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Paul Farmer: structural violence and the embodiment of inequality

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Chapter 43

Paul Farmer: Structural Violence and the Embodiment of Inequality

Fernando De Maio

Paul Farmer is one of the most influential advocates for health equity in the world today. His analyses – rooted in both social science and medicine, owing to his training in anthropology and infectious disease – highlight the importance of the social determinants of health. His work has challenged existing orthodoxies in medicine and global health, including the belief – widely held in the 1990s – that treatment for HIV or multi-drug-resistant tuberculosis (MDRTB) was impossible in poor settings. Farmer has questioned the reliance on ‘cost-effectiveness’ as a decision-making process in healthcare delivery, arguing instead for the centrality of equity. At the same time, his work has critiqued medical anthropology, medical ethics, and related fields, including human rights, for ignoring the fundamental causes of global health inequities. Farmer’s vision of ‘geographically broad and historically deep’ analysis offers a framework for a political economy of global health equity, a way of working that respects the tremendous benefits of biomedicine, yet highlights the social ‘fault lines’ that negate its discoveries for the majority of the world’s poor.

Central to Farmer’s work is the concept of *structural violence*, which he defines as:

...social arrangements that put individuals and populations in harm’s way...The arrangements are *structural* because they are embedded in the political and economic organisation of our social world; they are *violent* because they cause injury to people (Farmer et al. 2006:1686, emphasis added).

As a guiding concept, structural violence broadens and deepens our thinking about the causes of disease, explicitly linking our biology with global political economy. In this chapter, I use Farmer and the concept of structural violence as a way of understanding the embodiment of inequality. In particular, I explore how his ideas can be used in relation to the positivist research literature on income inequality and health. Farmer’s perspective offers a more nuanced

and global account of the pathogenic effects of inequality than is typically presented in public health and medical sociology.

Biography

Paul Farmer was born in Massachusetts in 1959 and raised in Florida. He studied medical anthropology at Duke University, and obtained his medical degree and PhD in anthropology from Harvard. He is currently the Kolokotronis University Professor at Harvard and also serves as the Chief of the Division of Global Health Equity at Brigham and the Women's Hospital in Boston, Massachusetts. He is the co-founder of Partners in Health (PIH) – one of the most important non-government organisations working in global health, with a significant presence in Haiti, Rwanda, Peru, Malawi, Russia and a host of other countries. PIH provides free care to impoverished populations, with expertise in HIV/AIDS, tuberculosis, cholera as well as cancer and other chronic diseases. They have also spearheaded a new movement in health services based on the use of community health workers.

His work developed at a unique time in global health. He saw first-hand the growth of the HIV/AIDS pandemic in the 1980s and 1990s, and owing to his dual role as a doctor in rural Haiti and in one of Boston's most well-equipped hospitals, he also saw the varying levels of care that could be offered to patients. He saw how politics and economics conspired to limit the poor's access to life-saving medicines. And he recognised this as an inequity: an inequality that is avoidable, unnecessary and unfair (Whitehead 1992; De Maio 2010).

Farmer's work

For many decades, health economists have integrated 'cost-effectiveness' analysis into health policy debates (Farmer et al. 2013). As a result, many medicines – including highly effective anti-retroviral therapy which essentially turned HIV from a death sentence to a manageable chronic disease in the 1990s – were deemed inappropriate technology for poor settings, effectively discarding the hope of the world's poorest people of benefiting from advances in biomedical and pharmacological innovation (Kovsted 2005; Hoen et al. 2011). Farmer has called his work a 'protest' against the social forces that foster inequities in health and a call for recognising the primacy of the right to health.

