The politics of relative deprivation: A transdisciplinary social justice perspective

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ABSTRACT

Relative deprivation was defined by Townsend (1987, p. 125) as “a state of observable and demonstrable disadvantage, relative to the local community or the wider society or nation to which an individual, family or group belongs”. This definition is widely used within social and health sciences to identify, measure, and explain forms of inequality in human societies based on material and social conditions. From a multi-disciplinary social science perspective, we conducted a systematic literature review of published material in English through online database searches and books since 1966. We review the concept and measurement of relative ‘deprivation’ focussing on area-based deprivation in relation to inequities in health and social outcomes. This paper presents a perspective based in Aotearoa/New Zealand where colonisation has shaped the contours of racialised health inequities and current applications and understandings of ‘deprivation’.

We provide a critique of Townsend’s concept of deprivation and area-based deprivation through a critical, structural analysis and suggest alternatives to give social justice a better chance. Deprivation measures used without critical reflection can lead to deficit framing of populations and maintain current inequities in health and social outcomes. We contend therefore that the lack of consideration of (bio)power, privilege, epistemology and (bio)politics is a central concern in studies of deprivation. Our review highlights the need for the academy to balance the asymmetry between qualitative and quantitative studies of deprivation through trans-disciplinary approaches to understanding deprivation, and subsequently, social and health inequities. We recommend that deprivation research needs be critically applied through a decolonising lens to avoid deficit framing and suggest that there is space for a tool that focuses on measuring the unequal distribution of power and privilege in populations.

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1. Introduction

There is growing evidence internationally that health and socio-economic inequalities between populations are widening. Typically, inequalities measured at a population level in many high-income countries are dependent on Townsend’s (1987) concept of relative deprivation. As a theory and method of identifying social inequality, relative deprivation has been used in various disciplines to measure and explain differences in health, crime (Kawachi et al., 1999a) and educational outcomes (Downey, 1994). We explore the definition and conceptual development of relative deprivation as applied to health inequities and provide an analysis of the theoretical and political issues relating to relative deprivation. We conducted a systematic review of literature on relative deprivation since 1966, sampling international research found on academic databases and books. Our analysis focuses on the epistemological and ideological problems associated with measuring relative deprivation where issues of power/knowledge and implicit assumptions of western measurements of standards of living are foregrounded. In addition, we argue that the emphasis on deficits inherent in deprivation discourses tends to mystify relative deprivation masking the significance of political economic processes and affluence as driving forces of inequalities.

Our critical review of relative deprivation is transdisciplinary with a commitment to social justice. Two authors approach this from an anthropological perspective drawing from Foucauldian and decolonisation theories while another author applies a quantitative geographic perspective to deprivation. Equity rests on an ethical
commitment to ensure a fair distribution of resources (Reid and Robson, 2007, p. 4). Social justice, for the purpose of this paper, means societies are free from socially produced afflictions such as war, occupation, poverty, marginalisation, exploitation, colonisation and structural violence. We believe this involves a critical interrogation in the political economic system and institutions that uphold inequality instead of blaming the most disadvantaged. Colonial ‘victim blaming’ and ‘deficit theory’ are common discourses when socio-economic or health inequalities between indigenous people and settlers in Aotearoa/New Zealand gain public attention (Reid and Robson, 2007, p. 5), while the underlying structural processes driving such disparities are often ignored in the literature on area-level relative deprivation.

We present a perspective from the colonial settler context of Aotearoa/New Zealand where social inequities between indigenous and non-indigenous people are profoundly shaped by historical and ongoing forms of colonisation and institutional racism (Bécares et al., 2013, p. 76). Land confiscation and dispossession, state violence and policies of assimilation were part of British colonial processes that in contemporary times are also embodied in the unequal health status within Aotearoa/New Zealand. For example, there is much evidence demonstrating these inequities in health and in socio-economic deprivation (Bécares et al., 2013; Robson et al., 2010; Reid and Robson, 2007). Social justice and equity in this context means addressing these stark inequalities in health outcomes and the history of colonisation and ongoing forms of oppression.

2. Methods and scope

This paper is the result of a systematic review of the English language academic literature on deprivation since 1966. We searched literature in the disciplines of sociology, anthropology, public health, geography, criminology, Hauora Māori (Maori health), development studies and psychology. Hauora Māori is an emerging health related academic discipline based on local indigenous epistemologies and experience. For the purposes of this paper, Hauora Māori is focused on improving the wellbeing of indigenous populations through strength-based, structural paradigms and right-based approaches.

Our systematic review followed the five stage process based on Khan et al. (2003). Stage 1 focused on framing the research question. The guiding questions for this review were: a) What is deprivation? b) How do different disciplines define and conceptualise deprivation? c) What are the aims of deprivation research? For the second step, “identifying relevant work” (Khan et al., 2003, p. 118), academic database and library searches were conducted to find the relevant literature. Some literature we found by tracing references from other relevant papers. Khan et al.’s (2003) third step, “assessing the quality of studies” was applied consistently throughout the whole review process. Stage four, “summarising the evidence,” was achieved through the organisation of sources into an annotated bibliography to provide an overview of the literature and used for interpreting the patterns and themes emerging from the literature. The final step, “interpreting the findings,” was largely done through anthropological and sociological theoretical frameworks with a consideration of the absences in deprivation discourses.

