits our view to the characteristics of those who are poor and leads us to be concerned with changing them rather than the society in which they live. Compassionate documentation of the experience of poverty and processes of impoverishment may motivate concerned observers, but it provides few new insight for those who are poor and it tell us very little about what can be done about poverty nor how to do it. A focus on inequality treats poverty, deprivation and disadvantage as relational positions and obliges those who wish to address them to look both at those who are poor and those who are not, (the latter group most often including the compassionate observers) and their relation to each other. In short, poverty is a characteristic of individuals while inequality is a relational property of societies or social groups.

Looking at poverty as an outcome of relations of inequality rather than a property of individuals changes the way we think about policy interventions. Addressing inequality necessarily raises the question of redistribution of wealth and thus raises questions of property – the ownership of wealth.[1] We are thus on a terrain that is both political and economic. We are talking about change and hence about economic growth or decline, but as volumes of literature on the indeterminacy of the 'trickle-down effect' have demonstrated the question of redistribution is both a political and economic issue. To say something about the politics of inequality means being able to identify what these relations of inequality are and how they have come to be what they are.

Sorting out the complexity of these questions inevitably demands some sort of theoretical framing. This paper reflects on the ways that three different theoretical approaches have

[1] I say necessarily, but policy institutions are not constrained by consistency. Though the World Bank report purports to be on health and inequality, the remedies it proposes are taken from its familiar micro 'menu of pro-poor policies': e.g. targeting, insurance, exemptions and strengthening the voice of the poor. These all focus on strengthening the capacity of the poor to take care of themselves, not on redistribution of wealth from rich to poor.

addressed the political economy of health inequality and how these might help us to sort out issues of health inequality in Mozambique. The first approach is the liberal tradition, within which inequality is a core concept and which informs much of the epidemiological literature on inequality in health. The second is Foucault's critical history of bioscience, which challenges the universalistic assumptions of liberalism and locates inequality within practices of power. The third is Marx's theory of class relations under capitalism, which locates diverse forms of inequality in the dynamics of class and suggests that capitalism has an inherent tendency to be unconcerned with the health of populations.

Mozambique is one of the countries where the World Bank has made an explicit effort to look at the relation between health and inequality. A group of health economists working with the Bank developed a way to rework the already long established Demographic and Health Survey (DHS) data to compare health inequalities with other social inequalities, particularly those between wealth groups, between regions and between country and city (Gwatkin 2001). Their method for calculating economic inequality depends on the construction of an asset index, based on household goods registered in the DHS. This paper reviews the study by Gwatkin and others (2002) of what we can know about changing patterns of health and wealth inequality in Mozambique by comparing the 1997 and 2003 DHS surveys. As well shall see, the answer is not very much. There are many methodological issues so one might argue that the problem is a technical one, to be resolved by perfecting survey techniques. I would argue, however, that the problem lies in the assumptions underlying the questions asked, and turn again to debates in liberal theory, to Foucault and to Marx to identify some of the questions that need asking.

The first section of this paper outlines the three different approaches to health and inequality, no one of them completely homogeneous and often in implicit conversation with each other. The second scans the dimensions of inequality that have received political framing in Mozambique. The third examines some indicators of states of health and health care, relying mainly on the DHS based study. The final section identifies issues that might be raised about these data from the perspective of the three different approaches to inequality in health. The purpose of this paper is not to provide a state of the art review of what we know about health inequality in Mozambique, but to reflect on how IESE might extend its research on social protection, accumulation and redistribution to the area of health.

The Body Politic: health and inequality

Liberal epidemiology

The terms inequality and redistribution are rooted in liberalism, for which inequality is a central philosophical, political and ethical problem. I thus begin with liberal epidemiology, which addresses these questions very explicitly.

Liberal epidemiology is a broad church, including both the kind of extreme utilitarianism and methodological individualism we have come to identify with neo-liberalism and its structuralist critics. Epidemiologists recognize that different health outcomes are socially and culturally shaped and try to sort out what the important variables are. The difficulties arise in deciding what these variables are and how one interprets them in the design of intervention. Liberalism has shaped the mainstream epidemiology in two ways: first in the models it uses as the basis for its statistical interpretation of causality and second in its understanding of change.

Liberal epidemiology begins with the health outcomes experienced and observed in the behaviour of individual bodies; it traces individual histories of particular bio-medical characteristics or events, e.g. fertility, morbidity or mortality[2]. Their standard models distinguish between the proximate bio-medical determinants of these events, such as exposure to infection, or frequency of sexual relations and the indirect socio-economic determinants that shape the proximate determinants. These relations are of course complex and multi-variate. Thus conventional epidemiology relies heavily on finding patterns of statistical correlation to establish important relationships. In practice the focus of interventions tends to be at the level of the proximate determinants while social and economic variables are relegated to the context of intervention. This is why opponents of this method, particularly medical anthropologists and some sociologists, charge them with bio-medical reductionism.

Take, for example, the explanation of the high incidence of AIDS in Africa taken by Helen Epstein (2007). She assigns central importance to incidence of concurrent sexual relations, a reflection of a normative African tradition of polygyny. She recognises the contributions of poverty, conflict, gender inequality and poor health care; she knows that it is not enough to just to advise people to abstain or to be monogamous. In Mozambique, as elsewhere, the relation between knowledge of AIDS and changes in sexual practices is tenuous. Her preferred policy interventions are, however, at the level of the individual and typically liberal: e.g., enhance women's freedom to choose through micro-credit schemes.

In its most utilitarian form, liberal epidemiology melded with neo-classical economics to reduce issues of redistribution in health to comparative cost-accounting. The likely impact of an intervention is calculated in terms of 'disability-adjusted life years' (DALYs). Its cost and DALYs are then compared with other possible interventions to determine what should be done.

Liberal epidemiology shares the progressive view of history of many demographers – with economic development, the expansion of the market, the rule of law and democracy, societies are expected to proceed through a series of transitions that reflect improvements in well-being. High fertility gives way to low fertility, life expectancy is extended, infectious communicable diseases become less important than chronic illness and countries become receivers of migrants rather than senders. The unidirectionality and simultaneity of these

[2] For a good illustration of this method, see Hill, K. 2003, 'Frameworks for studying the determinants of child survival', Bulletin of the World Health Organization 2003, 81 (2): 138-9.

transitions have been challenged even for Europe, but debates around them have given rise to questions that are relevant to the analysis of health and inequality in Mozambique. McKeown (McKeown 1976; McKeown & Brown 1955) suggested that improvements in therapeutic medical care (surgery, midwifery, medicines, hospitals and dispensaries, preventive therapy) could not have had a major impact on mortality trends in the 18th century. More important were improvements in environment, particularly hygiene, improvement in living conditions, particularly nutrition, and changes in the virulence of infecting organisms. Gandy (2003), focusing on the decline of tuberculosis, a particularly important issue given its current recurrence, thinks that McKeown gives excessive importance to nutrition relative to the explicit public health interventions that underlay environmental improvements.

There is a counter-tradition within liberal epidemiology to the methodological focus on individual behaviour in much of health economics and conventional epidemiology. These critics argue that what happens to individuals at the level of bio-medical outcomes must first be understood as a product of the social worlds within which they live. They are particularly concerned with the relation between illness and inequality. Richard Wilkinson and others[3] have shown that holding absolute poverty levels constant, health outcomes are worse for those who live in inegalitarian societies than for those who live in egalitarian societies. They thus conclude that unequal societies are also sick societies. In their research they look for the pathways or mechanisms that produce the afflictions of inequality. They focus on statistically showing links between health outcomes and particular social variables that might be characteristic of inegalitarian societies. Inequality, for example, could undermine social cohesion by undercutting the social connections ('social capital') that provide social protection. Or inequality might lead to greater stress at work and thus to psychological forms of affliction (Siegrist & Marmot 2004). Most of this work has been done in industrialised countries in Europe and North America.

There are others, however, such as Navarro and Shi (2001) or Farmer (1999) who deal specifically with global inequalities in health, their structural causes and the ways in which health policies themselves contribute to inequality. They are not so concerned with statistical correlation in their argumentation but with relations of power, both political and economic, that are no less real for being difficult to measure. Farmer, known particularly for his work on AIDS in Haiti, is concerned with 'structural violence' – social inequalities that put individuals and populations in danger (Farmer 2003). Navarro and Shil (op cit) identified three main determinants of health inequalities: inequalities of income, levels and distribution of public expenditure on health and public support to families. Navarro (1972) has been specifically concerned with the construction of more egalitarian medical systems and thus did early analysis of the Cuban health system.