Farmer strongly critiqued the practice – widely accepted in the 1990s – of running HIV trials in sub-Saharan African countries which sought to observe the 'natural transmission' of the disease in treatment-naïve groups. He argued that such work, though approved by US-based ethics boards, exploited already marginalised populations, using their bodies for 'biovalue' and never sharing the direct benefits of the newly developed medications (Quinn et al. 2000; Farmer 2003). Throughout, Farmer's work shows a deep antagonism to inequity

expressed through differential access to medical services. He and his colleagues in PIH have demonstrated the feasibility of providing advanced medical care in the poorest of places. In doing so, they have highlighted the real harm caused by the simplistic view that healthcare can be delivered under market mechanisms, writing 'As a physician who has worked for much of my adult life among the poor of Haiti and the United States, I know that the laws of supply and demand will rarely serve the interests of my patients' (Farmer 2003:5). Farmer's writing – at times ethnographic, epidemiological and historical – emphasises the voice and needs of the poor.

His work displays a keen sense of global interconnectedness. Eschewing anachronistic divisions of the world into 'developed' and 'developing' countries, his analysis brings to the foreground the permeability of national boundaries to the flow of disease, and contrasts this with the erection of political, economic and cultural barriers that inhibit residents of affluent countries from recognising their position in a global web. Farmer observes, 'the suffering of the world's poor intrudes only rarely into the consciousness of the affluent, even when our affluence may be shown to have direct relation to their suffering' (2003:31). Moreover, he writes:

...to argue that human rights abuses occurring in Haiti, Guatemala, or Rwanda are unrelated to our surfeit in the rich world requires that we erase history and turn a blind eye to the pathologies of power that transcend all borders (Farmer 2003:245).

This perspective is rare in a field that has for many decades been grounded in *modernisation* and *development* theories (Cardoso 1972; Kay 1991; De Maio 2014). For many people, improving global health is still a matter of charity and the transfer of knowledge (in the form of high-tech medical services and/or policy ideas) from the 'developed' to the 'developing' world. Farmer's perspective – with its clear ties to world-systems theory – challenges these notions.

In contrast to the more traditional 'public health' and 'international health' paradigms, Farmer's work is indicative of the nascent 'global health' perspective (Koplan et al. 2009; Kruk 2012). The differences between these perspectives are beyond semantic; they alter how we might go about research and what kinds of solutions we seek to develop. Whereas international health in many ways is centred on health *out there*, in low- and middle-income countries, and while public health has historically been driven by a focus on populations and the idea of equity in health, neither of these perspectives adequately conceptualise the *interconnections* between policies and practices in the Global North and the Global South. Global health is increasingly not just about what happens *out there*, but is more concerned with how health/disease is shaped by global economic, political and cultural forces that transcend national boundaries.

This conceptualisation of global health runs throughout Farmer's writings. In his first book, *Aids and Accusations: Haiti and the Geography of Blame*, Farmer (1992) analyses the HIV/AIDS epidemic in Haiti, showing the deep connections between the rural health conditions on the island and global forces, including US military and development policy. His early work in Haiti is based in the impoverished central plateau, particularly the village of Cagne. With ethnographic richness, Farmer's analysis depicts the plight of his patients – their health, their understanding of disease, how they make sense of suffering – while highlighting the structural forces that have fostered both disease outbreaks and the poverty that prohibits their access to healthcare. Central to his analyses is the construction of a hydro-electric dam in the region which flooded the area's best agricultural land, forcing peasants to precarious living conditions. It is that act of US-aided 'development' that forms the core of Farmer's history of the region, although his work displays a keen appreciation of the importance of longer-term history as well (illustrated most clearly in *The Uses of Haiti* (Farmer 1994), his most detailed treatment of Haitian political economy).

Farmer's work is best described as blending ethnography and public health, and overall seeks to analyse the global politics of health such that we understand the lived experience of individuals while recognising the deep structural roots of their suffering. Farmer observes in a passage clearly reminiscent of Mills' (1959) *Sociological Imagination*: '...to explain suffering, one must embed individual biography in the larger matrix of culture, history, and political economy' (Farmer 2003:41). It is this perspective that makes Farmer such a noteworthy theorist in global health.