We initially cast the net wide and found papers on “cultural” (Tulkin, 1972), “psychosocial” (Bos et al., 2009; Caldwell, 1970), “language” (Marcos, 1982; Glickman, 2007), “ecological” (Laughlin, 1974) and “emotional” (Wadsworth, 1976; Walsh and Beyer, 1987) deprivation, but conceptually they were unrelated to Townsend’s concept of deprivation. These forms of deprivation were not used as standardised tools to measure inequality on a population level. We therefore narrowed our focus on the uses of relative deprivation as a system of measurement of socio-economic inequalities.

3. Definitions and development of relative deprivation

Although many ‘types’ of deprivation are used in health and social sciences, there is an important distinction that should be made between social psychology and area-based/socioeconomic measures of deprivation. Social psychology bases the notion of relative deprivation on subjective feelings that people hold of being relatively deprived (Runciman, 1966). In contrast, the notion of relative area-based and socioeconomic deprivation used in public health, sociology and geography are often based on census data measured through variables constructed by academics. This paper focuses on the latter conceptualisation of relative deprivation as articulated by Townsend (1987, p. 125) as:

- a state of observable and demonstrable disadvantage, relative to the local community or the wider society or nation to which an individual, family or group belongs.

This is the most widely used definition in deprivation indices in health and social sciences (e.g. Carstairs and Morris, 1989a; Carlisle, 2001; Stafford and Marmot, 2003; Eames et al., 1993; Pampalon et al., 2010; Pampalon and Raymond, 2000; Testi and Ivaldi, 2009; Noble et al., 2006; Atkinson, 2003; Salmond et al., 2006; Krieger et al., 2003; Robinson et al., 1998; Abas et al., 2006; Halleröd, 2006).

Relative deprivation developed following the 1970s Alma Ata movement whereby modern statistical methods were incorporated in its methods of measurement (Salmond and Crampton, 2000, p. 9). The concept of relative deprivation was adopted by the social and health sciences more seriously in the 1980s, following Townsend’s (1987) seminal paper on deprivation. During the 1970s–1980s, area-based measures for deprivation were developed in Britain, US, Australia and New Zealand (Reinken et al., 1985). Since then, area deprivation measures have been developed in many high-income countries including Brazil (Pattussi et al., 2001), Canada (Pampalon and Raymond, 2000), the Netherlands (Drukker et al., 2003), France (Havard et al., 2008) and Spain (Benach et al., 2001). More recently, deprivation has also been used to investigate standards of living in post-socialist, transitioning economies in Eastern Europe (Silber and Verme, 2012).

Relative deprivation research also distinguishes between material deprivation and social deprivation. Material deprivation refers to the measurement of inadequacies in goods, services, resources, amenities and conditions of the physical environment (Salmond and Crampton, 2000, p. 9). By contrast, social deprivation refers to measurement of variations in social roles, relationships, functions, customs, rights and responsibilities of membership within a society and its subgroups (Salmond and Crampton, 2000, p. 9). In other studies, social deprivation was related to education and social support factors (Salmond et al., 1998) and indicators of social deprivation have included social disorganisation, lack of social cohesion, social networks and social capital (Pattussi et al., 2001). However, boundaries between material and social deprivation are often blurred with overlapping variables that make up social or material deprivation. Unemployment, for example, has been discussed as a form of social deprivation in some studies (House, 1982; Robinson et al., 1998), while in others a form of material/economic deprivation (Benach et al., 2001; Shihadeh and Ousey, 1998).

In 1987, Townsend argued that studies and measures of material deprivation were more theoretically developed than social deprivation. Since then, there have been growing studies on social
Deprivation (Patussi et al., 2001; Eames et al., 1993; Fone and Dunstan, 2006; Kingdom et al., 2007; Pearce et al., 2008b; Robinson et al., 1998). Indicators of socioeconomic deprivation, which combine the measurement of social and material variables, are widely used for analysing inequalities (e.g. Duncanson et al., 2002; Drukker et al., 2003; Havard et al., 2008; Riddell, 2005; Reid and Robson, 2007; Salmond et al., 1998; Zaman et al., 1997).

In geographic literature, a distinction is also made between rural (Cloke and Park, 1980; McLaughlin, 1986; Woodward, 1996) and urban (Barnett and Lauer, 2003; McCafferty, 1999) deprivation. However, these different forms of deprivation are rarely considered altogether and are located in different disciplinary contexts. Each concept reflects a particular interpretation of deprivation and is used to analyse different social issues.

Despite their different notions of deprivation, these examples all have a dependency on the notion of a standard of living that is ‘customary’ in a given society. Relative deprivation is thus “an absence of essential or desirable attributes, possessions and opportunities which are considered no more than the minimum by that society.” (Haase, 1999, p. 23). Relative deprivation is a multi-scalar concept that has been used to describe, monitor and compare inequalities between individuals, among small areas, in addition to regional and national levels. As a method for measuring inequalities, deprivation has been used for practical applications in health planning and resource allocation (Crampton and Davis, 1998; Gordon, 2003). At a theoretical level, deprivation is also treated as an explanation and as a determinant of health inequalities.

3.1. What relative deprivation is not

Poverty, access (Penchansky and Thomas, 1981) and social capital are often used interchangeably to describe or explain a similar social problem (Noble et al., 2006). Distinguishing relative poverty and relative deprivation is difficult although Townsend (1987, p. 125, 140) contends that the concept of deprivation should be applied to conditions and quality of life that are of a lower standard than is ordinary in a particular society, whereas living in poverty should refer to a lack of income and resources to obtain the normative standard of living. However, this distinction is not consistent in the literature, or internationally. For example, in the EU, poverty as a ‘scientific concept’ is defined in terms of both low income and deprivation as “the point at which resources are so seriously below those commanded by the average individual or family that the poor are, in effect, excluded from ordinary living patterns, customs and activities” (Gordon, 2003, p. 189). The debate regarding absolute or relative concepts of deprivation has also been applied to poverty (Townsend, 1985; Sen, 1983, 1985).