[3] See, for example, Marmot, M. & Wilkinson, R. 2006, *Social determinants of health*: Oxford University Press Oxford, Wilkinson, R. 1996, *Unhealthy Societies, The Afflications of Inequality*, London: Routledge, Wilkinson, R. 1997, 'Socioeconomic determinants of health: Health inequalities: relative or absolute material standards?', *British medical journal*, 314 (7080): 591, Wilkinson, R. & Pickett, K. 2009, 'Income Inequality and Social Dysfunction', *Annual Review of Sociology*, 35: 493-511, Wilkinson, R. G. & Marmot, M. G. 1998, *The Solid Facts: Social Determinants of Health*: Centre for Urban Health, World Health Organization.

One strand of work on the politics of health draws from sociological studies of the development of welfare states in industrialised or industrialising countries and thus overlaps with the literature on social protection. Initially this work reflected modernisation approaches that saw the quality and coverage of care progressing through different stages. In this tradition, the development of the providential state is related to the politics of democratisation. Writing in post-World War II Great Britain, Marshall (1998) saw class politics propelling citizenship from narrowly defined civil rights towards political rights and finally towards social rights. The development of public educational systems and social services, which improved the substance of life nonetheless maintained basic inequalities of class.

Currently much of this work, based on comparative case-studies, is typological, concerned with looking at the different pathways, or the varieties of capitalism, followed by different countries in their approaches social security (Esping-Andersen 1990) (Goodin et al. 1999; Gough et al. 2004; Kwon 1998). This literature is very focused on state policies and policy instruments such as taxation and regulation. One of Esping-Andersen's contributions is the concept of decommodification, which has been used to describe the ways in which access to health care can be either regulated or provided by the state in such a way that it effectively ceases to be a commodity.

In this counter-tradition, liberalism carries with it not just rational man but notions of justice, equality and human rights. Redistributive justice requires a calculation of costs, but market efficiency is not the criterion upon which decisions about health interventions should be made. In southern Africa, Nattrass's (2004) *The Moral Economy of AIDS in South Africa*, a robust plea for generalised use of ART (in South Africa) is a powerful illustration of both the strengths and limitations of such an approach.[4]

Foucault's critical history of bioscience and liberal politics

The assumptions, particularly the moral premises, of the liberal view of social inequality and medical intervention are critically examined in Foucault's work on the history of bioscience, again principally in Europe and North America.[5] Foucault does not dismiss the premises of liberalism. His concern is rather to show how they are embodied in practices of power that give materiality both to them and to the inequalities they describe. Foucault's work from the 1970s challenged many fixed ideas about the politics of health. He rejected the opposition between private liberal medicine subject to the laws of the market and concern with the health of collectivities, and the claim that the latter developed out of a critique of the former (Foucault 1997; 2000a; 2000b). He pointed out that concern with the well-being of

[4] See O'Laughlin, B. 2006, *AIDS, Freedom and the Moral Community of Citizens in Southern Africa*: Institute of Social Studies (ISS).

[5] The *Annual Review of Anthropology* has covered literature on health inequalities well in recent years. See particularly Nguyen and Peschard 2003, Janes and Corbett 2005, Pfeiffer and Chapman 2010.

the population is not specific to modernism. It was earlier been considered to be an obligation of sovereignty. Collective health was not narrowly defined in a biological way but included social and moral health, with disease often indicating pathology in other aspects of life. This vision would be familiar in many communities in Mozambique where floods, epidemics or the clustering of infantile mortality are evidence of social disorders subject to ancestral intervention and spiritual responses.

Change came for Europe in the 18th century. Foucault traces a bifurcated process: development of a medical market and a politics of health that takes disease as an economic and political problem which social collectivities must resolve. Redistribution would then be for Foucault a technique of governance, a practice of liberal power. He also emphasizes that the health of collectivities was never exclusively the responsibility of states; religious, charitable and scholarly institutions all were concerned with the health of collectivities and had health policies. And third, in line with Foucault's more general thinking about the embodiment of power, he refuses to separate analytically ideologies from social relations. Both are inextricably embedded in practices and both are material.

Foucault's work on the development of concern with the health of collectivities, what he calls 'social medicine', in Europe is particularly useful in obliging us to think critically and politically about what we mean by a 'health system'(Foucault 2000a) and certainly not to assume the ethical superiority of the welfare state. He describes three stages: the development of state medicine in Germany concerned with the observation and registration of disease and the regulation of medical practice and knowledge; the development of urban medicine in France concerned with the salubrity of the cities and their areas of danger, both environmental and social; and labour force medicine in England based in the sometimes conflicting fear of the proletariat and need to control the health of the labour force.

Anthropologists and historians of Africa who write about health and healing have taken Foucault to heart on the interpretation of practices, using social constructivism and the critique of liberalism to produce some very powerful accounts of health and reflections on the politics of health. Work on health and colonialism in Africa is particularly insightful in thinking about health and inequality as are reflections on the biopolitics of HIV/AIDS.[6] These studies show clearly that neither colonialism nor post-colonial neo-liberalism has simply reshaped Africa in their image nor do they suggest that bio-medical interventions are irrelevant. However, they leave certain theoretical and practical questions untouched. How does one recognize and understand relevant practices? How do inequalities come to be embodied in practices? Social constructivism provides powerful accounts of the experience of suffering and

[6] On the embodiment of inequality in post-Apartheid South Africa, see Fassin, D. 2004, 'L'incorporation de l'inégalité. Condition sociale et expérience historique dans le post-apartheid', in *Afflictions. L'Afrique du Sud, de l'apartheid au sida*, ed. D. Fassin, Paris: Karthala. On health and healing in colonial Africa see particularly Vaughan, M. 1992, *Curing their ills. Colonial power and African illness*, Stanford: Stanford University Press., and Comaroff, J. 1993, 'The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body', in *Knowledge, Power and Practice; the Anthropology of Medicine and Everyday Life*, ed. S. Lindenbaum, Berkeley: University of California Press . On the social and political construction of AIDS see Fassin Fassin, D. 2007, *When Bodies Remember, Experiences and Politics of AIDS in South Africa*, Berkeley: University of California Press.

affliction and historically insightful description of the inequalities – of gender, race, ethnicity, class - they reflect, but few conceptual handles on explanation and intervention. Perhaps for that reason the less able fall back on a rote critique of neo-liberalism (that Foucault would abhor) and/or a politics of human rights, which is after all rooted in the same liberal tradition that Foucault taught us to dissect. Redistribution figures, particularly in relation to global inequalities, but its political and economic spaces are vaguely defined.

To give an example of this indeterminate theoretical space, take Dozon and Fassin (1989) discussing the reluctance of African governments to address AIDS openly in the 1980s. Dozon and Fassin observed that African states are neither democratic nor provident. Their silence was dictated by domestic politics: the need to give the impression of control to the populations they governed, and the need to maintain political control with a very limited legitimacy. We are told what African states are not, but not what they are and thus it is difficult to understand this defence of sovereignty. Politics float in a conceptually unstructured world. Fassin goes further in his work on South Africa (Fassin 2008), but then there the state is neither so clearly undemocratic in the liberal sense nor improvident.

Marx: Class politics, accumulation and 'the law of population'

The problematic politics of health inequalities take us to a third current of work, Marxism. Like Foucault' approach, it involves a critical reading of liberal politics and provides some core conceptual handles to follow, particularly in the centrality it gives to relations of class. Marxism was of course a focus of Foucault's critique, not so much for its reductionism but for its modernist abstractions from practices and its absolute truth claims. It does make such claims and in doing so rescues us from political impasse, from drowning in the complexities of practices and the infinite critical dissection of liberalism or neo-liberalism. It does so by providing a clear theoretical account of the relation between health, inequality and accumulation that focuses on relations of class. It is a modernist venture that deals with both the politics and economics of redistribution.

If accumulation were only a Marxist synonym for economic growth, then the sensible thing would be to do away with the concept altogether. The reason for making the distinction is that accumulation in the Marxist sense captures the dialectical relation in capitalism between the forces of production – the development of the stock of productive goods and techniques of production and the relations of class that structure how wealth is produced, distributed and consumed. These relations of class fracture what could otherwise be thought of as homogeneous whole, e.g. the national economy, and make of it a contradictory unit, economically and politically.

This deconstruction of a functional whole society is particularly important if we wish to make a connection between accumulation and social protection. Economic growth is not

an end in itself, but the means of reaching some objective. Liberal and Marxist approaches look at these objectives in different ways. In conventional liberal approaches to social protection, the objective of economic growth should be pursuit of the common good, understood as the summation of the achievable needs and desires of all citizen. Social protection then serves to protect those whose needs and desires are for some reason excluded from this common pool, generally because external relations of power interfere with the harmonising action of the market. Social protection should be organised to build upon and strengthen the capabilities that all have to participate in the market. In this approach, capitalism is a universal system and everyone is a capitalist, for everyone including the poor has some sort of capital ('the poor too have assets'). The older generation in Mozambique will well remember the turbulence in rural areas that resulted from a rumour that Frelimo was applying such a definition of capital to cattle and that all herds were about to be nationalised. Capitals can be commodities that are directly exchanged in the market but they can also be properties that allow people entry to exchange on advantageous terms: human or social or natural or financial or physical (the pentagon of livelihoods theory).