Farmer's work on structural violence and inequality as a fundamental determinant of health developed in *Infections and Inequalities* (Farmer 1999). He offers an historically rich ethnographic perspective on the relationship between inequality and health outcomes (particularly HIV/AIDS, tuberculosis and MDRTB), and advances our understanding of the issue in important ways. He calls for empirical research on the relationship between social inequality and the development of MDRTB, noting that in settings of shared wealth or poverty, MDRTB is unlikely to develop. In the first setting, access to efficacious treatment will control tuberculosis. In the second setting, few have access to drugs and therefore resistance to the drugs is unlikely to develop. However, Farmer argues, in settings of *inequality* – where poor and rich coexist – forces leading to MDRTB may actually be strengthened. This is because of the unequal access to treatment that is characteristic of such areas; some people will receive treatment, others will not, and some will receive treatment on a sporadic basis – and it is this third situation (sporadic treatment) that leads to drug-resistant strains of tuberculosis. Throughout his work, Farmer identifies inequality itself as a fundamental cause of illness.

His analysis of structural violence deepened in *Pathologies of Power* (Farmer 2003). It is this book, perhaps more than his others, where the strongest analysis of inequality as the fundamental cause of preventable disease and illness is presented. This book is an explicit critique of human rights and medical ethics for ignoring global health inequities and of social researchers for conflating 'culture' with poverty. Farmer's work takes on a truly global perspective – from the plight of Guatemalan orphans to the Zapatista rebellion in Mexico, to Russian prisoners fighting prison-acquired multi-drug-resistant tuberculosis. His work weaves these geographically disparate populations in a way that no other global health analyst has done to date.

Tracy Kidder's (2004) *Mountains Beyond Mountains* is currently the only published biographical work on Farmer. Kidder's account follows Farmer at a critical point in time – when Farmer's work in Haiti began to draw widespread attention in the popular press, and PIH emerged as a central player in global health, partly as a result of new-found funding from the Bill and Melinda Gates Foundation. Kidder offers a well-grounded and balanced perspective on Farmer – writing of admiring Farmer's unwavering commitment to providing high-quality healthcare to the poor as a matter of social justice while also fearing that he would disappoint him for being unable to match his concern for the poor. Kidder writes: 'I'd feel sorry that so many Haitian children still died of measles ... but I'd also feel I could never be sorry enough to satisfy him' (Kidder 2004:29). The book is an accessible account of Farmer's work in global health, with nuanced analysis of some of the most important concepts underpinning his theoretical and methodological positions.

Central concepts

Three interrelated concepts/frameworks are used throughout Farmer's work: (1) structural violence, (2) 'geographically broad and historically deep' analysis, and (3) liberation theology.

Structural violence

Structural violence is the core conceptual tool used in his work. It is used as both a descriptive term and an explanatory concept – the key building block in his theoretical arguments over the nature of health inequities. In *Pathologies of Power*, Farmer (2008:8) writes:

For well over a decade, I have grappled, as have many others, with conditions that could only be described as violent – at least to those who must endure them. Since the misery in question need not involve bullets, knives, or implements of torture, this misery has often eluded those seeking to identify violence and its victims.

For Farmer, structural violence is a wide-ranging tool describing a 'host of offensives against human dignity', including poverty, racism and discrimination, gender inequality as well as 'the more spectacular forms of violence that are uncontestedly human rights abuses, some of them punishment for efforts to escape structural violence' (Farmer 2003:8). Within this conceptualisation, structural violence is a multi-level idea, through which different 'axes' of oppression – based on economic inequality, patriarchy, racism, or other forms of discrimination – may intersect to generate preventable morbidity and premature mortality in marginalised populations.

Farmer uses the term as a critical realist *generative mechanism* (Scambler 2001) – something that cannot be directly measured with positivist methods, but can be theorised about, and can be understood through its effects on observable phenomena. Farmer (2003:50) notes:

... today, the world's poor are the chief victims of structural violence – a violence that has thus far defied the analysis of many who seek to understand the nature and distribution of extreme suffering. Why might this be so? One answer is that the poor are not only more likely to suffer; they are also less likely to have their suffering noticed.