The definition of poverty has been widely debated due to its importance in strategies for measuring and eradicating poverty (Laderchi et al., 2003). The difficulty of distinguishing between poverty and deprivation results in part from the fact that both concepts are contested, inter-related, and therefore often conflated. One approach might be a simplified distinction between poverty and deprivation, as Noble et al. (2006, p. 172) argue: “the condition of poverty means not having enough financial resources to meet needs. Deprivation, on the other hand, refers to unmet need, which is caused by a lack of resources of all kinds, not just financial.” The task of disentangling deprivation and poverty for analytical clarity requires discussions of specific definitions of deprivation and poverty. There are no universal distinctions between deprivation and poverty in the literature we reviewed, the uses and definitions of these terms vary based on discipline, and the theoretical backgrounds and concerns of academics.

Relative material deprivation is often defined as limited access to resources, but this is not necessarily the case. While there is some evidence in the UK and US that increased levels of area deprivation are inversely associated with access to resources, research from New Zealand demonstrates that access to community resources is often greater in more deprived areas (Pearce et al., 2006; Pearce et al., 2008a). Similarly, social deprivation is not equivalent to a lack of social capital although these concepts are used interchangeably. Social capital is defined as “those features of social organisation, such as networks, norms of reciprocity and trust in others, which facilitate cooperation between citizens for mutual benefit” (Kawachi et al., 1999b, p. 1187). Social capital is related to issues of social cohesion where there is a high level of trust within the community. Drukker et al. (2003, p. 826) argue that a low level of social capital is generally associated with higher levels of socioeconomic deprivation (i.e. more deprivation), although anecdotal examples suggest that there can be more community trust in more deprived neighbourhoods and less social interaction among neighbours in less deprived areas. Clarity between relative deprivation and related concepts is therefore fundamental to understanding their differences and relationships to each other when applied in research.

4. Deconstructing disciplinary application/measurement of relative deprivation

Deprivation indices often respond to the need in the social and health sciences for the identification and measurement of inequalities (Dew and Kirkman, 2002). This need raises several important considerations, including: how one measures deprivation, how an individual or an area’s standard of living could best be quantified, and how the concept of relativity is incorporated in the criteria of measurements. To this end, Carstairs and Morris (1989b, p. 217) observed: “There is no definitive and unchallengeable method of measuring deprivation and the composition of an index of deprivation is a matter of considerable debate.” Deprivation indices are generally constructed to outline the criteria and variables of different aspects of deprivation. A number of composite measures have been developed and applied to social and health science research, but the formulae and method of calculation is a topic of debate (Atkinson, 2003; Berrebi and Silber, 1985; Dutta et al., 2003; Mukherjee, 2001).

Area-level deprivation is typically measured using composite indices where variables are selected to best depict social or material conditions that are considered below the society’s living standards. Therefore, such deprivation measures quantify the quality of life of individuals and neighbourhoods (typically defined from Census boundaries, or arbitrary administrative units). Furthermore, the relative deprivation of these areas is usually measured against ‘social norms’ that is arguably an academic concept and reflects dominant social groups’ cultural, socioeconomic and materialistic interpretations of ‘social norms’. Relative deprivation requires an understanding and analysis of social context and the hegemonic perception of a standard of living.

The aim of studying ‘relative deprivation’, Townsend asserts, is to:

Adopt a scientific conceptualisation which both allows for comparisons to be made through time about changes in conditions within a single society and differences in conditions between different societies at a simultaneous moment of time (1985, p. 660).

A plethora of studies and academic disciplines such as sociology, public health and hauora Māori, have used measures of deprivation to investigate equity and social justice. The publication of the Black
Report in the UK during the 1980s and the subsequent commentary regarding its contentious findings was influential in the use of area-level deprivation measures to investigate inequalities. Under such disciplinary paradigms, disparities in social, economic, political and health outcomes between subgroups in populations are often referred to in health as, analyses often compare the absolute and/or absolute measurable differences in health or social outcomes between the highest and lowest ranked groups (e.g. high vs. low income groups, least deprived vs. most deprived neighbouroughs). However, many of these differences should be better described as inequities in health, especially when the observed differences are unfair, unjust and avoidable (Whitehead, 1992). For example, forms of privilege and systematic racism are considered as key causal factors of inequitable ethnic distributions of deprivation and health in New Zealand (Reid and Robson, 2007). Monitoring forms of deprivation between groups in society can also reveal breaches of human rights and be used to promote rights-based approaches, interventions and legislation to encourage more equitable distributions of resources.

A number of scholars have argued for the need to assess deprivation as an area or spatial issue that affects health independently of individual circumstances (Carstairs and Morris, 1999; Stafford and Marmot, 2003). Measurement, weighting and scoring are constructed differently but the logic of deprivation has international consistency, many citing Townsend’s (1987) work. However, methods of measuring relative deprivation differ internationally. Each country tends to have their own standardised measurement based on their population census, administrative data or nationally representative surveys. Area-based deprivation is then mapped geographically to show areas that are more and less deprived within a city or nation-state.