In Marxist theory, the fact that the poor have some assets does not make them capitalists. Capitalism is an historically specific mode of production, grounded in particular class relations and ways of organising economic life. It is peculiarly dependent on achieving constant economic growth, a source of both its dynamism and its tendency towards recurring crisis. The objectives of social protection appear differently from different class positions. Capital in money form is generalised enough for those who have financial capital to control the means of production, to employ workers and to make sufficient profit through successful competition in the market so as to begin the process again. Their profit is a function of the productivity of labour but this can be increased by extending the working day, or persuading workers to work more intensively as well as through technical innovation in labour process and equipment. Innovation is a more likely profit-making strategy when workers are organised to protect their conditions of work and to push for higher wages. In low-skilled work, particularly in contexts of large-scale unemployment, such organisational efforts are difficult to sustain since employers can lower wages and intensify work by hiring casual, flexible and part-time workers.

This casualisation of labour is currently taking place in many sectors in South Africa [Bezuidenhout and Buhlungu (2007)], but it is not a new pattern. Work in the port of Maputo, both before and after Independence, distinguished between permanent skilled workers such as machine operators and clerks and the dockers hired on a casual basis to move irregularly arriving cargo between wagons and boats. Similarly, colonial plantations and large settler farms, like state-farms, distinguished between skilled tractor drivers and supervisors, paid on a monthly basis and often provided with family-housing and casually recruited field workers, men and women, paid a task-wage, trucked in daily or sleeping in sheds. Wage-patterns in Xinavane (Ibraimo, 2010) and recruitment practices of Chokwe farmers show that capitalist agriculture today makes similar distinctions, for reasons of profitability.

One of Marx's core insights about capitalism as a mode of production is the distinctiveness of its approach to the reproduction of those on whose labour it depends – its 'law of population'. Capitalism does not necessarily assure the reproduction of its own labour-force. A capitalist firm buys a commodity, labour-power, the payment for which is the wage, but the level of that wage is not necessarily enough to assure the everyday subsistence of workers nor the production of a new generation of workers. It is competition between capitalists in the labour market and the political organisation of workers that exert upward pressure on wages. Historically the most generalised example has been unpaid care work, much of it done by women and girls.

There have been, however, many different ways to pay wages below the cost of reproduction of the labour-force. The forced labour system used to recruit casual workers for plantations and urban sanitation services in Mozambique is an illustration. Contract grower schemes provide another more contemporary example. With a drop in world-prices the small growers are left without a purchaser of their crop and with no return to their labour. This protects capitalist organisers of the scheme against losses. This is what happened, for example, when some bio-fuel schemes held up construction of processing plants when the falling price of oil temporary drove down fuel prices.

The health of their labour force and its qualifications are an issue for capitalist enterprises. Those that are relatively large may set up their own health services as did some factories, plantation and the ports and railways in the colonial period. Some large companies have currently also asked to set up their own ART programmes, though this has been rejected by the Ministry of Health. It is not possible, however, for smaller enterprises to organise their own health services, and larger enterprises have also preferred to externalize responsibility for education and health of future generations, in the same way that they expect government to invest in infrastructure required for their functioning – grids of transport and energy.

The area of collective social health that Foucault described is thus a political reworking of the space of externalities. Collective social health is a product of states addressing externalities by acting in terms of the interests of capital as a whole. It is also a product of working people's defence both of their real wages and working conditions and their areas of autonomy, leisure and non-commodified space. Social health in a Marxist sense is thus an outcome of both class struggle and class alliances.

What then are the sources of inequality in a Marxist tradition? Classes are not income groups - the rich and the poor and the in-between - as in liberal theory. Classes are defined by their relation to the means of production; as political collectivities they are defined through histories of political action. Differences of ethnicity, race, or gender are not universal or natural relations of hierarchy. They are not created neither by capital nor by the liberal state but the terms of inequality are shaped by the ways they relate to the dynamics of class. Inversely, the dynamics of class are often lived in work-place struggle or in the labour-market through conflicting identities of race, or gender, or ethnicity.

The present is always history in a Marxist sense. Capitalism does not rewrite the world in a single image. There are many forms of capitalism and each carries with it different versions of its contradictions. The question to ask about redistribution, accumulation and health is not therefore whether redistributive growth is a possibility but how class politics shape different paths of accumulation, the shape and import of inequality and the nature of health and healing.

In the liberal tradition the central question about redistribution is 'How can we afford what justice demands?' The question demands a search for remedies for defects in how particular capitalisms function. In Foucault we find a deconstruction of that question, showing us how *homo economicus* lurks behind it, but left with little reason to believe that we could find a better question. For Marx the question must be 'How have these inequalities come to be and how can we organise production, distribution and consumption in different ways? The terms of redistributive schemes matter immensely, but we should never think that they provide enduring resolution of the inequalities of capitalist production.

Dimensions of health inequality in Mozambique

The question of redistribution poses a political conundrum: if inequalities imply not just difference but also hierarchical relations of power, then under what circumstances would hierarchy give way to allow for redistribution from one group to another? In relation to health, one frequent answer is that ill health poses problems for the collective good, but clearly that is not always true nor acted upon. The first issue must be to understand what inequalities are, how they have come to be and how they are politically recognised. The political discourses of health inequality in Mozambique invoke various dimensions of inequality: global differences between nations, the rural/urban gap, region, gender, race and income (rich/poor). Lurking behind them, but now rarely invoked nor analyzed lie relations of class. My goal here is not to do a thorough review of the existing literature on the dimensions of inequality in Mozambique, which would take us beyond the boundaries of Mozambique to other countries in the region and would demand reviewing historical accounts as well as contemporary literature on health and health policy. Rather I want to probe some assumptions, to identify some lacunae and to raise some questions about our understanding of health inequalities in Mozambique.

Global inequality between nations

The dependence of both government and non-governmental health expenditure on donor funding is well known, as is the influence of donors on health policy and the defence of the public health system by the Mozambican government. There are analyses of both broad patterns and specific case-studies focusing on particular regions or health sectors.

Pfeifer (2003), for example, did an insightful study of how NGO functioning in the post-war period in Manica led to a fragmentation of the public health system. Matsinhe (2006) provides a devastating critique of the assumptions behind internationally led HIV/AIDS strategies. We do not know, however, very much about the class alliances that lie behind both the adoption of particular health policies and resistance to them. Nor is there a study of the relations of inequality between Mozambique and South Africa which contribute to the politics of health inequality in Mozambique.

The Rural/urban gap

A second well-discussed dimension of health inequality is the rural-urban gap, yet when we look at it closely, it is not perhaps as clear as we might think. Historically, as Bagchi (2004) points out, cities were often not very healthy places to live. Crowded together in slum-housing with poor drainage and sanitation conditions city-dwellers are vulnerable to waves of contagious disease and polluted air exacerbates respiratory problems. Moreover whereas some rural poor are able to scratch subsistence production from a small plot somewhere, urban people generally have no land at all, purchasing all their everyday subsistence in markets. In the case of sub-Saharan Africa, however, the concentration of health facilities in urban areas was very clear, particularly in colonies of settlement like Mozambique. Harsh influx controls in many urban areas in the colonial period reinforced the concentration of infrastructure and social services in cities. This is well illustrated in Gulube's (2003) history of the health system in southern Mozambique. Yet Gulube also shows the clustering of facilities along coastal Mozambique, a reflection of the location of centres of accumulation. More generally in colonial Africa, public health systems were located near production or recruitment centres and narrowly focused on the immediate health conditions of their (usually male) workers at work places, not in the rural communities from which they came (Vaughan 1992).

The political weight of the rural-urban gap was the reason why the colonial government made some further investment in the rural health grid as part of its psycho-social offensive during the struggle against colonial rule. It is reflected in Frelimo's decision to nationalise health care and to extend the public health system outside existing centres of accumulation, in the name of worker-peasant political alliance. And it was also why Renamo made the destruction of rural health posts such an important part of its strategy for undermining the political legitimacy of Frelimo. We know relatively little about the current dynamics of the rural-urban gap, its relation to accumulation and the class alliances that sustain it. It has been suggested, for example, that the rural/urban gap in Africa was a political outcome of the sensitivity of ruling parties to urban-based political movements and particularly to the political weight of the trade unions (This vision makes capital a neutral arbiter).