In particular, he criticises medical ethics and human rights discourses for ignoring structural violence, thus becoming tools for 'managing inequality' rather than overcoming it.

'Geographically broad and historically deep' analysis

'Geographically broad and historically deep' analysis is the salient characteristic of Farmer's methodological stance. The geographic scale is influenced by his conceptualisation of global health and global economic ties: 'the world as we know it is becoming increasingly interconnected. A corollary of this fact is that extreme suffering... is seldom divorced from the actions of the powerful' (Farmer 2003:42). Understanding the HIV/AIDS epidemic in Haiti, MDRTB in Peru, or maternal mortality in Rwanda requires analysis of not just what is happening in those countries but also of the global forces that influence (often by constraining) the actions that have been taken in those countries. From this perspective, to understand structural violence in one setting requires both a micro and macro analysis. Similarly, understanding these phenomena requires deep engagement with the history which manifests in contemporary power relations – for example, Farmer argues that understanding the HIV/AIDS epidemic in Haiti cannot be understood without analysis of the effects of decades-old development projects (the Peligre Dam) on the living conditions of rural peasants, nor without a longer-term view of the country's struggle for democracy over international interference.

Liberation theology

Liberation theology is described by Farmer as his 'moral compass', and throughout his work, takes the place usually afforded by researchers to a theoretical perspective. Arising from progressive Catholic theologians in Latin America in the 1950s and 1960s, liberation theology is firmly grounded in the lived experience of the poor. It is most closely associated with the work of Gustavo Gutiérrez, Leonardo Boff, Jon Sobrino, Óscar Romero and Juan Luis Segundo (Gutiérrez 1998). Its fundamental assertion is that social inequality is the product of 'structural sin'. Liberation theology applies Catholic social teachings to understanding socially and politically produced suffering (Boff and Boff 1987; Gutiérrez 1998), arguing that efforts to understand and alleviate poverty must be structural in nature – they must grapple with the political economy that generates poverty in the first place (Farmer 2014). Liberation theology offers a politically focused analysis of suffering – and its message has been influential in a range of Latin American social movements. It is closely associated with Marxist concepts of class struggle, class consciousness, alienation and exploitation, as well as ideas drawing on dependency theory explaining the *development of underdevelopment* in Latin America (Frank 1969; Dussel 2003).

Farmer takes liberation theology's Marxist core as his own, without explicitly aligning himself or being explicitly interested in academic Marxism. Farmer (2003:138) writes:

...liberation theology has been one of my intellectual sources. Liberation theology, curiously enough, is the branch of theology most likely to turn to social theory, history, political economy. This would seem like an indirect way for an anthropologist to delve into the social sciences. But liberation theology adds something not found in any discipline: *how is this relevant to the suffering of the poor and to the relief of that suffering?* Thus, unlike most forms of social analysis, liberation theology seeks to yoke all of its reflection to the service of the poor.

Thus, liberation theology provides Farmer's theoretical perspective (a world-view in which poverty is *produced by* mechanisms of exploitation) as well as a guide for social action, placing utmost value on providing a 'preferential option for the poor'.

From liberation theology, Farmer (2003) derives what he describes as a 'simple methodology': *observe, judge, act*. Observation is described by Farmer as traditional scholarly analysis – critically important, but by itself insufficient. Farmer is clear in his work that it is not enough to study the suffering of the poor; that the task at hand is to change the world and reduce that suffering. In doing so, Farmer emphasises the second and third elements of liberation theology's methodology – judgement and action.

In his writing about judgement, Farmer explicitly challenges not only factors associated with structural violence but also our ways of thinking about them. He observes:

Liberation theologians are among the few who have dared to underline, from the left, the deficiencies of the liberal human rights movement . . . When children living in poverty die of measles, gastroenteritis, and malnutrition, and yet no party is judged guilty of a human rights violation, liberation theology finds fault with the entire notion of human rights as defined within liberal democracies (Farmer 2003:142).

