

2004

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Recommended Citation

Galal, Osman and De Vogli, Roberto (2004) "Challenges for Reducing Inequities in Health and Healthcare for the 21st Century," *International Journal of Global Health and Health Disparities*, 3(1), 9-19.

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CHALLENGES FOR REDUCING INEQUITIES IN HEALTH AND HEALTHCARE FOR THE 21ST CENTURY

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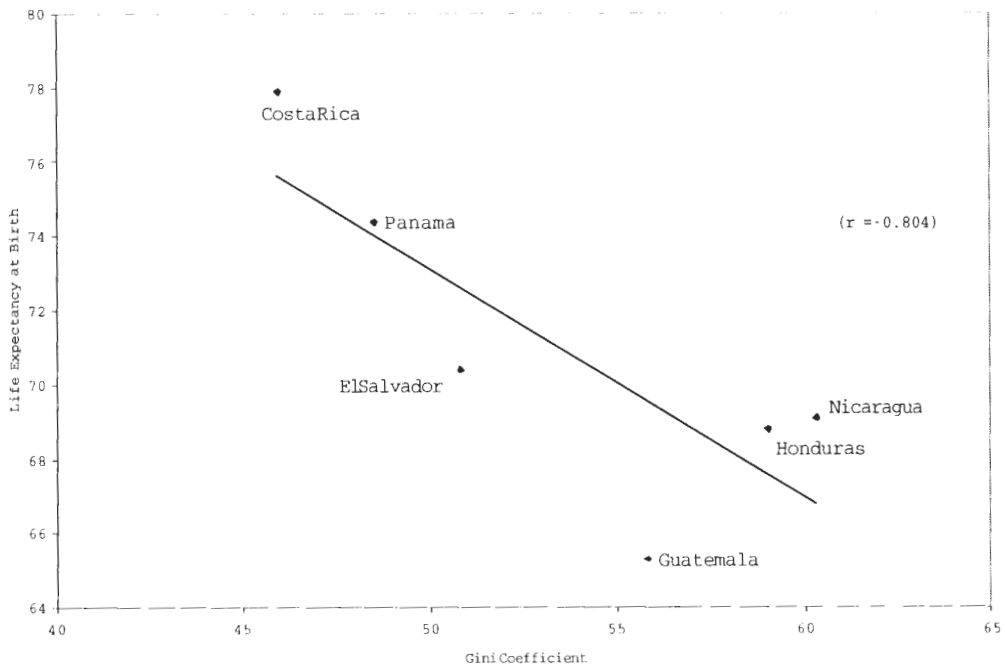
ABSTRACT

Human life expectancy during the time of the Roman Empire was approximately 28 years. In 1990, global life expectancy had increased to 65 years. The advances in life expectancy in the 20th century were remarkable by any standard. Although many factors contributed to this enhanced life expectancy, including medical technologies, by far the largest proportion of the increase occurred as a consequence of economic growth, rising living standards and nutrition. Despite the large improvements in terms of life expectancy, significant health variations still remain between countries and across different socio-economic classes within countries. As the 20th century proceeded, a growing dichotomy existed between those who are healthy and have access to medical care and those who are not healthy and do not have access to such services. Moreover, evidence shows that such inequities in health and healthcare are increasing. The present paper will analyze the dynamics of shifts in health profile during the early period of the last century and describe the major determinants of inequities in health and healthcare at the international level. Challenges facing the reduction in inequalities in health and healthcare will be discussed.

THE HEALTH STATUS OF THE WORLD AND ITS MAJOR RISK FACTORS

Human life expectancy during the time of the Roman Empire was approximately 28 years. In 1900, life expectancy had been extended only nine years, to an average of 37 years throughout the globe. In 1990, it had increased and reached 65 years, an increase of 28 years during the 20th century. Global life expectancy increased faster in the last 40 years than it did in the preceding 4,000 years [1]. Such advances were remarkable by any standard, especially in developed nations, and they were mainly attributable to control of infectious diseases. The last years of the 19th century and the first of the 20th corresponded to the “golden age of medicine” to describe a radical transformation of medical knowledge, practices and policies. During this period of time, researchers identified microbes as the specific causes of major diseases and went on to develop therapeutic measures to destroy them in those who were infected. This era is typically associated with the “conquest” of epidemic infectious diseases [2].