The socially constructed yet theoretically driven criteria for the measurement of deprivation is evident in the different indicators included in deprivation indices, which are dependent on how deprivation is defined (Berberi and Silber, 1985, p. 810). Historically, most indices used in the UK are Townsend’s (Phillimore et al., 1994), Carstairs’ (Carstairs and Morris, 1991) and Jarman’s (Jarman, 1983). A number of papers have compared the different variables across different indices for measuring deprivation (e.g. Haase, 1999; Crampton and Davis, 1998; Morris and Carstairs, 1991). In Haase’s (1999, p. 19–20) comparison of seven different deprivation indices used in the UK, only two variables were held in common: unemployment and overcrowding.

Pringle and Walsh (1999, p. 317) argue that when constructing deprivation variables, there is a need to distinguish between actual and potential deprivation. For example, some variables used in deprivation measures include ‘single parent’ or ‘ethnic minority’ as a deprivation indicator, which would fall into the category of potential deprivation rather than actual deprivation. While these two indicators have strong associations with lower socioeconomic positions, they are not outcomes of deprivation, but are social positions at greater ‘risk’ of being deprived. There is a bias here that these populations are perceived to be ‘bad populations’, their level of deprivation then becomes a reflection of their moral character. Thus, deprivation measures, variables and indices are constructed at the discretion of academics and government sectors, and they reflect culturally and historically specific notions of what it means to be deprived.

A problem with deprivation variables is the assumption that the opposite is good. The indices tend to privilege employment, two-parent families, belonging to the dominant ethnic group(s), non-crowded homes, having a car, and having certain possessions that are part of a customarily acceptable standard of living. Rather than examining and questioning the social, economic and political structures and processes that make it more difficult for single mothers, unemployed, and ethnic minorities to live, these characteristics or variables of individuals are framed as the problem that needs resolution rather than the inequitable context and power relations.

4.1. Power/knowledge and the (bio)politics of deprivation

In the literature, there are many definitions of, and approaches to measuring deprivation, with each author arguing for the ‘robustness’ of their interpretation and methodology. Deprivation is an example of an ‘experience-distant’ concept used mainly by specialists, academics and professionals to further scientific, philosophical or practical aims rather than an experience-near concept that people use to describe their experiences (Geertz, 1983, p. 57). A significant problem associated with defining deprivation is one of power and control, Michel Foucault (1980) noted that scientific knowledge and discourse can disqualify perspectives, understandings, and conduct of the non-academic other, forming a constant articulation of power on knowledge and knowledge on power (Foucault, 1980, p. 51).

The process of maintaining such dominate discourse and knowledge in turn has been argued by Foucault to be a key controlling mechanism of power to create social ‘norms’ which transform populations into disciplined citizens (Foucault, 1980; Pigg et al., 2009). Surveillance for example, is a form of discipline that is a technique of power and social control that coerces bodies, people, and populations to be “docile” through hierarchical observation, normalising judgment and examination (Foucault, 1979, p. 136). Therefore, when applying a Foucauldian analysis to the concept of deprivation, it is apparent that scientific discourses create privileged epistemologies that can inform and maintain processes of power.

Foucault extended his philosophical analysis of power by proposing two additional yet complementary processes of power to that of his notion of discipline: biopower and biopolitics. Biopower is “the power to make live and let die” (Foucault, 1997, p. 241), and was established following the emergence of 17th century liberalism. Measurement, calculation and statistical surveillance of populations is an ‘art of government’ and a technique of biopower – the knowledge, discourses and strategies of state control that aim to govern a population’s life forces (Nadesan, 2010, p. 8). The discourse and measurement of deprivation is part of this governing apparatus and management of life in both population/public health and statistical monitoring of inequality. As an extension of the concept of biopower, biopolitics “deals with the population, with the population as a political problem, as a problem that is at once scientific and political, as a biological problem and as power’s problem” (Foucault, 1997, p. 245). Deprivation research is thus embedded in the biopolitical sphere that is concerned with the management and monitoring of populations. We use this concept here as part of a broader structural analysis of the problem of inequality we take in this paper. The role of political economy requires greater analysis in the production and reproduction of privilege and disadvantage.

The concept of privilege is an important theoretical tool that academic disciplines use to elucidate deprivation. Privilege has been defined as an invisible, unearned form of power that bestows advantages upon the individuals and groups who hold privilege in society (McIntosh, 1988). Limiting research to only focus on deprived populations and mechanisms that create associated disadvantage ignores broader political and social dimensions that create privilege (Stephens, 2010). Therefore, increasingly, social and health science and disciplines are advocating a ‘studying up’ (Chapman and Berggren, 2005) strengths-based approach to deprivation-related research where the focus is placed upon
“making visible the practices of those with privilege that work to simultaneously preserve and increase power and access to resources while denying access to other groups” (Stephens, 2010, p. 997). The focus on deficit in deprivation discourses fails to address affluence as a problem that shapes inequalities. Furthermore, the power to define what is ‘customary’, what constitutes a ‘society’ and who draws the administrative boundaries commonly used in relative deprivation research are of political importance and often defined by those with privilege.

Although we advocate a focus on privilege and those with power to understand how disadvantage is created and maintained (Stephens, 2010), there are currently no measurements to analyse what proportion of the population are overly privileged. The implications of this means that affluence continues to be rendered invisible in terms of its influence in driving inequities and perpetuates the current status quo of concentrating the academic focus on disadvantaged communities.