Moreover, 'the goal of judging is not producing more publications or securing tenure in a university . . . [the task is to] *change* the world' (Farmer 2003:144–5). Lastly, Farmer's position on *action* is particularly important. Throughout his work, it takes the form of 'pragmatic solidarity' with the poor. Drawing on the work of Paulo Freire, Farmer (2003:153) explicitly critiques traditional views of charity:

Those who believe that charity is the answer to the world's problems often have the tendency – sometimes striking, sometimes subtle, and surely lurking in all of us – to regard those needing charity as intrinsically inferior. This is different from regarding the poor as powerless or impoverished because of historical processes and events . . . There is an enormous difference between seeing people as the victims of innate shortcomings and seeing them as victims of structural violence.

Farmer thus places structural violence at the core of his theoretical gaze while also insisting – as did Marx in his *Theses on Feuerbach* – that our work must not only describe the world and its suffering, but must also seek to change it.

Scholarly lineage

Among the wide range of theorists who have written about health inequities, the strongest lineage is to be found in the ideas of Rudolph Virchow – the Prussian pathologist whose work on the links between living conditions, material deprivation and infectious disease is now acknowledged as a landmark in the social determinants of health literature (De Maio 2010). It is Virchow who famously concluded that 'disease is not something personal and special, but only a manifestation of life under (pathological) conditions . . . Medicine is a social science and politics is nothing else but medicine on a large scale . . .'

(Virchow [1848] 1985) – an idea with clear echoes in Farmer's writings. Virchow taught us that the role of the physician is social and political, not merely

scientific (Mackenbach 2009) – something which Farmer also reflects. Both Farmer and Virchow illustrate that the practice of medicine ought not to be separate from social activism and should work towards social justice.

Farmer's work also displays strong ties to the Latin American tradition of social medicine (Waitzkin et al. 2001; Barreto 2004). Although largely ignored in the English-language literature, it is the tradition of social medicine that has done the most to conceptualise disease as a product of both biological and socio-political processes. Its basic philosophy is radical, positing that a population's level of health cannot be understood – and thereby cannot be improved – without explicit engagement with its material conditions and its economic and political organisation. Moreover, the tradition is centred on social theory – calling for 'critical and ideological analysis of what is usually presented as purely technical knowledge' (Tajer 2003:2023). It is known as both a body of literature and as a political movement, one that values the articulation between theory and social change. All of these elements are fundamental to Farmer's work – which emphasises material conditions (framed as structural violence) and simultaneously critiques 'technical knowledge' (including inadequate regulations for treating MDRTB, unjust systems for pricing medicines, and uncritical formulations of 'health transition' in poor countries).

As well, a range of other theorists are also cited throughout Farmer's work – from Immanuel Wallerstein and *World Systems* to Arthur Kleinman and *Social Suffering* to Amartya Sen and *Capabilities*. All of these theorists contribute to Farmer's vision – one which centres on structural violence expressed through inequality as the fundamental cause of health inequities in the world today.

Pathogenic effects of inequality

Farmer's work is in many ways the qualitative/ethnographic counterpart to Richard Wilkinson's quantitative statement of the pathogenic effects of inequality. That area of work – which has grown exponentially since the publication of *Unhealthy Societies* (1996) – tests the basic idea that inequality (as a characteristic of the places in which we live) has direct influence on our health. The hypothesis has generated intense debates – with disagreements on methodological, theoretical and epistemological issues (Muntaner and Lynch 1999; Subramanian and Kawachi 2003; Coburn 2004; De Maio 2010). However, many central issues remain contested, and a consensus on the hypothesis is far from clear.

