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INTERNATIONAL RECRUITMENT OF HEALTH WORKERS TO THE UK: A REPORT FOR DFID

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Whilst the issue of international migration of health workers is sometimes presented as a one-way linear "brain drain", the dynamics of international mobility, migration and recruitment of health workers re complex, covering individual choice, motivations and attitudes to career development; the relative status of health workers in different systems; the differing approaches of country governments to managing, facilitating or attempting to limit outflow or inflow; and the role of recruitment agencies as intermediaries in the process.

The study is based on analysis of published and unpublished data provided by professional registration bodies and government departments, combined with information from organizational case studies in the NHS, and key informant interviews in the UK, Ghana and Barbados, with international recruitment agencies, and with international organisations.

The data on inflow of health workers, derived from registration records and from work permits, confirms that there ahs been a significant upward trend in inflow of health workers from other countries in recent years. There has been significant upward growth in inflow of doctors to the UK. IN 2002, nearly half of the 10,000 new full registrants on the GMC register were from non-EU overseas countries. There have been significant year on year growth in inflow of nurses to the UK since the mid 1990s. In 2001/02, more than half of new nurse registrants in the UK were from overseas/EU sources. The Philippines, South Africa, Australia, and India have been the most significant sources countries in recent years.

IN 2002/03, one in four new "overseas" (i.e. non-EU) nurse registrants were from the DoH 'proscribed' list of developing countries (i.e. the list of countries appended to the DoH Code of Conduct on International recruitment, as countries not to be targeted for active recruitment by the NHS). A further half was from the Philippines and India. There has been no growth in the number of nurses coming from countries of the EEA in recent years. Overall, it is not known what proportion of international nurses are recruited by the NHS or by other sectors; however the NHS is the main source of nursing employment in the UK - it employs approximately three out of every four working nurses in the UK.

The Department of Health in England, and its counterparts in the other three UK countries are all committed to NHS staffing growth as an integral part of achieving "modernization" and meeting targets set out in the NHS Plans. Achieving the NHS Plan targets for staffing growth in England and the other UK countries relies on "home based" solutions such as attracting more applicants to pre-registration education, but international recruitment remains an activity which is an explicit policy intervention developed by the Department of Health in England; more recently the Welsh Assembly has also highlighted international recruitment as part of its overall approach to achieving staffing targets.

Generally the approaches used to facilitate international recruitment to the NHS have become more systematic in recent years. This includes the various methods of targeted recruitment directed at individual doctors, the introduction of a NHS recruitment website for nurses, and the development of regional recruitment coordinated through NHS Workforce Development Confederations.

None of the NHS respondents interviewed in the study reported actively recruiting from developing countries (other than India and the Philippines) in recent years, but some acknowledged that they had employed 'walk-ins' - individual nurses from developing countries who had applied on their own initiative, or were already based elsewhere in the UK.

As well as active recruitment, there are four types of "passive" recruitment which contribute to increasing the number of international health workers coming to the UK but which do not 'break' the Department of Health Code. These are:

- " As noted above, some staff are employed after they take the initiative to apply as individuals from other countries.
- Some workers will be resident in the UK, but not yet in employment - such as refugees.
- Some health workers will move jobs relatively quickly once they have arrived in the UK. In some cases independent sector employers have deliberately targeted overseas nurses from the Indian and African sub continents, charging them a fee, and offering them an adaptation course so that they could become UK registered and move on to NHS employment.
- The fourth development is the increased access to employment opportunities which has been created by the Internet. In this situation, the employer may not be directly "active" in beginning the recruitment process, but the web is certainly making it easier for nurses in developing countries with internet access to identify career opportunities in developed countries.

The Department of health, England, issued guidelines on international recruitment in 1999. A Code of Practice on International recruitment replaced this in October 2001. The Code required NHS employers not to actively recruit from developing countries, unless there was government-to-government agreement. A full list of these 'proscribed' countries was made available in early 2003.