Regional inequality: North, Centre, South

A third much examined dimension of health inequality in Mozambique is regional divergence, particularly the question of southern privilege in health indicators and health provisioning. Divergence was clear in the immediate post-war period of the early 1990s, but even then it was not clear if this was a reflection of the destruction of the war or a pre-existing contribution to its causes. An underlying question is whether, like the rural-urban gap, regional divergences do not reflect the regional patterning of accumulation rather than political loyalties to home constituencies or the residence of political elites.

Gender

A fourth political dimension of inequality in health is that of gender, generally understood as the particular vulnerability of women on the one hand and the particular virtues of women as care-givers on the other. This inequality is difficult to see at the level of health statistics since many available health programmes focus on women - as reproducers of children. As Foucault and others have pointed out, the concern appears not so much to be with women as persons but with 'social medicine', the health of the collectivity.

Race

A fifth dimension is race, not currently explicitly mentioned in discussion of inequality in health in Mozambique, either domestically or in international agencies. This is historically interesting since race was an important dimension of health in the colonial period. It remains a major issue in health care debates in South Africa Race, or colour, was explicitly used in labour force statistics until the early 1960s in Mozambique; those with permanent jobs and access to benefits were mainly white. Gulube notes that there were special facilities for those who were indigent and/or black in the central hospital in Maputo. The nationalisation of health and the extension of the public health system (along with the flight of a large part of the white population) undercut the importance of race in health debates. Yet race sometimes emerges, along with nebulous categories such as 'the elite'[7] in discussion of privilege.

[7] See Sumich, J. 2008, 'Politics after the Time of Hunger in Mozambique: A Critique of Neo-Patrimonial Interpretation of African Elites', *Journal of Southern African Studies*, 34 (1): 111-25.

Class

And this brings us to a final dimension of inequality that currently almost never explicitly appears in political discussion of health in Mozambique – class. Even relative income rarely appears. There is discussion of the poor, but the word rich with its inevitable links to taxation and redistribution is not uttered. This is a significant silence since arguably the dimensions of inequality in health most heatedly discussed – regional and urban privilege – have been rooted since the colonial period in patterns of accumulation and thus class politics. In the first years of independence this relation was referred to in the political slogan 'worker-peasant alliance', its redistributive message somewhat undercut by the assumptions that a state declared socialist would necessarily be a representative of such an alliance and that the petty bourgeoisie would be workers like any other.

Indicators of health inequality in Mozambique

The dimensions discussed above appear in health debates with some assessment of their relative importance, generally given political legitimacy by the translation of these dimensions into measurable indicators. This already poses some problems for the way we recognize gender and class since these are relations and processes not directly measurable properties of individuals. It is easier to count how many children a woman has, for example, than to determine how wide the gender divergence in forms and levels of agricultural wages is. Or whether workers paid on a target wage basis are more productive in the long-term than those paid a day-wage, or if this depends on whether they work more hours a day. Or whether enterprises adopt more mechanised production processes in response to organised wage demands.

Much of the literature on health and inequality in Mozambique focuses on access to health services, whether preventive or curative care, rather than on relative states of health. This is partially because provisioning is somewhat more easily measured and recorded than are states of health, but it is also because it is a more restricted universe in policy terms. From the unresolved epidemiological debates discussed above, we know that access to health care has an impact on health, but that it is also affected by other things – nutrition, environment, the work we do, the knowledge we have, even though we do not necessarily agree on their relative importance. But pursuing these connections extends the areas of relevant policy intervention into the unstructured world of 'indirect determinants' in epidemiological models. The narrower relation between measures of health provision of health care is a more manageable universe.

There are, however, some surveys that are intended to follow the relation between inequality, health outcomes and forms of health provisioning. Noteworthy of course in Mozambique is

that this means not only the Mozambican state, but a range of global institutions – various instances of the UN and the World Bank – that fund and oversee bioscientific practices. If we are concerned with the relation between health redistribution, the problem is not that there is power embedded in measurement and control but whose power and what is measured.

The household and expenditure survey of 2002-3 (IAF) provides some data on inequality in access to and quality of health care. The recent preliminary report of the INSIDA survey on AIDS is used to look at rural/urban inequality in HIV prevalence. But most of the survey data are taken from one source, the Mozambique Demographic and Health Surveys (DHS) of 1997 and 2003. They give us the possibility of looking comparatively at a period that leads from the immediate post-war recovery through a period of political and economic restructuring in Mozambique and South Africa, economic and political crisis in Zimbabwe and the acceleration of HIV/AIDS. They are the only surveys that permit links to be made between wealth and states of health at the household level. The data from the DHS surveys, along with income data from the Household and Expenditure surveys, are used by the UNDP to calculate their comparative measure of well-being, the HDI, a weighted index of infant mortality, women's fertility, education and income. When the World Bank began to feel the critique of its structural adjustment programmes and returned to its earlier concern with the possibilities of redistributive growth (Chenery et al. 1974), it formed a group of health economists who worked out methodology for using an asset index to link household wealth to health outcomes.

The question of the relation between inequality, health and redistribution is a question of change – looking at what is happening over time. There are limited possibilities of looking for directions of change using these data. The DHS compare only two different years 1997 and 2003. The health data are taken from only one IAF. The ETSDS Expenditure Tracking and Service Delivery Survey was carried out once, in 2002. The INSIDA survey on AIDS completed this year is said to be very thorough but was also very expensive and not likely to be repeated soon. Given the limitations of these surveys is there anything to be gained from looking at these data? Yes, if we must remember that they do not necessarily provide a very representative picture of reality. What is of particular interest are anomalies, outliers and inconsistences in the data that would help to define questions and signal areas needed for research.

The tables in the appendix to which this section refers are grouped in two categories – indicators of inequality in health and indicators of inequality in health care. They are discussed below in that order but the reader may have to go back and forth between these two groups. To look at inequality in states of health, I have drawn from survey data on children's diarrhoea, child mortality, women's fertility and the HIV prevalence. To examine inequality in access to health care, I have taken general data on household access to health care provision and need, data on treatment of young children's acute respiratory infections, and quality of primary health facilities. The tables explore only three different dimensions of inequality: rural/urban divergence, regional divergence (provincial and North/Centre/South differences) and income group differences (as measured by wealth or expenditure data).

Measures of inequality in states of health

The first three tables consider only at one indicator of illness, children under three having diarrhoea in the two weeks preceding the survey[8]. Table 1 shows a very large reduction between 1997 and 2003 in the rural/urban gap. Indeed in 2003 the incidence of diarrhoea was slightly higher in urban areas than it was in rural areas (21.1% of children vs. 17.6%). Table 2 looks at provincial variation. There is no clear southern bias in these figures. We see that the urban rate is being pulled up by the distinct worsening of child diarrhoea incidence in the city of Maputo (from 17.4% to 28.9%). The improvement between the two years is remarkable in many provinces, but the inter-provincial differences in improvement are even more striking. In Tete, for example, the rate fell from 25.9% to 10.6% whereas in Manica the decline was only from 21.6% to 18.3%. Table 3 shows no clear patterns of variation by wealth, which could be interpreted as evidence of the levelling impact of health conditions and care in Mozambique. These tables on themselves tell us nothing about sources of change, but raise questions about environment, nutrition, disease and forms of health provisioning. In the end, despite major improvement and reduction in inequalities, we must confront the fact that about a fifth of Mozambican children had diarrhoea within a two-week period.

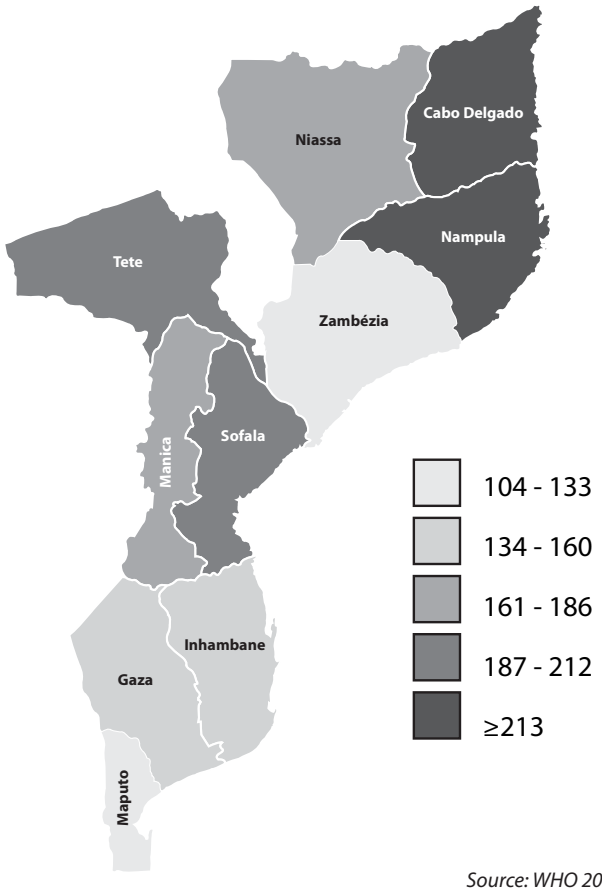
Tables 4 through 6 look at variation in mortality in children under 5, based in the number who died out of 1000 children born. Here there is also improvement in both rural and urban areas, and the gulf between rural and urban areas has lessened but neither are dramatic. In the end we still see child mortality of 192/1000 in rural areas. The provincial data show a North/South gradient, with much lower mortality in Maputo city and province in particular.