More than 200 statistical studies have examined the relationship between income inequality and population health, and approximately 90 per cent of these have found at least some support for the hypothesised relationship. However, once control variables are taken into account, this figure drops to approximately 40 per cent (Wilkinson and Pickett 2009b), with little agreement in the

literature surrounding the distinction between confounders and mediators, the geographical level in which the hypothesis should be tested, the regions in the world where the hypothesis might apply (Lynch et al. 2003; Subramanian and Kawachi 2003; Lynch et al. 2004), and which health indicators should be used (De Maio 2007, 2008). Despite a large and growing body of research, agreement on the validity of the hypothesis, the mechanisms that underlie it, and the global forces that shape it has not been reached (Deaton 2002; Starfield and Birn 2007; Subramanian and Kawachi 2007; De Vogli et al. 2009; Bernburg 2010).

The bulk of literature suggests that income inequality is associated with poor health outcomes, at least in the United States (Ross et al. 2000; Backlund et al. 2007; Wilkinson and Pickett 2009a), with some contested exceptions (Deaton and Lubotsky 2003; Muntaner 2003; Subramanian and Kawachi 2007). The extent to which this model applies in within-country analyses in other parts of the world, including the relatively more equal countries of Scandinavia (Böckerman et al. 2009) and Central and Eastern Europe (Bobak et al. 2007) has been called into question. As well, non-significant findings have been published using data from other relatively equal countries, including Germany (Breckenkamp et al. 2007), Denmark (Osler et al. 2002, 2003), Canada (Veenstra 2002; Auger et al. 2009) and Japan (Shibuya et al. 2002).

Lending credence to the idea of a 'threshold' effect, wherein income inequality has a detectable effect on health but only at or above a certain level of inequality, significant effects have been detected in the relatively unequal countries of China (Pei and Rodriguez 2006), Italy (De Vogli et al. 2005), Brazil (Cavalini and de Leon 2008) and Chile (Subramanian et al. 2003), as well as in Argentina (De Maio 2008; De Maio et al. 2012). At the same time, recent multi-country analyses (Pickett et al. 2005; Moore 2006; Dorling et al. 2007; Pickett and Wilkinson 2007) have generated renewed support for the hypothesis, although this has been disputed in work using self-rated health measures (Jen et al. 2009). The net result of the empirical work in this area is deeply nuanced.

The core of the literature has been described by both friendly critics (Coburn 2000; Muntaner 2003) and hostile critics (Wainwright and Forbes 2000; Scambler 2001) as positivist, as it relies almost exclusively on statistical analysis of secondary data and looks to build a general theory from repeated observations of correlations between exposure (inequality) and effect (poor health). Most studies in this area have utilised some form of regression analysis. Some of the most intense debates in this field have been over measurement issues – the use of morbidity or mortality indicators, the geographical level at which to study the hypothesis, the operationalisation of income distribution, and the appropriateness of ecological versus multi-level statistical approaches. All of these are indicative of an epistemological approach that is guided by

the idea that to 'measure is to know'. While never fully succumbing to the abstracted empiricism forcefully criticised by C. Wright Mills in the *Sociological Imagination* (1959), most of the studies in this area have largely ignored generative mechanisms (Scambler 2001) that are reflective of political economy. Income inequality has tended to be the starting point of the analysis, and the political/social determinants of that inequality have been neglected.

This has been perhaps the most important weakness of the scholarship on the income inequality – health hypothesis. A great deal of attention has been given to pathways that may link inequality to poor health, with insight drawing on psychosocial, social cohesion and neo-materialist traditions (De Maio 2010). Relatively few studies have focused on the mechanisms underlying patterns of income inequality, with the result being that a political economy of the health effects of income inequality is at best only preliminarily sketched out in the literature.

It is precisely this missing element that can be at least partly addressed by a closer consideration of Farmer's work, for structural violence is the generative mechanism that can manifest in high levels of economic inequality and poor population health indicators. Other scholars, including David Coburn, have expressed similar positions. Indeed, critical realist scholars like Coburn have called for an alternative approach, one that investigates the causes and not just the effects of income inequality. For Coburn, this represents 'a broader, more contextualised and more sociologically meaningful causal model' (2004:43; see also Coburn 2000). Coburn (2001:50) argues:

... numerous researchers have explored methods of ameliorating the effects of poor social conditions on the health of the underprivileged... [but] hardly any have asked about the possible causes of inequality itself. Yet, examining the causes of social inequalities, and not simply their effects, changes our understanding of the causal sequences involved in the income inequality/health status relationship.