The major limitation of the Code, in terms of preventing all active recruitment from developing countries is that it does not cover the independent sector, which continues to recruit from countries on the proscribed list. The Independent Healthcare Association has published guidelines on international recruitment but these relate primarily to the provision of adaptation courses in the UK. The other limitation, from a UK perspective, is that the Department of Heath Code only covers NHS employers in England.

The continued inflow of nurses and doctors from developing countries which is evident from registration data is not in itself evidence of the code being 'broken' -it is explained, in part at least, by entrants coming for education purposes (particularly the case for doctors), by individual health workers taking the lead to apply for jobs in the UK, and by non UK nurses actively recruited by non-NHS employers. It is not possible to quantify the relative size of each of these 'inflows' with current information.

The Code, by its very existence has drawn attention to UK international recruitment activity. Other developed countries have also been active but have not introduced similar frameworks.

The dynamics of international recruitment and migration are such that new methods are being developed which require that the Code is kept under review. One example, noted elsewhere in this report, is the developing use of the Internet as the focal point for international recruitment. Another example is the use in the NHS in England of "short term" entry of clinical teams from other countries, such as South Africa.

Ghana, Barbados and other countries that are experiencing a net outflow of health workers need to be able to assess why this is happening and evaluate what impact it is having on the provision of health care in the country. Many have to rely on incomplete data or incompatible data from different sources, which often means that it is not possible even to have an accurate picture of the trend in outflow of health workers, let alone any assessment of the impact of this outflow on the health services.

It is important to be able to assess the relative loss from outflow to other countries in comparison with other internal flows, such as health workers leaving the public sector to work in the private sector or leaving the health professions to take up other forms of employment. International outflow may be a very visible but relatively small numerical loss of workers compared withy flows of workers leaving the public sector for other sources of employment within the country.

It is crucial that the UK, and other destination countries assess the relative contribution of international recruitment compared with other key interventions (such as home-based recruitment, improved retention, and return of non-practising health professionals) in order to identify the most effective balance of interventions. This assessment has to be embedded in an overall framework of policy responses to health sector workforce issues if it is to be relevant.

The UK is currently prominent as an active recruiter of health workers, most notably doctors and nurses. This is unlikely to change in the short term. It was clear from the case studies in Ghana and Barbados that many nurses, doctors and other health professionals will be interested in accessing the "pull" factors that are on offer in developed countries.

The demographics in many developed countries such as the UK - a growing, ageing population and an ageing nursing workforce - make it likely that many of these countries will be actively encouraging inflow of health workers. Stopping migration is unlikely to be a viable option - which essentially leaves two other policy stances - non intervention, or some level of intervention to attempt to manage the migration process so that it is nearer "win-win", or at least is not exclusively "winlose", with the countries that can least afford to lose being the biggest losers. The developing programme of "managed migration" in the Caribbean may provide some working examples.

The next round of policy research on the trends and impact of health worker migration should assess these interventions and possible interventions, to identify which, if any, have the potential for mutual and beneficial impact.

The main recommendations drawn from this report are:

- One crucial gap is the absence of data on the numbers of international nurses recruited by, and working in the NHS. It is recommended that consideration should be given to assessing the potential to routinely collect this data (such data is routinely collected for doctors).
- The Department of Health Code does not cover the independent sector; whilst a recent Parliamentary Answer suggest that extension to the independent sector cannot be easily achieved, if this is not possible, it is recommended that DFID examine the potential (along with DH) to work with the independent sector representative bodies to develop a parallel Code which cover independent sector employers.
- Relatively little is known about the international health workers in the UK - in terms of their experiences and future career plans (including likelihood of return to source countries or onward movement to other countries). This is one area that is recommended as a priority for future research.
- The position of many developing countries which are sources of international health workers is weakened by inadequate workforce data and planning capacity. It is recommended that DFID and other donors give consideration to supporting improvements in HR databases in these countries.
- The gender issue in relation to the migration of nurses is an important factor; another recommendation is that donors give consideration to supporting strengthened nurses professional associations in source countries, so that the position of nurses in society can be supported by stronger advocacy.
- Finally the issue of how - or if - to "manage" migration of health workers is important, and requires more considered investigation. It is recommended that further policy research be supported to examine the aspects of managed migration highlighted in the report.