If we look at the child mortality by province, regional difference is more marked in 2003 than in 1997(see 2003 map in Figure 1 below). Despite major improvement in many provinces, the absolute level remains very high everywhere except Maputo City and province and Zambezia. But there are anomalies: the sharp declines registered in Zambezia and Nampula, and the worsening child mortality registered in Manica and Cabo Delgado. The gap between the richest and the poorest declines slightly but is still broad. Most striking of all, however, is the very high incidence of child mortality, around 200/1000, in the three lower quintiles, i.e. 60% of the population.

Tables 7 through 9 look at difference and change in women's fertility (TFR). They show a small decline in urban fertility, a substantial increase in rural fertility (5.3 to 6.1) and a corresponding increase in the gap between rural and urban fertility levels. Fertility declines in the South and in Manica and increases in all other provinces. These differences are significant in themselves, but in the post-war context are unlikely to tell us anything about deeper inequalities in health and well-being.

[8] I have chosen simple diarrhoea (without blood in feces) because it seemed the least illness to show a treatment effect, i.e. ; i.e those who have a chance of treatment, thus the better-ff, are more likely to recognise the incidence of the illness.

Figure 1: under 5 child mortality by province

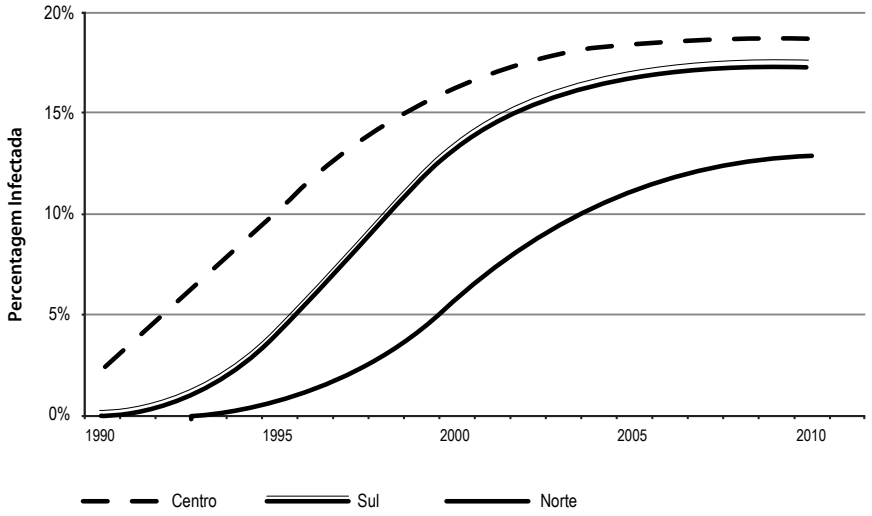


Source: WHO 2006 from DHS 2003

A final indicator of relative states of health considered here is prevalence of HIV. Until recently statistics on prevalence were based on data from sentinel sites that recorded prevalence among pregnant women coming to health posts. Using models based on experiences elsewhere, projections were then made to the broader population. A recently completed INSIDA study will bring more reliable and detailed data on HIV/AIDS in Mozambique, but preliminary results are already available. Table 11 shows that HIV prevalence is higher in urban than in rural areas and it is also higher among women than men, particularly in the youngest age-grouping.

AIDS is an entrenched pandemic and thus it is important to look at the HIV prevalence over time. We see very different regional patterns, as traced by the Ministry of Health in figure 2, based on preliminary results from the INSIDA study.

Figure 2: Estimated HIV prevalence in adults 15-49 years by region, 1998-2010



Source: Ministry of Health http://www.misau.gov.mz/pt/hiv_sida, downloaded 8/8/2010

HIV prevalence increased rapidly in the 1990s in central Mozambique, and is still highest there, even though it now appears to be stabilizing.9 This is a correction from earlier data based on projections from sentinel site data for pregnant women that showed the rate to be highest in the South. Prevalence may also be stabilising in the southern provinces after a rapid increase between 1995 and 2005. Gaza province has, however, the highest rate of prevalence in the country at 30%. Rates in northern Mozambique are increasing though at a lower rate than in the period between 2000 and 2005.

It is important to look at these figures in time because policies easily mistake moving targets for fixed patterns, as has happened elsewhere in the region. Despite the greater physiological vulnerability of women to infection, AIDS was thought to be an illness of mobile men and commercial sex workers; policies failed to see the predictable vulnerability of permanent partners. The disease seemed to cluster in urban areas and along transport corridors; the inevitable spread of these clusters to rural areas was overlooked. Differences in regional patterns of accumulation underlie different patterns of infection, but it would be unwise to as-

[9] Remember that stabilisation of prevalence rates can represent either a decline in new inflections or increases in mortality among those infected or both.

sume that AIDS spares men or rural people or northern Mozambique. If we take knowledge of disease to be part of a state of health, Table 12 from the preliminary INSIDA report does not augur well. It shows a very low general knowledge of HIV/AIDS among both women and men in rural areas. Years of AIDS research shows that people do not necessarily act on the basis of biomedical knowledge but that gives no advantage to ignorance.

Measures of inequality in provision of health care

The other way of looking at inequality in health is to focus on health care, including not only the distribution of facilities, drugs and staff but also the accessibility of health care and its relative quality. Accessibility is affected by many things besides the structure of fees: the distance to a health facility, the capacity to pay for transport, the informal payments required to be examined. In tables 12-14, drawn from the IAF household survey of 2002-2003, access is measured by physical availability and the gap between need and use. Quality is measured by subjective satisfaction.

Table 12 shows the problem with measuring inequality in health care according to individual estimations of need and satisfaction; inequality is already embedded in expectations. Despite a very wide gap between rural and urban in accessibility, rural households use health care providers almost as much as urban households (10.8% vs. 11.3%) and like urban people many are satisfied with what they get (61.9% vs. 63.4%). Table 14 shows somewhat predictable results: the lowest quintile has much less access to health care than the richest quintile; households across all quintiles estimate very similar levels of need; the rich are more likely to use health care providers; and all show similar levels of satisfaction with what they get. When we look at interprovincial differences in Table 13, however, there are many more puzzles. We can see that accessibility is heavily skewed towards Maputo province and City and to some extent Gaza (remember the influx of medical assistance after the floods of 2000). There are wide gaps between assessments of need and use in Cabo Delgado, Nampula, Zambezia and Tete, but less so in Niassa, Manica and Sofala. And Maputo City, which has the highest access and the lowest need and use, also has the lowest level of satisfaction.

The next three tables (15-17), taken from the DHS, use a narrower measure of need and access, the percentage of children with acute respiratory infection (ARI) were born in the three years preceding the survey who were taken to a health facility for treatment. In table 15 we see major improvement in rural areas (from 28.3% to 55%), but still a wide gap between rural and urban areas. Yet when we look at provincial data in Table 16, some puzzles emerge. Recourse to treatment generally improves, sometimes dramatically, but not in ways that correspond clearly to provincial patterns in child mortality in Table 5. Despite the clear improvement in treatment of respiratory infections and a slight decline in the incidence of diarrhoea (see Table 2) in Manica, for example, child mortality increased dramatically (Table 5).

The wealth data in Table 17 also pose some issues. The gap between poorest and the wealthiest has decreased, yet the very poorest clearly less often seek treatment for the respiratory illnesses of their children. Still all the other quintiles show no clear gradient in recourse to treatment, despite a clear break between the top 40% and everyone else in the child mortality data in Table 6 What if anything does this tell us about the accessibility of treatment and its consequences for child mortality?