Even if Townsend’s definition of deprivation is argued to be the most coherent and robust, relative deprivation is often measured against a standard of living that is considered ‘customary’ in a given society. This requires an understanding of what is ‘customary, or at least widely encouraged and approved, in the societies of which they belong’ (Townsend, 1987, p. 126). However, definitions of ‘customary’ may vary within a ‘society’, where boundaries and definitions are not always clear. As the concept of ‘society’ is also contested in the social sciences (Ingold, 1996), it is important to clearly define ‘society’ in this context. For example, depending on the research question, society may refer to the nation-state, a cultural or ethnic group, or even supranational entities, such as “Europe”. Furthermore, while the boundaries of a society may be defined, problems arise when trying to define “customary” or a widely accepted standard of living (Narayan, 1998). Similarly, the cultural heterogeneity and stratification inherent within a society would suggest that consensus on defining ‘customary’ would be difficult, if not impossible, to achieve. Therefore, the power to define and construct indices of deprivation is typically ascribed to those (academics/politicians/professionals) with the most cultural capital in power/knowledge regimes. Furthermore, what is defined as the definition of ‘customary’ may not necessarily be socially just and quality of life may not exclusively be predicated on social and material circumstances.

In relative deprivation research, the view of the academic is usually presented as ‘objective’ and the layperson’s perspective is treated as ‘subjective’. These are modernist dichotomies that have been rigorously critiqued in anthropology, sociology and philosophy (e.g. Calhoun, 2000). The situated nature of knowledge becomes authoritative when it is constructed as ‘objective’ (Kleinman, 1995:82). For example, medical anthropologists generally believe that:

All research, including that mediated by complex laboratory techniques is subjective and interpretive. Apart from anything else, the types of things that a researcher sees and records (as well as the types of things that are left unrecorded or not seen at all) are, inevitably, influenced by the cultural and disciplinary background of the researcher and their research environment (Parker and Harper, 2006:4).

The false dichotomy of objectivity and subjectivity are arguably taken for granted in relative deprivation discourses and these epistemological questions derive from power relations. Another false dichotomy addressed by Williams (2003) is composition and context, which have been analytically separated by multi-level models. There have been debates during the 1990s regarding the extent to which neighbourhood influences on health were best ‘explained’ by context more than composition (Macintyre and Ellaway, 2009, p. 86). Williams (2003) argues that the separation of composite and contextual factors is problematic; they are intertwined. We would argue these dichotomies are false because they are entangled and mutually constitutive. Analyses of their interactions and entanglement might provide better insight as to how they both influence health.

4.2. Socio-economic determinism and the absence of agency and narrative

A major justification for deprivation research is based upon the premise that inequalities in health are socio-economically determined. Crampton and Davis argue that, “Social and economic conditions are powerful determinants of health status of individuals and populations” (1998, p. 81). The language of “social determinants” of health is commonly used in social epidemiology and medical sociology, which conceals a causal relationship between deprivation and health. Meanwhile, critical medical anthropology tends to discuss ‘bio-social interaction’ to explain health outcomes (Nguyen and Peschard, 2003). Within social science debates regarding the tension between structure and agency, Crampton and Davis’ (1998) favour structure as a determinant of social phenomenon over agency. Such a position questions whether deprivation indices really describe composite structures. We contend that deprivation indices describe and interpret the (characteristics of the) conditions of structures, rather than merely the structures themselves.

The notion of ‘structural violence’ (Farmer, 1996, 2004; Singer and Castro, 2004) is used widely in anthropological analyses of health inequality. This concept highlights violence of hierarchical power structures in the creation and reproduction of inequality and seeks to identify the structures more directly. For example, from his work in Haiti, Farmer (1996) describes how political and economic forces for which no one person is held responsible, create high risk environments for communicable diseases such as HIV/AIDS and tuberculosis for the most marginalised groups in society. However, such analysis of structure is rare in deprivation-related studies, and it may be argued that most studies address neither structure nor agency adequately. Rather, a significant proportion of deprivation-related research focuses on mapping and measurement of deprivation to provide spatial and statistical descriptions of an effect of structural violence.

Given the conventional epistemology of public health and quantitative geography, we are not surprised that the experiences and agency of people, their perspectives, and life history, are excluded from a plethora of research using area deprivation measures to investigate inequalities in health and social outcomes. There are a limited number of qualitative studies that delve into people’s lived experiences and their ideas of deprivation (Storey, 1999; Whitehead, 1994; Woodward, 1996). Voices of those living in deprived areas are excluded in most analyses as experiences of deprivation are typically reduced to deciles or quintiles of the population apportioned to increasing levels of disadvantage. We acknowledge that the quantification of deprivation is indeed an invaluable tool to highlight inequalities. However, quantitative studies can only provide a two-dimensional map of inequality. Quantification could be argued as the professional transformation of human suffering commonly practiced by researchers, academics and health professionals (Kleinman and Kleinman, 1991). Experiences of human suffering in their local contexts then become lost through statistics (Kleinman, 1995, p. 82).

Narrative, particularly ethnographic accounts of experiences provide a more three-dimensional understanding of the lived reality of people categorised as ‘deprived’. When people speak or
narrate their own experiences of pain, which ‘unmakes’ or disrupts the lifeworld of the sufferer, this can be a process of sense-making: “the imaginative linking of experiences and events into a meaningful story or plot, is one of the primary reciprocal processes of both personal and social efforts to counter this dissolution and to reconstitute the world” (Good, 1994, p. 118). In this sense, narrative can also be part of a healing process that can be mutually beneficial for research and subjects of deprivation or health research. Furthermore, ignoring the qualitative aspect of research “would mean failing to examine deprivation in the context that really matters: the life of the deprived person” (Eyles, 1987, p. 221). This aspect of deprivation is severely lacking in the literature.