POVERTY AND PLACE: POLICIES FOR TOMORROW: THE EVOLUTION OF AMERICAN NEIGHBOURHOOD POLICY AND WHAT IT MEANS FOR THE UNITED KINGDOM

Bruce Katz, Vice President, The Brookings Institution

Casual visitors to America's great cities are often struck by the vast areas of deprivation that abut vibrant downtowns, major freeways, urban rail yards, and once-grand commercial corridors.

In a suburban nation that treasures the 'new', these places stand out for their visible poverty and often dilapidated, sometimes vacant housing and commercial structures. Bearing the mark of a succession of government programmes, these communities seem strangely out of place in our prosperous country - a grim reminder of the racial, ethnic, and class divisions that persist beneath celebrations of the American dream.

Since the 1960s, such run-down neighbourhoods have held a fascination for scholars and journalists, conservative theorists and liberal thinkers. These precincts have been the laboratories for a plethora of foundation experiments, government demonstrations, and federal policies and programmes. And yet, the impact of these efforts - amounting to tens of billions of dollars over several decades - remains decidedly mixed. To be sure, some neighbourhoods can point to real improvements. But many initiatives - despite the best of intentions - have failed to alleviate, and in some cases have exacerbated, the deteriorating economic and social conditions in inner cities.

What do these forlorn scenes have to do with similar ones in the United Kingdom? At first sight, the American neighbourhood experience and American neighbourhood policy appear far removed from the demographic, market, development, social, and governance realities of Britain. Neighbourhood conditions in the US seem much harsher and racially driven than those in Britain. The American 'safety net' has frayed, leaving working families incapable of meeting basic family needs such as health care and childcare. American metropolitan economies are dispersed and decentralized, leaving inner-city neighbourhoods isolated and remote from the new locus of economic activity. And America's central government - despite its array of neighbourhood interventions - remains mostly hostile or indifferent, and leaves most urban neighbourhoods (and cities, for that matter) to fend for themselves.

And yet, there is much to learn from the American experience, in part because US neighbourhood policies -heavily influenced by the work of scholars like William Julius Wilson - are beginning to work out the answers to probing, fundamental questions about the origins and impact of deprived areas. Can neighbourhoods of extreme poverty be revitalized if their socio-economic composition, the concentrated levels of poverty, remains the same? What neighbourhood strategies make sense in weak markets of population loss, economic stagnation, low housing demand, and high vacancy rates? What is the appropriate role of community-based organisations in revitalizing neighbourhoods and regenerating markets? What is the role of the private sector? In fact, the most advanced American neighbourhood policies re now trying to do exactly what Joseph Rowntree intended for his foundations: to'...search out the underlying causes of weakness or evil in the community, rather than ...[remedy] their most superficial manifestations...'

This paper will therefore examine the American response to areas of deprivation over the past several decades, in hopes of distilling policy and programmatic lessons for both Britain and the US. Its central thesis is simple but far-reaching:

A true rebirth of distressed areas (and the cities in which they re located) will only occur if we make these places neighbourhoods of choice for individuals and families with a broad range of incomes, and neighbourhoods of connection that are fully linked to metropolitan opportunities.

For Britain and America alike, this thesis fundamentally challenges neighbourhood policies which, under the guise of 'revitalizing communities,' reinforce patterns of concentrated poverty - a root cause of neighbourhood distress. It also demands that neighbourhood actions operate within the broader metropolitan 'geography of opportunity' rather than the insular, fixed borders of deprived areas.

The paper will proceed along four lines.

First, the paper will discuss 'where we are' and provide the broader context for areas of deprivation in the UK. The section will set the basis for later policy discussion by providing a basic overview of who lives in these neighbourhoods, where they are located, what are their impacts and why they exist.

Second, the paper will discuss 'how we have responded' and describe the various ways in which the federal government has responded to areas of deprivation. This section will discuss the strengths and limitations of three distinct sets of neighbourhood policies.