Although medical care surely contributed to this enhanced life expectancy, there is evidence that its effect on health was quite limited. The largest proportion of the increased life expectancy occurred as a consequence of economic growth, better living standards and improved nutrition, as demonstrated by McKeown in his very famous project in the field of historical epidemiological in England and Wales [3]. In other words,



Source: De Vogli R. and Rescalli F. (2004) Desigualdad Económica, Capital Social y Salud en América Central. Paper presentation at the XII National Conference on Economic Sciences, March 3-6, 2004, Quetzaltenango (Guatemala).

Such relationship appears for countries that are in economic transition as well. Russia, for example, where income inequalities sharply increased after opening up the economy to the international market performs quite poorly in terms of life expectancy compared to other former Soviet bloc countries whose inequalities are lower [10].

Income inequality and disinvestment in health and social services have serious health consequences in developed nations as well. According to Wilkinson, in the developed world, rather than the richest, it is the countries where income differentials between rich and poor are smallest which have the highest average life expectancy. At a threshold of 8,000 – 10,000 \$/per capita further increases of GNP per capita have little effect on life expectancy. In a very influential study, Wilkinson showed that the United States, despite having one of the highest living standards in the world (the real GDP per capita was 24,680\$ in 1993) has a lower life expectancy (76.1 years in 1993) than less affluent but more egalitarian countries such as the Netherlands (GDP, 17,340\$; life expectancy, 77.5 years), Israel (GDP, \$15,130; life expectancy 76.6) or Spain (GDP, \$13.660; life expectancy 77.7 years). Moreover, societies with the smallest income differences between rich and poor, such as Sweden and Japan, tend to enjoy the highest life expectancy (78.3 and 79.6 years, respectively) [11]. A subsequent study claimed the relationship between income inequality and health vanished to a large extent when new studies with better data from different countries were available [12]. However, a more recent investigation of 22

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wealthy nations found a very strong negative correlation between income inequality and health ($r=-0.860;p<0.001$) and confirmed Wilkinson's relative income hypothesis [13].

In the developed world, countries such as the U.S. and U.K. that perform unexpectedly low in terms of life expectancy compared to other developed countries, are also characterized by disinvestment in a variety of human-related services that are dramatically important for the poor such as health and social services [14].

Unfortunately, in the era of globalization, income inequalities are sharply increasing with the richest countries becoming richer and the poorest countries remaining poor. At the same time, there is a general tendency to reduce public expenditures on health and social services even in those countries that have traditionally invested an important percentage of GDP in such services [15].