On possible answer to the inconsistency between improvement in access to treatment and patterns of child mortality might lie in the quality of treatment children receive (despite the high rates of satisfaction recorded in the IAF 2003). Here a rural/urban gap is well documented, in primary as well as in secondary and tertiary facilities. The ETSDS survey done in 2002 showed the rural/urban gap in quality of and access to primary facilities. Table 18 registers some aspects of this gap. We see it not just where we might expect it, as in access to electricity, but also in stocks of basic drugs for primary health such as EPI vaccines for children and fansidar for chloroquine-resistant malaria.[10]

The ETSDS survey also addressed regional differences in the kinds of primary care provided. For sampling reasons having to do with the location of facilities (see Muñoz 2002), Zambezia and the City of Maputo were singled out, allowing us to see that the old tripartite political division is too crude to explore inter-provincial inequalities. Tables 19 and 20 look at the percentage of users reporting access to a wide range alternative health care facilities from hospitals, to traditional practitioners and medicine vendors in markets. Table 19 shows that urban residents have much more access to the National Health System (NHS) than do rural people, with particularly better access to hospitals (70.5% of urban respondents vs. 18.6% of rural respondents said that had access to hospitals). At the same time, they are also better served by pharmacies and private clinics. Note incidentally that the survey recorded much less treatment by health staff working from home in both city and country than popular accounts have suggested.

The provincial data show that the city of Maputo is very much an outlier – in access to hospitals and health centres, in the importance of private clinics and in its lesser (but not unimportant) recourse to traditional healers. In central Mozambique, including Zambezia, we find both higher access to religious organisations and NGOs and lower access to health centres and health-posts, confirmation, perhaps, for Pfeiffer's (op cit) observation on the crowding out of the NHS by NGOs in Manica.

If we take some distance from these data and return to the dimensions of health inequality political is recognised in Mozambique, it is important that in the period of post-war recovery there was improvement in many aspects of both health and health care in Mozambique and some of the regional inequalities and distance between cities and rural areas were reduced. Yet ultimately one must grapple with the stubbornly high rate of child mortality nationally and continuing inequalities between city and country and between wealth groups.

[10] Presumably these gaps have been addressed by the GAVI programme since this 2002 study.

The last two summary tables (20 and 21) assembled from data already in the appendix, show the rural/urban and wealth gaps in under five mortality compared with what has happened with two diseases of children – diarrhoea and respiratory infections. Dramatic improvement in treatment of respiratory infections and a substantial decline in diarrhoea in rural areas (and increase in the city of Maputo) did not bring down the rural/urban child mortality gap very much and the wealth gap even less. Perhaps more interesting is Table 6, which shows very little difference in child mortality within the bottom 60%, not reassuring because it is so high, around 200/1000.

If we return to the various dimensions of inequality that have stirred political debate in Mozambique, results of the probing the health inequality data are not particularly informative. Provincial differences seem significant, but the north/centre/south division that has so much political resonance is too crude to capture the different health and health care situations of particular provinces. Urban areas are clearly privileged in provisioning of health care and health outcomes, but the category needs deconstruction to take account of the very specific position of the city of Maputo, political capital and long-term centre of accumulation. Gender differences appear in the INSIDA study, but the interpretation of the higher HIV prevalence among women deals neither with the politics of sexual hierarchy not with the dynamics of epidemics. As for class, the closest we come is wealth quintiles.

About ten years ago, I attended a session where David Gwatkin enthusiastically explained the construction of the asset index (indeed a clever exercise) to a group of development ministry officials and NGO representatives in the Netherlands. At the end of his presentation one of the NGO people raised his hand and said 'So what? Poor people have worse health than the rich. That's no surprise'. Taken aback by the tone of hostility, Gwatkin simply responded, 'Yes, but it's important to show it'. A better defence might have been to suggest that variation in the relation between the two over time allows us to see the impact of different policies. But of course it is not so simple since the relations are always complex and depend upon the questions we ask. In the next section, I return to the three approaches discussed above and outline some questions they might lead us to ask about health inequalities and the politics of redistribution in Mozambique.

Redefining the terrain of research on inequality and health care mean in Mozambique

Insights from the liberal debates on health inequalities

Many of the conventional neo-liberal approaches to health inequalities focus on tight targeting in provisioning of allopathic health care, to assure that such measures do not compromise economic growth. Thus the focus of research is on the calculation of DALY's or top-

ics such as the organisation of exemption schemes. Liberal debates on health inequalities suggest that a much broader range of research is needed.

The first relevant debate within liberal epidemiology is about the importance of curative health provisioning in the reduction of mortality. Improvements in rates of child mortality in the post-war period may not be due to the recovery of the network of primary health care, which is after all patchy and much of it dependent on donor funding and NGO staffing. It is possible that lower child mortality is due to a general improvement in nutrition that has to do with the sorting out of land conflicts and the passage of a land-law that protected the rights of communities to land and contributed to the re-establishment of peasant production in the post-war period. Improvements in states of health may have been interdependent, that is, with economic growth, and notably not in line with neo-liberal recommendations for rapid development of land markets. Other aspects of public health that have to do with the environment of everyday life – sanitation, quality of air, parasitic infestations of air, soil and water, chemical exposure in work (including application of fertilizers by cotton-growing peasants in their own fields) have a differentiated impact on different groups of people. The worsening high rates of infantile diarrhoea in urban areas, for example, could suggest that drainage and water provisioning may be deficient.

Second, many liberal critics of neo-liberalism would note that the strict methodological individualism that underlies both much contemporary health economics and conventional epidemiology makes it difficult to see structural patterns. Collectivities are treated only as collections, aggregates of individuals or households. Wholes are nothing more than the statistical summation of their parts. This poses particular problems for the ways in which these methodologies conceptualize the determinants of health, particularly as far as environmental variables or access to health care are concerned. These have to be redefined as assets that are differentially owned by households and assigned values so that they can be measured at a household level. Arguably spatial mapping might give us a clearer and simpler picture of environmental dimensions of inequality, and would certainly provide a better basis for understanding the relation between patterns of accumulation and the dynamics of environmental health.

Beginning with collectivities would often simplify the design of interventions. Once the poverty of around 60% of rural households has been noted, for example, it should not be surprising that access to health care and mortality figures showed little differentiation within this group. There is thus little reason to focus research on the impact of exemptions. The key issues would have to be how the training of health professionals, maintenance of facilities and provision of drugs for general primary health care could be rapidly improved in areas where income deprivation is so generalised that commercial provisioning is not likely to function profitably. The same applies to preventive and environmental health measures. Rather than devoting time to finding a methodology that can take account of differential access to public goods in household surveys (cf. Deaton 1997), research should focus on how best to improve general access to these in areas where most households are deprived of them. To find out which areas these are does not require detailed household surveys, but rapid surveys of regional environmental health conditions.

Thirdly, a liberal focus on health inequalities would demand a much broader range of indicators of gender and generational inequality, deconstructing household assets to consider who really owns and controls what, and how these affect health outcomes. There would be more research on how domestic violence affects other aspects of health, and men too should be asked questions about their sexuality and sexual practices. Structural liberalism would focus not just on the households but also on the gendered assumptions underlying the institutions of law and government, particularly on questions of ownership of property and legal jurisdiction.

Fourth, structuralists would observe that these data tell us very little about how inequalities between nations affect health outcomes in Mozambique. The DHS, the IAF, and INSIDA surveys and the HDI index are based on internationally standardized methodologies, intended to measure variation between countries whose dependence make them objects of study. What we see in the suffering of individuals is often the outcome of global patterns of 'structural violence' over which they have little control.

The embedding of inequality in the practices of health governance

For Foucault observation is a technique of power in liberal governance. He would therefore remark, I think, many of the same gaps in evidence on health inequalities that liberalism would ask us to fill, but he would oblige us to interpret those gaps politically as what they represent, not as what they are not. Such data are based in the bioscientific practices of the liberal modern state, both asserting power and constructing it in particular ways.

Thus the comparative household surveys sponsored by international organisations and funded by established liberal states do not deal well with the complexity of households, particularly in rural areas, in the Mozambican context. Interviewers are left to muddle through, to apply the categories in ways that provide the best possible fit. This process is itself part of the creation of socially recognisable citizens in the providential liberal polity. Szreter (2007), for example, considers the registration of births and deaths to have been the basis for social citizenship in Europe and recommends it as a development intervention. In Mozambique, funding and technology have been made available to register voters but not to assure registry of birth or to issue identity documents. These are required for, among other things, international mobility, and might serve as more reliable instruments than sample surveys for understanding patterns of fertility and mortality.