A few exceptions include qualitative or ethnographic research, and these are typically complementary to other quantitative studies. Whitehead et al. (1994) conducted an ethnographic study of drug trafficking among ‘economically deprived’ African–American men in the inner cities of Washington and Baltimore that corresponds with and complements quantitative research findings. Similarly, Storey’s (1999) study of the perspectives of deprivation among rural residents in Cork and Kerry in Ireland is one of the few qualitative geographic studies. Woodward (1996) in her qualitative geographic analysis of ‘rural’ deprivation with rural residents reveals the disjuncture between academic definitions of the perspective of rural residents themselves. These studies are quite anomalous in their engagement with those people whose living conditions deprivation indices aim to describe and measure.

4.3. Eurocentrism of cartography and time-space separation

Area-based deprivation rests on a western notion of space. In Smith’s influential book, Decolonizing Methodologies, she argues that “space in often viewed in Western thinking as being static and divorced from time” (2006, p. 52). The method of cartography is a colonial practice and conception of space separated from time reflects a taken for granted dominant cultural bias that undermines indigenous knowledge. In Te Reo Māori (the Māori language), for example, there is no separation between time and space (Smith, 2006, p. 52). Statistics as a science of the state categorises people and the (re)search of meta-patterns in deprivation of health status to inform academics, health sector professionals or the government. Statistics and censuses can also be seen as form of governmentality and surveillance of the population, where the locus of power and decision-making for social justice and equity relies on the state in popular democratic modernist discourses. These experiences highlight the need to critically reflect on deprivation application through a decolonising lens to avoid deficit framing discourses that maintain racial discourses and associated societal inequities.

Area-based deprivation methods are subject to the ‘ecological fallacy’ (Salmond et al., 1998). The conflation of people and place assumes neighbourhood homogeneity, and that people of a place are affected in the same way or interact with their environment in the same way. Place and space are important concepts in area-based deprivation and geography in general but ‘places’ also have social and cultural meanings, class, status, and ethnicity of residents of a place can also contribute to its meanings (Kearns, 1993).

Deprivation scores or the marking of areas as ‘deprived’ can sometimes have the consequence of further stigmatising residents of a certain area (Salmond and Crompton, 2000). A distinction between people and place may be analytically important to distinguish between the characteristics of deprived areas and characteristics of people who live in those areas (Benach et al., 2001, p. 224). For example with discourses on rural deprivation, McLaughlin (1986, p. 206) argues that “not all locals in rural areas are deprived nor are all the deprived in local areas locals.” Deprivation indices are developed for specific time periods, often Census years, and understandably ignore historical neighbourhood conditions. Thus, the majority of research investigating widening inequalities in health has used ‘period-specific’ indicators of deprivation (e.g. Blakely et al., 2004; Boyle et al., 2005; Exeter et al., 2009; McLoone, 1996). However, this approach ignores the social mobility that neighbourhoods experience over time. Some areas in the ‘most deprived’ category for the early time point may have changed following generation schemes or gentrification, while the social conditions in other neighbourhoods may have declined. Singh (2003) used an alternative approach, in which the recent deprivation conditions were used retrospectively to investigate inequalities between 1969 and 1998. He found that inequality in US mortality rates and area deprivation widened substantially from 1969 to 1998. However this raises methodological issues about whether it is appropriate to apply contemporary measures designed for area deprivation in the present to measure deprivation in the past. Considering the relativity of deprivation and the continuous improvements to standards of living over time, retrospectively measuring deprivation may not reflect historical contexts adequately, especially in areas that have experienced considerable structural change, such as population increase or decline, gentrification and/or de-industrialisation.

Comparisons of deprivation over time are also fraught because census boundaries are reconfigured regularly to reflect population change and to manage the enumeration of the Census. In Scotland, however, census boundaries have been built from residential postcodes and Exeter et al. (2005) developed Consistent Areas Through Time (CATTs), ensuring that all households are allocated to the same small area for 1981, 1991 and 2001. Using CATTs, they created a ‘stacked’ deprivation index to identify the deprivation trajectory of neighbourhoods through time. Areas that were persistently least deprived (i.e. least deprived in both 1981 and 2001) had significantly lower mortality than those areas where deprivation worsened. In persistently most deprived neighbourhoods the mortality rates increased by approximately 10%.

As discussed above, the notion of ‘customary’ resources in 1960s will be different in the 1990s as a result of socio-structural change. Census data and deprivation variables and measures are specific to a moment in time. While Exeter et al. (2011) overcame some of these issues, their analysis is ecological in nature and does not consider the mobility of individuals over that 20 year period. Harris et al. (2006, p. 208) argue, “deprivation is only measured at one time-point, so we are unable to capture cumulative disadvantage over a person’s lifetime and across generations, which might have an additional effect on health inequalities”. Thus, life histories of people or historical, political-economic processes that might affect and explain why deprivation exists are often left out of analyses. Nevertheless, quantitative research based on longitudinal studies have been influential in our understanding of inequalities in health (e.g. Goldblatt, 1990; Bartley and Plewis, 1997; Norman et al., 2005).

4.4. Deprivation, oppression and marginalisation

Variables selected for inclusion as indicators of deprivation are usually informed by the availability of information through census or administrative data sources. However, a standardised ‘one size fits all’ model of a deprivation index will likely be ineffective at capturing the complexities and cultural specificity of diverse populations. Household overcrowding, for example, is a commonly used indicator of area deprivation that affected 8% of the NZ population in 2001 (Statistics New Zealand, 2006). However a household, including nuclear and extended families sharing homes together, can also be considered as a valued cultural practice among indigenous and minority populations (Pene et al., 1999). In western
cultures, individual privacy may be valued in a household, but living in isolation may also be seen as a form of social deprivation from other cultural perspectives. Many people living in one household could signify a supportive family environment. As previously mentioned, variables can sometimes confuse actual and potential deprivation.