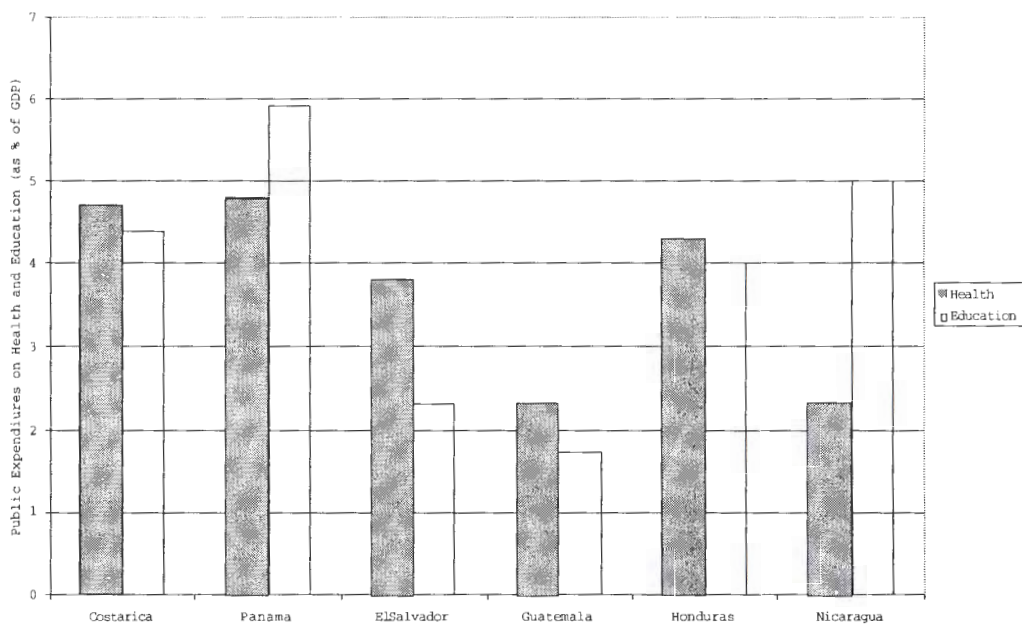
HEALTH INEQUITIES WITHIN COUNTRIES

The effect of poverty on health can also be seen when analyzing inequalities across different social classes within the same country. Better health has been consistently associated with having more income, more years of education and a prestigious job, as well as living in neighbourhoods where a higher percentage of people have higher incomes and more education [16]. In developing countries, there are striking variations in terms of health between different segments of society. In South Africa, for example, infant mortality is five times higher among the black and whites [1]. A study conducted in Brazil demonstrated that there is a huge gap between under-five mortality rates among the poorest income quartile (113.3/1,000 live births) and the richest income quartile (only 18.7/1,000 live births). Conversely, data from Vietnam and Pakistan showed that the under-five mortality rates between richest and poorest income quintiles are quite similar (53/1,000 live births vs. 47.4/1,000 live births and 160/1,000 live birth vs. 145/1,000 live births respectively) [17]. Again, such different health gaps are associated with different national policies. In China, Chile and Russia, where economic reforms have been aggressively promoted, gaps in life expectancy are widening over time with disturbing evidence of the net deterioration of health among certain groups. On the other hand, in Bangladesh, strong pro-equity policies had the effect of decreasing child mortality rate of the most disadvantaged groups at the fastest rate [1].

Even in high income countries where there is little absolute poverty, there are important inequalities in health status that span the full socioeconomic spectrum. In a study of 300,000 men in the United States, mortality declined progressively across 12 categories of household income from less than \$7,500 to more than \$32,499 [18]. Research shows that not only are poorer people more likely to die prematurely or be sick than richer people, but also that an individual's standing in the social hierarchy is highly correlated with health [19]. This finding was first demonstrated by Marmot and colleagues who found that among males, age 40 and 64 years, the death rate was about three and a half times higher for those in clerical positions as for those in administrative grades. Interestingly enough, none of those studied were living in poverty and all had access to the British socialized health care system [20].

As the twentieth century proceeded, a growing dichotomy existed between those who have access to healthcare and those who do not. Although the relationship between per capita health expenditure and life expectancy is quite weak [6], there is substantial concern about disparities in terms of public health expenditure between countries. Much of global expenditure for health is used in developed nations, while little is spent for poor countries where mortality and morbidity are higher. Health expenditure ranges from US\$ 20 per capita in developing countries to US\$ 2,470 per capita in developed countries. In the poorest countries, where basic healthcare is strongly needed, governments invest a very small percentage of GDP in health. A study among six countries in Central America (Figure 4) showed that Guatemala and Nicaragua, with the poorest life expectancy at birth (65.3 and 68.8 respectively) were also those countries spending the lowest percentage of GDP per capita on health (2.3 percent and 3.8 percent respectively) [9].

Figure 3: Public Expenditure on Health and Education as percentage of Gross Domestic Product across six nations in Central America



Source: De Vogli R. and Rescalli F. (2004) Desigualdad Economica, Capital Social y Salud en America Central. Paper presentation at the XII National Conference on Economic Sciences, March 3-6, 2004, Quetzaltenango (Guatemala).

In 2002, the United Nations Population Fund (UNFPA) showed antenatal care differentials along various regions of the world. In 44 developing countries studied, more than three-quarters of pregnant women visit a doctor, a nurse or a midwife. However, in South Asia and North Africa, where women's mobility is more restricted, this figure is nearer one third. In the same continents, women are less likely to have skilled assistance at delivery or to have their children in a health facility [21]. Access to family planning is also a major concern for women living in poor nations. In Sub-Saharan Africa, contraceptive prevalence is only about 10 percent. In Pakistan, this figure is 9 percent [22].