From this perspective, the health effects of income inequality are important but should be examined through the wider lens of political economy rather than epidemiology. Inequality, in other words, needs to be cast in a wider mould – as one aspect of structural violence.

One implication of this new approach is that future studies of the income inequality/health relationship will need to overcome the tendency to be constrained by national boundaries. Following Farmer's 'geographically broad and historically deep' methodological stance, new studies in this area will need to incorporate a more nuanced globalist perspective. Taking the 'generative mechanisms' behind income inequality seriously will require grappling with international political economy. Farmer observes: 'Drawing on the work of

many, I underline the pathogenic role of inequity ... societies riven by social inequality have poorer health indices than societies in which comparable levels of wealth are more evenly distributed' (2003:20). Yet Farmer (1999:281) critiques an important feature of the Wilkinson-derived literature, noting that:

...the cost of modern inequality is even greater than that calculated by Wilkinson and others who define 'societies' as nation-states. When he writes that 'it is clear that the main problems of poverty (at least within the developed world) are problems of relative poverty', Wilkinson misses the worst of it ... The sick of rural Haiti, urban Peru, and sub-Saharan Africa may be invisible to those tallying the victims of modern inequality, but they are, in many senses, casualties of the very same processes that have led to crime and decreased social cohesion 'at home'.

Farmer thereby offers a nuanced perspective on what the income inequality hypothesis may look like from a global health perspective – raising an important critique that one of the most debated hypotheses in social epidemiology and medical sociology has left out the bulk of the world's poor from its purview. When he argues that the Wilkinson-derived literature 'misses the worst of it', Farmer reminds us that the income inequality/health relationship must be understood from a global perspective. Farmer (2003:20) observes:

...it is important to sound a warning about the habit of conflating the notion of society with that of nation-state. We already live in a global society... calls of a right to equity must necessarily contend with steep grades of inequality across as well as within international borders.

Farmer's observation raises a critical challenge for researchers who study the health effects of inequality: to take globalisation seriously, to incorporate – rather than ignore – the suffering of the world's poor, and perhaps most importantly, to not only observe, but judge and act upon our findings.

Conclusion

Farmer's perspective on global health is built, above all, on the concept of structural violence. And structural violence is, admittedly, a nebulous term – something that can describe gross violations of human rights to high levels of income inequality to complex international trade agreements that inhibit the generic production of medicine. For some, this represents a fundamental liability – for if structural violence can manifest in so many different ways, it ceases to be a useful explanatory force, becoming instead, a 'black box' (Janes and Corbett 2009). Moreover, structural violence cannot be measured in the

same way that economic activity can be measured; we have no metric for structural violence that mirrors the specificity of gross domestic product per capita (the most common measure of a country's economic development) or the Gini coefficient (a commonly used measure of inequality). As such, the positivist disciplines of the social sciences (including epidemiology and quantitative sociology) have been hard pressed to incorporate the concept into their theories. And the interpretivist disciplines, including anthropology and qualitative sociology, may likewise avoid the concept, as it challenges ethnographic research to move from its traditional focus on the local and presents a stronger *determinism* than is usually welcomed in those disciplines.

Despite these drawbacks, Farmer urges us to give structural violence a central role in social science research on health. In particular, the concept of structural violence gives us a way of expanding the 'frame' of the income inequality hypothesis, moving beyond a traditional positivistic account of the pathogenic effects of inequality towards a more holistic analysis that models both the causes and effects of inequality. This is a critical difference – for if we fail to incorporate the causes of inequality into our analyses, we miss out on the generative mechanisms that lead to health inequities (Scambler 2001). The deep structural roots remain obscured, and our knowledge is limited as a result. More importantly, our capacity to think of, propose, and implement structural solutions is inhibited – leading to the continuation of avoidable, unnecessary and unjust patterns of disease in the world.

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