Marginalisation based on age, gender, ethnicity, (dis)ability, religion, immigration status and sexuality are inadequately theorised in a transdisciplinary manner in studies of deprivation. Within nation-states, nomadic, travelling or homeless people are often excluded from administrative databases. Immigration status can also play a huge role in access and affordability of health care (Fassin, 2004). Without health insurance, some populations may be unable to afford and thus access certain health care.

The main form of oppression or discrimination investigated in Aotearoa/New Zealand literature on deprivation is racism and colonialism in relation to Maori (e.g. Reid and Robson, 2007). Other oppressions that relate to experiences of deprivation and health inequities could be important topics for further research including: homophobia and transphobia in relation to mental health or suicide rates of gender diverse and non-heterosexual people; sexism or patriarchal family structures’ relationship to family, partner or gender violence or sexual abuse; stigmatisation and exclusion of people with disabilities; age-based prejudices and discrimination that affect young and elderly people. Within these diverse communities, socioeconomic deprivation may be a marker of oppression, although conceptualising deprivation as separate to racism, for example, may be disloyal to people’s lived experiences.

In Maori health literature it is argued that the legal system has played a significant role in the colonisation of Aotearoa (Robson et al., 2010). The imprisonment rates among Maori correspond with institutional racism in the justice system. Justice issues and police harassment disproportionately affect Maori (Robson et al., 2010). The lack of political power and access to legal rights or human rights has yet to be incorporated in discourses of deprivation and health. The stigma of criminalisation, restriction of movement and freedom, limits of dietary choice in the prison environment has only substantially been addressed in research into Maori health (Reid and Robson, 2007). “Prison inmates not only lose their freedom but also lose the ability to influence matters affecting their health, including sanitation, diet, level and type of physical activity, social environment, communicable disease exposure, and health care” (Carr, 2007, p. 221). While the majority of literature on health and deprivation has neglected this institutional environment, there have been studies in the US on deprivation in prison and how suicide rates are affected by overcrowding (Huey and McNulty, 2005).

Depivation and health discourses use socio-economic inequalities to explain health inequalities, but the political — how hierarchical power relations might relate to inequalities in health — is also part of people’s lived experiences of inequality. There has yet to be a measurement or index that speaks to what might be called political or legal deprivation — political disadvantages people experience due to systems of domination such as gender-based oppression, racism, class and settler colonialism where historical laws have worked in the favour of dominant groups and classes.

5. Overcoming problems of deprivation—challenges for social justice

We have described how deprivation operates as both a mechanism for description and explanation at the intersection of health and social sciences. But how successful are deprivation measures at achieving these objectives? How effective are studies of deprivation in changing the conditions for the deprived and disadvantaged? Have they helped to reduce disparities in health and society? Deprivation indices have been fairly useful for measuring, identifying and monitoring inequality. However, in the last 20–30 years, the gap between the rich and poor and inequality in health outcomes has increased since studies of deprivation began (Shaw, 1999). There must be acknowledgement, however, that to some extent the (relative) ‘widening gap’—typically measured as a Rate Ratio (RR), results from more rapid improvements in health outcomes (e.g. decreased mortality rates) in the least deprived neighbourhoods than in the more deprived communities (e.g. Benach et al., 2001; Eames et al., 1993; Carstairs and Morris, 1991; Boyle et al., 2005; Exeter et al., 2009, 2011). Although deprivation tools can be useful, they do not operate within a theoretical, value free contexts. Interventions that continue to target areas of extreme deprivation will fail to identify structural violence that creates systems of privilege and disadvantage. Therefore there is a need to develop a tool that focuses on measuring the mechanisms that create unequal distributions of power and privilege within populations.

To address some of our critiques, we propose a number of suggestions and challenges for consideration when conducting future research on deprivation and inequalities. Here we want to offer some practical, open-ended solutions for further theorising of inequality and strategies for social justice.

Data obtained from the census or administrative sources do not provide a consensus of the meaning of deprivation or what the ‘customary’ resources required for a relative standard of living against which deprivation is measured. Kleinman (1995) argues that international health research requires narratives and numbers, history and epidemiology, ethnography and policy analysis. We agree that a multi-disciplinary, multi-methods approach would be the most effective for a holistic understanding of inequality. Deprivation and social inequality are social justice issues that require recognition beyond mere description and measurement. Public health researchers, geographers, social scientists and epidemiologists all need to critically reflect upon their role and complicity in social and health inequalities and inequities. First, we ask, is measuring and identifying inequality enough? Instead of witnessing the widening gaps, monitoring and measuring the changes that are occurring, academics and the health sector need to be engaged in social change and politicise the problems of inequality rather than describing them simplistically. The British Medical Association affirms the need for academics to focus on the underlying values of equity and social justice when conducting research into deprivation: “In the interests of justice and public health, there should be a commitment to combat extreme social inequalities with the aim of eliminating deprivation” (1987, p. 40).