HEALTHCARE INEQUITIES WITHIN COUNTRIES

There are not only remarkable differences between countries in terms of access to healthcare, but also the distribution of public health services within social strata is very unequal. First, in developing countries health expenditures are highly skewed toward the needs of the richest groups of society. In Indonesia in 1990, only 12 percent of government spending for health was for services consumed by the poorest 20 percent households, while the wealthiest 20 percent consumed 29 percent of the government subsidy in the health sector [23]. In India, around 32 percent of the benefit from public health services goes to the richest population quintile, compared with around 10 percent to the poorest quintile [24].

Also, the poorest individuals in developing nations are less likely to get the care they need. A study of a sample of eight developing countries found that poorer groups have lower probability of obtaining care when sick, are less likely to be seen by a doctor, and have a lower probability of receiving medicines when they are ill [25]. Another study found that in Asian and sub-Saharan African countries the poorest women were half as likely as the richest women to be assisted by a physician, nurse or midwife during childbirth [21].

Unfortunately, in attempts to control costs, many developing countries are experimenting with market strategies. Much of healthcare reforms implemented have been driven by a set of technocratic principles that emphasizes efficiency and effectiveness and give little consideration to equity [26]. For poor people in developing countries issues of cost repeatedly arise. The introduction of user fees for primary health care services, sponsored by international financial institutions such as the World Bank, is a particularly serious problem. For poor families who are already highly vulnerable, the costs of a sudden illness is devastating, both because of lost income and because of the costs of treatment. While the actual treatment itself can be prohibitively expensive, in many cases there are other hidden costs that add to the overall financial burden of healthcare. There is evidence that the introduction of user fees for health services is associated with reduced utilization of health clinics, especially among those groups who cannot afford to pay such services [27].

Not only the poor living in developing countries have problems of access to healthcare, but people living in industrialized countries as well. This is especially true in the United States that has a less efficient and more inequitable healthcare system among wealthy nations. First, the U.S. healthcare system is the most expensive in the world: in 1999 the United States spent 53 percent more on health care than any other OECD

country spent [28]. Second, the system is highly unequal: in 1999 one out of every six Americans, 32 million adults under the age of 65 and more than 10 million children, remained uninsured [29]. Lack of health insurance, however, is not equally distributed across different social classes, but it is more likely to affect the poorest populations [30].

Challenges for Reducing Inequities in Health and Healthcare for the 21st Century

In summary, the challenge of improving health and reaching the goal that has been set by the World Health Organization in 1978 “Health for All by the Year 2000,” needs some urgent actions. According to our analyses, inequities in health and healthcare seem the most plausible culprits for not having reached such a goal. The life expectancy gap between developing and developed nations is due to risk factors such as malnutrition, poor housing, lack of adequate water supplies and sanitation and unsafe sex. Such factors, however, are all strongly linked to poverty. As demonstrated by results on different levels of life expectancy between countries with similar GDP per capita, economic growth alone is not the solution to this problem. In order to eradicate poverty and reduce health inequalities worldwide it is also necessary to re-invest in equitable public health and social services as well as to reduce or contain income inequality. Such measures may also have positive effects in terms of economic development. First, there is evidence that high levels of income inequality may reduce economic growth. Second, disinvestment in public health, education and social services, can also be detrimental to the economy because of the social and economic costs associated with increased levels of poverty (e.g. higher crime, lower social cohesion) [31].

With regard to inequities in healthcare services, to adjust imbalances between rich and poor countries as well as rich and poor populations urgent actions are strongly recommended. While a higher share of global expenditure on health must be spent for poor nations, developing countries need to operate a radical shift of emphasis from tertiary and quaternary healthcare activities for the wealthy to more cost-effective treatments and preventive measures for the poor. Moreover, given the high rates of infant and maternal mortality of many developing countries, which are also the most important determinants of global health inequalities, emphasis should be placed on reproductive health services. Finally, user fees for primary healthcare should be immediately removed because of potentially serious detrimental effects on healthcare.

ACKNOWLEDGMENTS

The abstract of the present article was presented at the last conference on Food, Health and Poverty in Lisbon (Portugal), July 1, 2003.

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