Foucault might also draw our attention to the ways the asset index construes inequality. The DHS registers 'background characteristics of households' and includes a list of household assets, mainly consumer durables and house types. No proxy for social capital has been cobbled in, as household surveys have attempted to do in South Africa. Land is also

excluded, comprehensible since the DHS is already very long and land ownership is a very difficult thing to quantify in a context where individual household registry is not a customary form of land access. Foucault would perhaps observe as Scott (1998) has, however, that this non-recognisability of different forms of property is part of a political process that imposes survey and registration of land as a necessary technique of governance. Foucault might suggest that what is called urban bias in health provisioning is actually an expression of authoritarian medical interventions and controls imposed in cities from the colonial period onwards as a technique of governance.

Foucault would also undoubtedly observe that gender and generation are not precisely excluded from the DHS data; there are in fact long sets of questions about women's and children's states of health and women's reproductive practices. Foucault has drawn attention to the ways in which liberal states have medicalized women's sexuality and reproduction and assigned a privileged position to the survival of children as they made collective health an object of governance. He would have drawn attention to the way in which HIV positive young women are now held accountable for their affliction in the presentation of the INSIDA report.

The liberal equivalence of women's individual health and social health is evident in development discourse on fertility and inequality. The Human Development Index (HDI) and some of the Gender Development Index (GDI) methodologies assume that lower fertility is a measure both of a reduction in poverty for households (with correlations to show it) and an indication of improvement in the status of women. Yet correlations do not establish the direction of causality. Fertility proves not to be a robust indicator of gender status in rural areas. Anthropologists working on health issues in rural Mozambique often find that women themselves consider having many children to be a desirable sign of prosperity, fulfilment and ancestral harmony, but this is a reality not readable in development rhetoric.

Finally, I think that Foucault would oblige us to see the embodiment of the rural/urban divide in statistics on health as part of the process that constructs that divide, as ambiguities that are reinterpreted as sharp difference and thus become so.

Class dynamics in health inequalities

Marx, like Foucault, would locate health inequalities in contemporary Mozambique, and the categories with which they are measured, in the institutions of the liberal state in history, but would see that history to be rooted in the contradictions of class.

From this perspective the roots of the rural/urban divide lie in the residual position of workers' families under capitalism, a residualism that was legally enforced by controlled movement of people from city to country and back across colonial Africa. This division externalised accountability for all conditions of living in rural areas – the availability of water, of fuel,

of health care, of education of local governance, relegating all to the responsibility of 'tradition'. That did not turn pre-colonial history into a fiction or decimate all pre-colonial institutions in either city or country, but it did create a constantly traversed political boundary between them. Independence did not magically purge this division nor the residual position of the rural. Post-colonial health policy challenged the divide in the organisation of a national health system, but accumulation strategies did not. 'Agriculture as the base and industry as the dynamising element' effectively meant concentration of investment in urban areas. 'Tightening the belt' was considered to be easier for peasants because they had subsistence production to turn back to. Some planners wrote regional development plans based on where natural resources were located, treating the livelihoods of rural people as a residual variable.

Marx might suggest that the treatment of fertility as an indicator of women's and a country's level of illness is a resurgence of Malthus's assignment of the causes for immiseration under capitalism to the sexuality of the poor. He would ask why the relation between class and AIDS in southern Africa is understood only as the relation between infection and poverty at the individual level, when the rapid expansion of AIDS has so clearly something to do with changes in migration and household organisation related to major shifts in regional patterns of capital accumulation. He would observe that fragile models of 'home care' for AIDS patients seem to rely on the externalisation of the costs of reproducing the labour force and the assumption that caring women will be available, particularly if the afflicted retreat to rural areas they left long ago.

Marx would find the methodological practices of the World Bank (WB)/DHS asset index significantly misleading, clouding issues of class. Most obviously of course, trying to describe economic inequality purely as an outcome, the distribution of consumer goods, makes it impossible to trace shifts in class structure. Land is excluded from the list of assets yet it is the means of production that is still for most rural people in Mozambique an essential part of well-being. The list of assets probably also exaggerates the relative wealth of urban households, cloaking evolving class differences under the mantle of the rural/urban gap. Applying the index to the 1997 data Gwatkin et al (2002) found non-significant numbers of cases in the two poorest quintiles in urban areas. This is very unlikely, for by any measure there were still large numbers of war refugees squatting in peri-urban areas in 1997.

Most observers of class dynamics in contemporary Mozambique talk about the accumulation of wealth at the very top. The design of the household surveys does not allow us to easily spot class polarisation, particularly important if we are considering the political basis of redistributive claims. The sampling strategy is based on normal distributions. The number of cases is so small that sampling is very unlikely to capture households with significant control over capital, in either rural or urban areas. Wealth quintiles are too gross a measure to show us the impact of sharpening polarisation on health outcomes.

Of course, household surveys are not necessarily the appropriate instrument for looking at the evolution of class; indeed they should be used for what they can do, not redesigned

to do something they cannot. To understand what lies behind the shifting well-being of people in both rural and urban areas and the possibilities of redistributive politics, we need surveys that explicitly look at the ownership of property, more often captured at the level of enterprises. Neo-liberals might focus on the inefficiency of regulation in Mozambique. Foucault might dissect the extensive reporting that settler farms and firms were required to do in the colonial period, the inflated claims of the *planos de fomento* and the imaginative bureaucratic plans of state enterprises in the socialist period as representations of power. Marx would search for the power of capital, not the presence or absence of the liberal state, in the selective control of capital by the colonial state and in the 'informality' accorded to present-day capitalist enterprises. These are only minimally controlled by health and safety legislation, or indeed even by the fiscal surveillance of the state.

Marx would, I think, be particularly interested in sorting out the class dynamics hidden within the homogenizing category of the informal sector, so important in the literature on social policy. To what extent does its scale reflect in Mozambique, as in South Africa, the casualisation of jobs that were once open to formal regulations on health and safety and which provided workers some claims to benefits and health care? Contractors hire Mozambicans now, for example, to fill positions in the South Africa mining industry once subject to accords with the Chamber of Mines. What are the recruitment, work and benefit regulations imposed on new mining industries? The informal employment status also applies to manual work in agriculture, tasks that have been allocated to casual recruitment since the retreat from forced labour in the last decade of colonial rule, and which are often done by women and youth. Is there any regulation of health conditions in recruitment and processes and places of work? Think, for example, of workers in Chokwe jammed into lorries and then sitting for hours in the sun to see whether or not they will have a day's work. What about the payment terms and exposure to chemicals of small grower who have contracted with processing and marketing companies selling export crops? How do trade unions and peasant organisations like UNAC address these issues politically?

In considering the relation between health and inequalities Marxism thus addresses not just patterns of redistribution, but the dynamics and forms of accumulation. Marx would of course not expect capitalism to suddenly shift from patterns of accumulation based on the maximisation of exchange value to the pursuit of use-values. Capitalist accumulation is structurally subject to crisis and each moment of recovery follows a period of immiseration of those who work. Marx was, however, as Foucault would probably acerbically note, enough of a modernist to recognize that the organised pursuit of well-being by those who labour has pushed capital into growth based in technical innovation and constrained redistribution of wealth.

Conclusion

Inequality constitutes a more revealing beginning point for understanding the relation between health and poverty than does a focus on the health of the poor *per se.* But this is only because it poses clearly the question of relationship between those who are not equal and hence issues of redistribution. Otherwise inequality is an empty frame. It can be as mechanical or technical in its approach to social medicine as neo-classical optimisation models of rational action. This paper is an attempt to show how different theoretical traditions fill that frame analytically and to define loosely some of the questions for Mozambican research on inequality and health that follow from this reflection.

As is obvious, I have most interest in and sympathy with exploring what a Marxist approach to inequality in health would be. In doing so, yes, I risk reductionism and loss of the richness, complexity and variety of everyday experience observed in the moving accounts of humanitarian liberals concerned with structural violence or by the distanced, wise and historically informed eye of Foucault. But I take theory to be a tool that should help us to see the world clearly and to change it. What Marxist theory suggests is that the direction of that change is indeterminate; no theory of capitalism will give us a perfect predictive design for collective health. What happens depends on the terms of class struggle. Documenting the struggles of poor and oppressed people may give encouragement to social movements and undercut the arrogance of analysts and policy-makers, but it will be their actions that change the world, not the stories we tell about them.

Appendix: Survey data on health and inequality

Inequality and Health

Children under five with diarrhoea

Table 1: Percentage of children under three years who had diarrhoea in the two weeks preceding the survey by area of residence[11]

Residence	1997	2003
Urban	30.6	21.1
Rural	18	17.6
Urban/rural	1.7	1.2

Table 2: Percentage of children under three years who had diarrhoea in the two weeks preceding the survey by province[11]

Province	1997	2003
Niassa	20.6	14.3
Cabo Delgado	23.4	20.9
Nampula	25.1	28.5
Zambezia	34.6	12.2
Tete	25.9	10.6
Manica	21.6	18.3
Sofala	18.7	15.7
Inhambane	7.6	19.7
Gaza	8	13.6
Maputo Province	18.6	12.3
Maputo Cidade	17.4	28.9

[11] Source: Macro International Inc, 2010. MEASURE DHS STATcompiler. http://www.measuredhs.com, August 5 2010.