What solutions have been offered in the literature to solve the problems of deprivation and inequality? Many solutions offered in studies of deprivation are policy changes or local health initiatives (British Medical Association, 1987), but it is not known to what extent the recommendations in academic articles are actually taken seriously and applied when targeting government to make changes. Eames et al. (1993, p. 101) suggest that improving child benefits and pensions, providing employment opportunities and quality housing can reduce premature mortality rates in England. In addition to policy and welfare-based interventions, rights-based approached to health directly challenge health inequalities by identifying them as breaches of basic human rights such as access to health, shelter and food, and create robust legal pathways to advocate for equal opportunities and outcomes for all people. For example, Jones et al. (2014) draw attention to the importance of Maori and indigenous rights to health through international law and the failings of the New Zealand government to fulfil these obligations. The State can (and does) choose to act in opposition to
solutions proposed by academics. Benefits get cut, state housing gets sold off, workers become redundant, and health care becomes increasingly privatised. The saturation of neo-liberalism into state affairs has resulted in government institutions contributing to widening inequalities.

The role of the State is rarely questioned or critiqued in studies of deprivation and healthy inequality, but as a form of centralised power that institutes and legitimates inequality in power and decision-making, it plays a crucial part in influencing inequities in health. Solutions and recommendations offered in much of the literature are changes in social policy and re-allocations of funding and resources to meet the needs of the most deprived. These top-down government-based solutions construct the population as passive. Rather than agents, people at the grassroots of society are only receptors of government services and resources. Social justice then becomes a top-down process, which is based on naive assumptions of the State as an institution whose sole purpose is to 'serve the people' when historically, and in contemporary times, the State has been an agent of the institutionalisation of inequality. The challenge to academics committed to social justice is to look for solutions from bottom-up approaches rather than only top-down because politicians in power will not always implement our recommendations.

Our review has highlighted the need for the academy to balance the asymmetry between qualitative and quantitative studies of deprivation. This could be achieved through the implementation of trans-disciplinary, mixed method research, as both qualitative and quantitative research is important and complementary to further our understanding of the nature of deprivation and its multidimensional manifestations. There is an apparent lack of genuine ethnographic research on the meanings, experiences and perspectives of deprivation among the ‘population’ most affected by these circumstances. Multi-scale investigations ranging from local neighbourhoods to policy and the political economy, critical observations and analyses are required to provide a more holistic overview of deprivation and relations to power. Coburn (2004) argues for an alternative approach to theorising health inequalities in the developed world through historical qualitative analyses that critique the contemporary contexts shaped by neoliberalism and global capitalism as well as the concurrent erosion of welfare states.

In the context of Aotearoa, and many other countries that have made a connection between deprivation or health inequality and colonisation and racism (Bhopal, 2006; Reid and Robson, 2007; Bécares et al., 2013; Bramley et al., 2004), the challenge is also to address the ongoing effects and new forms of colonialism. These are also entangled with other forms of oppression and marginalisation based on gender, sexuality, class, immigration status, age, religion, and disability etc. The state and the health institutions have the biopower to “make live and let die.” In this instance, inequities of life expectancy, for example between Māori and non-Māori, is a 7.3 year gap (Statistics New Zealand, 2013). Social justice and achieving holistic equitable health in this context necessarily involves decolonial praxis that addresses the history of land confiscation, “destabilisation of cultural foundations” and ongoing social, economic and political marginalisation of indigenous people (Jones et al., 2014: 55). Anti-racism and recognition of indigenous sovereignty and self-determination are key cornerstones of social justice and health equity given the connections many researchers have made between racism, colonisation and negative health outcomes (Harris et al., 2006; Bhopal, 2006; Bécares et al., 2013; Reid and Robson, 2007).

6. Conclusion

Relative deprivation has been an important concept for understanding and measuring social inequalities in relation to socio-biological ill-health. In the literature on deprivation, the concept and methods of measuring deprivation serve a variety of purposes in various disciplinary contexts. There is a broad range of empirical studies done in predominantly western countries, while some articles are more theoretically based as a form of measurement to identify inequality. Deprivation and health studies provide a socio-economic explanation for differences in rates of disease, mortality, hospitalisations, mental health status and other indicators of health status. Theory-based articles either focus on evaluating or describing the concept of deprivation or the methods of measuring and calculating deprivation scores. We have raised some problems with the current measures and applications of relative deprivation, particularly the epistemology of deprivation and the problematic distinction between objectivity and subjectivity widely used in deprivation discourses. The general lack of political analysis; consideration of agency; power and political deprivation; qualitative research; intersectional analysis of oppression; and studies into policy and health systems constitute some of the problems in the literature on deprivation from an anthropological perspective. Employing rights-based approaches under a decolonising lens could help approach these issues by shifting the gaze from more privileged perspectives to a more equitable understandings.

What is evident from this review is that there are gaps in the deprivation discourse that need to be addressed. The quantitative analysts would benefit from being balanced by more qualitative research on deprivation, firstly to even understand what deprivation means to the general populace or whether this analytical concept has become a possession of academia uncommon in everyday discourses among ‘lay’ people. If deprivation is a relative concept, then academics who attempt to construct a definition and conceptualisation of deprivation need to consult with wider society on the meaning.

The implications of this review raise further questions about the solutions to the problems of deprivation, as a concept, measurement and as lived experiences. From a social justice framework committed to equity, health and inequality, researchers would benefit from a closer analysis of power and analyse the workings and operations of capital, the state, and social institutions that govern access to, content and forms of therapy, treatment and cures. Deprivation research is ultimately part of a broader project of social justice, to find solutions and decrease both inequality and inequity, but the current solutions and approaches offered are often complicit in the structures and processes that reproduce inequality and thus require critical re-evaluation. Considerations of cross-cultural differences within and between the boundaries of nation-states and intersectional analyses of racism, gender oppression, political economy, ideology, colonialism and deprivation could provide a more critical framework for developing solutions that treat the root causes of inequality.

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