Third, the paper will describe 'where we are going' and discuss the ongoing evolution of American neighbourhood policy. Fit will argue that American policy makers should embrace a new paradigm of 'neighbourhoods of choice and connection.'

Finally, the paper will discuss 'what this means' for UK neighbourhood policy. This is a propitious time for such a discussion, given the burst of intellectual and programmatic energy around areas of deprivation over the past half decade.

DEFENDING ECONOMIC, SOCIAL AND CULTURAL RIGHTS: PRACTICAL ISSUES FACED BY AN INTERNATIONAL HUMAN RIGHTS ORGANIZATION

Kenneth Roth, Executive Director, Human Rights Watch: Human Rights Quarterly

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International organizations like Human Rights Watch are legitimately urged to pay more attention to economic, social and cultural rights. But practical prescriptions are often simplistic - typically involving only the rhetorical invocation of these rights. The strength of organizations like Human Rights Watch is not their rhetorical voice but their shaming methodology

-their ability to investigate misconduct and expose it to public opprobrium. That methodology is most effective when there is relative clarity about violation, violator, and remedy. That clarity is best achieved when misconducts can be portrayed as arbitrary or discriminatory rather than a matter of purely distributive justice.

MONITORING EQUITY IN HEALTH AND HEALTHCARE: A CONCEPTUAL FRAMEWORK

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This paper aims at articulating a conceptual framework for monitoring equity in health and healthcare. The focus is on four main questions: What is health equity? What is monitoring? What are the essential components of a system for monitoring health equity? And Why monitor health equity? Monitoring equity in health and healthcare requires comparing indicators of health and its social determinants among social groups with different levels of underlying social advantage, i.e. groups who occupy different positions in a social hierarchy. A framework is presented for formulating the key questions, defining the social groups to be compared, and selecting the health indicators and measures of disparity that are fundamental to monitoring health equity. Although monitoring health equity is a scientific endeavour, its fundamental objective is guided by values; technical challenges should be addressed as part of a broader strategy to confront the political obstacles to greater equity.

While not sufficient for effective action to achieve greater equity in health, information can play an important role. Moving towards greater equity requires selective attention to the needs of disenfranchise groups, and more powerful groups are likely to resist such efforts. To meet this resistance, information on health equity must be scientifically sound and technical strategies for monitoring equity must be placed in the context of a broader strategy to address formidable political obstacles. Efforts to obtain, analyze, and disseminate information on equity must consider where, how, and who to involve to intervene most effectively against the tide of prevailing forces. ON an encouraging note, while striving for greater equity in health involves facing tremendous challenges, the challenges are likely to be fewer than if the focus were on equity in wealth, since most societies exhibit far less tolerance for disparities in health than in wealth (58).

The technical challenges encountered in trying to monitor health equity can be daunting, particularly given a dearth of existing data sources that are populationbased and include adequate information on both social groups and health indicators that are most relevant in a given setting. While better data and methods are needed to monitor equity, in virtually every country in the world - even the poorest nation with the most limited data - far more can be accomplished with the existing data and simple methods, given conceptual clarity about what we want to monitor and why. Monitoring health equity is a scientific endeavour, but its fundamental objective is guided by values - the ethical principle of distributive justice, and concerns of human rights, including non-discrimination and the right to health.

Eight steps in policy-oriented monitoring of equity in health and its determinants are:

1. Identify the social groups of a priori concern. In addition to reviewing the literature, consult representatives of all social sectors and civil society, including advocates for disadvantaged groups.
2. Identify general concerns and information needs relating to equity in health and its determinants. Again, in addition to the literature, consult representatives of all social sectors and civil society, including advocates for disadvantaged groups.
3. Identify sources of information on the groups and issues of concern. Consider both qualitative and quantitative information.
4. identify indicators of (a) health status, (b) major determinants of health status apart from health care, and (c) healthcare (financing, resource allocation, utilization, and quality) that are particularly suitable for assessing gaps between more and less-advantaged social groups.
5. Describe current patterns of avoidable social inequalities in health and its determinants.
6. Describe trends in those patterns over time.
7. Generate an inclusive and public process of considering the policy implications of the patterns and trends. Include all the appropriate participants in this process (e.g. all relevant sectors, civil society, NGOs).
8. Develop and set in motion a strategic plan for implementation, monitoring, and research, considering political and technical obstacles, and including the full range of appropriate stakeholders in the planning process.