Table 3: Percentage of children under three years who had diarrhoea in the two weeks preceding the survey by wealth quintile[11]

Wealth quintile	1997	2003
Lowest	20.9	18.8
Second	26.5	17.4
Middle	19.4	18.4
Fourth	20.7	18.2
Highest	18.4	20.5
Lowest/highest	1.1	0.9

Mortality of children under five years

Table 4: Child (under 5) mortality by residence[11]

Residence	1997	2003
Urban	150.4	143.2
Rural	236.9	192
Rural/urban	1.58	1.3

Table 5: Child (under 5) mortality by province[11] sorted from low to high in 2003

Province	1997	2003
Maputo Cidade	96.9	89.2
Maputo Province	146.5	108.1
Zambezia	183.1	122.9
Inhambane	192.7	149.1
Gaza	208	156.2
Manica	158.8	183.7
Tete	282.7	205.5
Sofala	241.6	205.7
Niassa	213.1	206
Nampula	319.1	219.5
Cabo Delgado	164.7	239.8

Source WHO 2006 from DHS 2003

Table 6: Child (under 5) mortality (%) by wealth quintile[11]

Wealth quintile	1997	2003
Lowest	277.5	196.2
Second	213.7	199.8
Middle	215.8	203.3
Fourth	187	154.6
Highest	144.6	108.1
Highest/lowest	1.92	1.81

Total Fertility Rate

Table 7: Total fertility rate by residence[11]

Residence	1997	2003
Urban	4.6	4.4
Rural	5.3	6.1
Rural/urban	1.2	1.4

Table 8: Total fertility rate by province[11]

Province	1997	2003
Niassa	5.4	7.2
Cabo Delgado	4.5	5.9
Nampula	5.1	6.2
Zambezia	5	5.3
Tete	6.6	6.9
Manica	7.5	6.6
Sofala	4.9	6
Inhambane	5.3	4.9
Gaza	5.8	5.4
Maputo Province	4.5	4.1
Maputo Cidade	3.7	3.2

Table 9: Total fertility rate by wealth quintile[11]

Wealth quintile	1997	2003
Lowest	5.2	6.3
Second	5	6.1
Middle	5.4	6.3
Fourth	5.9	5.2
Highest	4.4	3.8
Highest/lowest	1.2	1.7

HIV/AIDS

Table 10: HIV prevalence by sex and residence

	Urban	Rural
Women	18.4	10.7
Men	12.8	7.2

Source INSIDA 2010 Resumo do Relatório Preliminar

Table 11: % of women and men with good general knowledge of HIV/SIDA by residence

	Urban	Rural
Women	40.2	27.8
Men	46	29

Source: INSIDA 2010 Relatório Preliminar, p. 22

Health Care

Use of health care providers

Table 12: Percentage of households needing and using health providers by area of residence 2002-3[12]

Area of residence	Access	Need	Use	Satisfaction
rural	20.9	17	10.8	61.9
urban	68.1	13.5	11.3	63.4

Table 13: Percentage of households needing and using health providers by province 2002-3[13]

Province	Access	Need	Use	Satisfaction
Niassa	29.7	11.8	9.2	67.2
Cabo Delgado	35.6	19.1	12.5	50.4
Nampula	35.5	20	11.4	66
Zambezia	21.5	17.6	11.4	50.6
Tete	26.9	17.5	10.5	60.1
Manica	28.1	11.8	9.2	67.5
Sofala	38.9	16.5	14.6	74.2
Inhambane	21.2	13.4	9.8	74.5
Gaza	54.7	11.6	9.8	71.9
Maputo Province	69.4	11.5	9.2	65.3
Maputo Cidade	75.2	10.6	8.9	54.1

[12] Source: Instituto Nacional de Estatística, 2004, Relatório Final do Inquérito aos Agregados Familiares Sobre Orçamento Familiar, 2002/03.

[13] Source: Instituto Nacional de Estatística, 2004, Relatório Final do Inquérito aos Agregados Familiares Sobre Orçamento Familiar, 2002/03.

Table 14: Percentage of households needing and using health providers by expenditure quintile 2002[14]

Expenditure quintile	Access	Need	Use	Satisfaction
Lowest	2304	15.4	9.1	64.7
Second	30.2	15.7	10.2	62.4
Middle	30.3	16	10.6	59.1
Fourth	40.3	16.6	11.6	64.2
Highest	56.1	15.9	13.2	61.8

Treatment of children with acute respiratory infections in a health facility

Table 15: Percentage of children with ARI born in 3 yrs preceding survey who were taken to health facility by residence [11]

Residence	1997	2003
Urban	64.8	62.5
Rural	28.3	55
Urban/rural	2.3	1.3

[14] Source: Instituto Nacional de Estatística, 2004, Relatório Final do Inquérito aos Agregados Familiares Sobre Orçamento Familiar, 2002/03.

Table 16: Percentage of children with ARI born in 3 yrs preceding survey who were taken to health facility by province[11] (sorted from low to high in 2003)

Province	1997	2003
Niassa	83.9[15]	45.7
Nampula	15.9	50.5
Maputo Cidade	65.7	52.9
Zambezia	29.5	54.5
Inhambane	56	55.4
Sofala	40.1	56.2
Gaza	43	61
Tete	67.3	64.4
Cabo Delgado	14.7	64.7
Maputo Province	33.5	73.3
Manica	49.8	78.4

Table 17: Percentage of children with ARI born in 3 yrs preceding survey who were taken to health facility by wealth quintile[11]

Wealth quintile	1997	2003
Lowest	17.3	41.7
Second	31.9	61.2
Middle	45.8	56.2
Fourth	56.5	67.9
Highest	46.1	63.6
Highest/lowest	2.7	1.5

[15] Anomalous, small number of cases of children with ARI (14).

Quality and coverage of health care provision

Table 18: Quality of Primary Health Facilities: Rural and Urban, Mozambique

% of facilities:	Rural	Urban	Total
With clinical staff above elementary level	60.5	77.7	62.4
offering child vaccination with all EPI vaccines available	70.7	93.6	73.3
reporting stockout of essential drugs in last 6 months	60.1	45.8	58.5
With access to water	69.4	80.7	70.7
With electricity	32.7	73.1	37.2
With chloroquine in stock	96.8	97.1	96.8
With fansidar in stock	29.1	49.2	31.4

Source: Lindelow et al. 2004, extracted from various tables

Table 19: Percentage of users reporting access to alternative health care providers by residence

Provider	Rural	Urban
Community health post	3.3	1.9
Hospital	18.6	70.5
Other health centre or post	34.7	67.7
Private for profit clinic	0.4	10.4
Nurse or doctor working from home	0.8	2.9
Outside services from facility staff	0.0	1.7
Religious organization or NGO	20.0	14.5
Traditional medical practitioner	76.4	51.2
Pharmacy outside facility	0.3	38.5
Market (that sells medicine)	5.0	12.2

Source: Adapted from Lindelow et al 2004, Table 53, p. 82

Table 20: Percentage of users reporting access to alternative health care providers by province

Provider	North	Central	Zambezia	South	Maputo City
Community health post	1.5	2.7	2.6	6.4	0.0
Hospital	34.2	11.1	25.1	40.4	84.6
Other health centre or post	62.2	23.4	25.1	56.7	77.5
Private for profit clinic	0.2	0.2	0.7	2.9	26.9
Nurse or doctor working from home	1.0	0.0	0.3	4.7	1.6
Outside services from facility staff	0.0	0.0	1.0	0.7	0.0
Religious organization or NGO	1.2	22.5	30.1	12.1	26.3
Traditional medical practitioner	77.9	92.3	77.8	48.0	18.4
Pharmacy outside facility	3.9	14.9	4.6	7.7	48.5
Market (that sells medicine)	4.0	1.4	13.5	1.4	14.3

Source: Adapted from Lindelow et al 2004, Table 53, p. 82

Table 21: The rural/urban gap in selected indicators of child health[11]

Indicator of children's health	1997	2003
Child mortality (R/U)	1.6	1.3
Child Diarrhoea (R/U)	1.7	1.2
Child ARI treatment (U/R)	2.3	1.3

Table 22: The wealth gap (lowest to highest quintile) in selected indicators of child health[11]

Indicator of children's health	1997	2003
Child mortality (L/H)	1.9	1.8
Child Diarrhoea (L/H)	1.1	0.9
Child ARI treatment (H/L)	2.7	1.5

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