The entire process is repeated from the beginning, incorporating new knowledge and awareness.

ECONOMIC AND WELFARE EFFECTS OF THE ABOLITION OF HEALTH USER FEES: EVIDENCE FROM UGANDA

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Household level data for Uganda for 1999/2000 and 2002/03, before and after the abolition of user fees for public health services, are used to explore the impact of this policy on different groups' ability to access health services and morbidity outcomes. We find that the policy change improved access and reduced the probability of sickness in a way that was particularly beneficial to the poor. Although the challenge of maintaining service quality remains, aggregate benefits are estimated to be significantly larger than the estimated shortfalls from the abolition of user fees.

Few interventions in the area of public service provision have been as controversial and subject to as fierce a debate as the imposition of user fees for health services. Some think that at least a moderate level of cost recovery is justifiable to put social services on a more sound footing and that potential negative side effects from a modest user fee for health treatment are a small price to pay for the increased accountability and improvement in service quality that can be achieved through such a measure. Others hold equally firm views to the opposite, thinking that charging for treatment will strongly discriminate against the poor who, especially in an economy that is still largely based on subsistence, will be hard pressed to come up with the cash required to make such payments. Even though, on theoretical grounds, both outcomes are possible, what happens in practice will have far-reaching implications for the ability of the poor to access health care and thus to realize their full economic potential. To make informed policy decisions, empirical evidence to identify, in any given setting, the relevant factor, will therefore be critical.

THE CHRONIC POVERTY REPORT 2004-05

The Chronic Poverty Research Centre Manchester, United Kingdom info@chronicpoverty.org

Between 300 and 420 million people are trapped in chronic poverty. They experience deprivation over many years, often over their entire lives, and commonly pass poverty on to their children. Many chronically poor people die premature from health problems that are easily preventable. For them poverty is not simply about having a low income; it is about multidimensional deprivation - hunger, under-nutrition, dirty drinking water, illiteracy, having no access to health services, social isolation and exploitation. Such deprivation and suffering exists in a world that has the knowledge and resources to eradicate it.

This Report's concern about chronic poverty leads to a focus on poverty dynamics - the changes in wellbeing or ill-being that individuals and households experience over time (Chapter 1). Understanding such dynamics provides a sounder basis for formulating poverty eradication policies than the conventional analysis of national poverty trends.

The chronically poor are not a distinct group. Many different people suffer such deprivation (see Chapter 2); people who are discriminated against, stigmatized or 'invisible': socially-marginalized ethnic, religious, indigenous, nomadic and caste groups; migrants and bonded labourers; refugees and internal displaces; disabled people or those with ill-health (especially HIV/ AIDS). In many contexts poor women and girls, children and older people (especially widows) are likely to be tapped in poverty.

While chronically poor people are found in all parts of the world (see Chapter 3 for an overview and Chapters 6 to 10 for specific regions) the largest numbers live in South Asia (135 to 190 million). The highest incidence is in sub-Saharan Africa, where 30-40% of all present day 'US$1/day' poor people are trapped in poverty - an estimated 90 to 120 million people. East Asia has significant numbers of chronically poor people, between 55 to 85 million, living mainly in China.

Within countries there are often distinct geographies of chronic poverty, with concentrations in remote and low-potential rural areas, politically-marginalized regions and areas that are not well connected to markets, ports or urban centres. There are also concentrations of chronically poor people in particular slum areas in town and cities as well as the millions of homeless people sleeping in streets, stations, parks and burial grounds.

The causes of chronic poverty are complex and usually involve sets of overlaying factors. Sometimes they are the same as the causes of poverty, only more intense, wide-spread and lasting. In other cases, there is a qualitative difference between the causes of transitory and chronic poverty. Rarely is there a single, clear cause. Most chronic poverty is a result of multiple interacting factors operating at levels from the intrahousehold to the global. This is illustrated by Maymana and Mofizul's story (Chapter 4): their chronic poverty is an outcome of ill-health, widowhood, a saturated rural labour market, disability, social injustice and poor governance. Some of these factors are maintainers of chronic poverty: They operate so as to keep poor people poor. Others are drivers of chronic poverty: they push vulnerable non-poor and transitory poor people into poverty that they cannot find a way out of:

There are several important maintainers of chronic poverty.

1. No, low or narrowly-based economic growth means that there are few opportunities for poor people to raise their incomes and accumulate assets.
2. Social exclusion and adverse incorporation interact so that people experiencing discrimination and stigma are forced to engage in economic activities and social relations that keep them poor - poorly paid, insecure work; low and declining assets, minimal access to social protection and basic services; and dependency on a patron.
3. In disadvantaged geographical and agro-ecological regions poor resources, weak economic integration, social exclusion and political marginality create 'logjams of disadvantage'.

4. High capability deprivation, especially during childhood - poor nutrition, untreated sicknesses, lack of access to education - can diminish human development irreversibly.

5. In weak, failing or failed states economic opportunities re few, lack of health services and social protection means that people can easily fall into desperate poverty, children go uneducated, violence destroys assets and discourages investment, and poor people have few means of asserting their rights.

6. Weak and failed international cooperation over the 1980s and 1990s has deepened poverty through structural adjustment and over-rapid economic liberalization, allocated aid away from countries with large numbers of chronically poor people and blocked off trade opportunities for poor countries.

Not all chronically poor people are born into long-term deprivation. Many slide into chronic poverty after a shock or series of shocks that they cannot recover from. These include ill health and injury, environmental shocks, natural disasters, violence, the breakdown of law and order, and market and economic collapse. These are the drivers of chronic poverty. When shocks are severe and/or repeated, when people have few private or collective assets to 'fall back' on, and when institutional support (social protection, public information, basic services, conflict prevention and resolution) is ineffective, such processes re likely to trap people in poverty.

The knowledge now available about chronic poverty must be used to mobilize public action and reshape development strategy. While there are many policies that are potentially beneficial for the poor and for the chronically poor, many people living in chronic poverty are not 'just like the poor but a little bit further down the poverty spectrum'. Overcoming chronic poverty requires policy-makers to reorder their priorities and set their sights higher than the current consensus on poverty reduction policy.

Development strategy needs to move beyond the bounds of its present emphasis on economic growth hundreds of millions of people are born poor and die poor in the midst of increasing wealth. Chronically poor people need more than 'opportunities' to improve their situation. They need targeted support and protection, and political action that confronts exclusion. If policy is to open the door to genuine development for chronically poor people, it must address the inequality, discrimination and exploitation that drive and maintain chronic poverty.

Action on chronic poverty needs a framework to:

Prioritize livelihood security. A much greater emphasis is needed on preventing and mitigating the shocks and insecurities that create and maintain chronic poverty. This is not only about providing recovery assistance but also about giving chronically poor people a secure position from which to seize opportunities and demand their rights. Thus, social protection policies are of great importance.

Ensure chronically poor people can take up opportunities. It is crucial both to promote broadbased growth and to redistribute material and human assets, so that chronically poor people can take up economic opportunities.

Take empowerment seriously. Policy must move beyond the cozy rhetoric of participatory approaches, decentralization and theories about rights. It needs to address the difficult political process of challenging the layers of discrimination that keep people trapped in poverty.

Recognize obligations to provide resources. Chronic poverty cannot be seriously reduced without real transfers of resources and sustained, predictable fiancé. The political indifference to meeting national and international obligations on poverty eradication needs to be challenged and ways found to foster social solidarity across households, communities and nations.

The need for policy change must not mask the fact that it is the chronically poor themselves who are the leading actors in overcoming their poverty. To-date, when their existence is recognized, the chronically poor are perceived both in policy and the popular imagination as dependent and passive. Nothing could be further from the truth. Most people in chronic poverty are striving and working to improve their livelihoods, and the prospects for their children, in difficult circumstances that they have not chosen. They need real commitment, matched by actions and resources, to support their efforts to attain their rights and overcome the obstacles that trap them in poverty.

CULTURAL LIBERTY IN TODAY'S DIVERSE WORLD

United Nations Development Programme (UNDP) Human Development Report 2004

How will the new constitution of Iraq satisfy demands for fair representation for Shiites and Kurds? Which and how many - of the languages spoken in Afghanistan should the new constitution recognize as the official language of the state? How will the Nigerian federal court deal with a Sharia law ruling to punish adultery by death? Will the French legislature approve the proposal to ban headscarves and other religious symbols in public schools? Do Hispanics in the United States resist assimilation into the mainstream American culture? Will there be a peace accord to end fighting in Cote d'Ivoire? Will the President of Bolivia resign after mounting protests by indigenous people? Will the peace talks to end the Tamil-Sinhala conflict in Sri Lanka ever conclude? These are just some headlines from the past few months. Managing cultural diversity is one of the central challenges of our time.

Long thought to be divisive threats to social harmony, choices like these - about recognizing and accommodating diverse ethnicities, religions, languages and values - are an inescapable feature of the landscape of politics in the 21st century. Political leaders and political theorists of all persuasions have argued against explicit recognition of cultural identities - ethnic, religious, linguistic, racial. The result, more often than not, has been that cultural identities have been suppressed, sometimes brutally, as state policy through religious persecutions and ethnic cleansings, but also through everyday exclusion and economic, social and political discrimination.

New today is the rise of identify politics. In vastly different contexts and in different ways - from indigenous people in Latin America to religious minorities in South Asia to ethnic minorities in the Balkans and Africa to immigrants in Western Europe people are mobilizing anew around old grievance along ethnic, religious, racial and cultural lines, demanding that their identities be acknowledged, appreciated and accommodated by wider society. Suffering discrimination and marginalization from social, economic and political opportunities, they are also demanding social justice. Also new today is the rise of coercive movements that threaten cultural liberty.

And, in this era of globalization, a new class of political claims and demands has emerged from individuals, communities and countries feeling that their local cultures are being swept away. They want to keep their diversity in a globalize world.

Why these movements today? They are not isolated. They are part of a historic process of social change, of struggles for cultural freedom, of new frontiers in the advance of human freedoms and democracy. They are propelled and shaped by the spread of democracy, which is giving movements more political space for protest, and the advance of globalization, which is creating new networks of alliances and presenting new challenges.

Cultural liberty is a vital part of human development because being able to choose one's identity - who one is - without losing the respect of others or being excluded from other choices is important in leading a full life. People want the freedom to practice their religion openly, to speak their language, to celebrate their ethnic or religious heritage without fear of ridicule or punishment or diminished opportunity. People want the freedom to participate in society without having to slip off their chosen cultural moorings. It is simple idea, but profoundly unsettling.

States face an urgent challenge in responding to these demands. If handled well, greater recognition of identities will bring greater cultural diversity in society, enriching people's lives. But there is also a great risk.

These struggles over cultural identity, if left unmanaged or managed poorly, can quickly become one of the greatest sources of instability within states and between them - and in so doing rigger conflict that takes development backwards. Identity politics that polarize people and groups are creating fault lines between "us" and "them". Growing distrust and hatred threaten peace, development and human freedoms. Just in the last year ethnic violence destroyed hundreds of homes and mosques in Kosovo and Serbia. Terrorist train bombings in Spain killed nearly 200. Sectarian violence killed thousands of Muslims and drove thousands more from their homes in Gujarat and elsewhere in India, a champion of cultural accommodation. A spate of hate crimes against immigrants shattered Norwegians' belief in their unshakable commitment to tolerance.

Struggles over identity can also lead to regressive and xenophobic policies that retard human development. They can encourage a retreat to conservatism and a rejection of change, closing off the infusion of ideas and of people who bring cosmopolitan values and the knowledge and skills that advance development.

Managing diversity and respecting cultural identities are not just challenges for a few "multi-ethnic states". Almost no country is entirely homogeneous. The world's nearly 200 countries contain some 5,000 ethnic groups. Two-thirds have at least one substantial minority - an ethnic or religious group that makes up at least 10% of the population.

At the same time the pace of international migration has quickened, with startling effects on some countries and cities. Nearly half the population of Toronto was born outside of Canada. And many more foreign-born people maintain close ties with their countries of origin than did immigrants of the last century. One way or another every country is a multi-cultural society today, containing ethnic, religious or linguistic groups that have common bonds to their own heritage, culture, values and way of life.

Cultural diversity is here to stay - and to grow. States need to find ways of forging national unity amid this diversity. The world, ever more interdependent economically, cannot function unless people respect diversity and build unity through common bonds of humanity. In this age of globalization the demands for cultural recognition can no longer be ignored by any state or by the international community. And confrontations over culture and identity are likely to grow - the ease of communications and travel have shrunk the world and changed the landscape of cultural diversity, and the spread of democracy, human rights and new global networks have given people greater means to mobilize around a cause, insist on a response and get it.

INCOME INEQUALITY AND HEALTH: WHAT HAVE WE LEARNED SO FAR?

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Many developed countries have experienced a sharp rise in income inequality during the past three decades, and the United States is no exception (1). For example, the average annual salary in America in inflation-adjusted 1998 dollars increased from $32,522 in 1970 to $35,864 in 1999, that is, a modest 10 percent increase over three decades. By contrast over the same period, the average annual compensation of the top 100 chief executive officers rose from $1.3 million (or 39 times the pay of an average worker) to $37.5 million (or more than 1,000 times the pay of an average worker) (2). Recent trends in wealth inequality have been equally noteworthy. The net worth of families in the top docile rose by 69 percent, to $833,600 in 2001, from $493,400 in 1998. By contrast over the same period, the net worth of families in the lowest fifth of income earners rose 24 percent, to $7,900. The median accumulated wealth of families in the top 10 percent of the income distribution was 12 times that of lower-middle-income families through much of the 1990s, but in 2001, the median net worth of the top earners was about 22 times as great (3).

It is by now widely accepted that income poverty is a risk factor for premature mortality and increased morbidity (4). It should also be noted that there exists persuasive evidence indicating the reverse pathway, from poor health status to persistent poverty and poorer economic growth (5). In this review, however, we focus on the question: Does the unequal distribution of income in a society pose an additional hazard to the health of the individuals living in that society? Earlier ecologic studies, summarized elsewhere (6,7)), suggested an association between income inequality and poor health status. However, these studies have been criticized because of their inability to disentangle the effects of individual income (and income poverty) from the contextual effects of income inequality (6). In other words, an ecologic association between income inequality (e.g. measured by the Gini coefficient of income distribution at the US state level) and poor health (e.g. measured by age-adjusted morality rates within each state) may reflect either a contextual effect of income inequality on health, or a compositional effect of income-poor individuals residing in unequal states, or both. In attempts to overcome this methodological limitation of ecologic studies, researchers have published nearly two dozen multilevel studies of income inequality and health since 1997. Multilevel studies have the ability to simultaneously assess the associations of individual income and societal income inequality with individual health status.

In this paper, we review the published multilevel studies of income inequality and health. Although the published evidence so far is by no means conclusive about the relation between income distribution and population health, our aim is to draw attention to some emerging patterns in the accumulated findings and to suggest future directions for research in this topic.

As our review suggests, the evidence implicating income disparities as a threat to public health is still far from complete. In this review, we highlighted what we have learned and what we still need to know. What is at stake is whether policy makers and the public health community ought to be concerned about the societal distribution of income in addition to the alleviation of income poverty through economic growth alone. As we have argued, the answer to that question depends on a combination of better data, more sophisticated analytical methods, and more rigorous application of theory and mechanisms connecting income inequality to public health.

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