

Global Public Health: The importance of tackling inequality

CDP Introduction

Importance of health

- Critical importance in itself
- Part of MDGs
- Important area of global action, via
 - Global Health Partnerships (GHP)
 - WHO/UNICEF
 - Aid (bilateral and multilateral).
- Our report special focus on health inequalities, and on GHPs

Large health inequalities

- Between countries
 - High income countries life expectancy 80; low income countries 59.
 - Under 5 mortality, high income countries 7; low 110
- Within countries.
 - LE in Glasgow (54) below that of India as whole
 - Rate of infant mortality top fifth wealth of population in Egypt three times that of bottom.

Why health inequalities matter

1. Health is foundational: basis for all activities, so health inequalities more important to people than any other.
2. Illhealth is a source of poverty, low productivity, poor education. Child ill health can worsen lifetime opportunities.
3. The higher health inequality, the worse the health of the worst off relative to national average. Inequality matters especially for the poor
4. Health inequalities are also a reflection of other inequalities.
5. Higher health inequality *leads to worse aggregate health. Of 155 papers, 70% of the studies with conclusive results found that health on aggregate was worse in more unequal societies.*

The health MDGs:

- Goal 4: child health -reduce by 2/3 under 5 mortality
- Goal 5: maternal health– reduce by $\frac{3}{4}$ maternal mortality; achieve universal access to reproductive health.
- Goal 6: have halted and begun to reverse spread of HIV/AIDs; secure universal treatment; halted and begun to reverse spread of malaria and other major diseases.

Health inequalities and the MDGs

- Inequalities make it more difficult to achieve MDGs.
- Improving conditions of the worst off is fundamental objective of the MDGs. In health prevented by high inequalities.
- Promoting MDGs without considering health can actually worsen inequalities as its easier to improve conditions of better off.

Problems in assessing health inequalities

- Inequality or inequity? Some natural inequalities (according to age, gender, disability..).
- Equity is equality of outcomes among groups of people with similar natural health propensities. But we may prefer to move towards equality of outcome, compensating for natural disadvantages.

What measure?

- Different measures of health:
 - Outcomes
 - Quantity of life statistics (life expectancy, death rates etc.)
 - Quality of life (functioning; perceived health).
 - Physical, mental, social health
 - Access to services
 - Access to health care
 - Quality of care.

Inequality among whom?

- categories

- Individuals (Vertical inequality)
- Groups (Horizontal inequality): according to region, geography, race, religion, income class..
- Group inequality is generally inequitable – no ‘natural’ reason for such inequality.

Strong evidence of sharp inequalities on each dimensions and by each categorisation in rich and poor countries

- In 55 developing countries, attendance for maternal delivery among the poorest fifth, less than half richest.
- 6 African countries, poorest fifth two thirds less likely to get modern care when ill than richest.
- Big racial/ethnic differences in health:
 - Washington DC LE is 63; Montgomery county 80.
 - Roma life expectancy 5-6 years below rest of population.
 - Indonesia Chinese infant mortality, one quarter other Indonesians.
- And regional:
 - Northern IMR 53%, 42%, and 40% below Southern in Cote d'Ivoire, Ghana and Nigeria.

And by gender

- Life expectancy and IMR generally better for women.
- But not in many Asian countries
- Women's health quality often worse.
- And access to health care generally worse.
- Gender differences influenced by environment and norms.
 - Some specific health hazards for women – cooking stoves. Spousal abuse. Maternal mortality.
 - Cultural norms often give less priority to women's health
- In some contexts men are disadvantaged – Russian federation 1990s, male LE fell from 64 to 58; women's from 74 to 71.

3 types of performance by country

- Mass deprivation, with elite receiving better care -- e.g. Niger.
- Queuing: improved access as people get wealthier -- e.g. Namibia, Liberia and Uganda
- Exclusion : a minority are excluded from health care – Colombia, India.

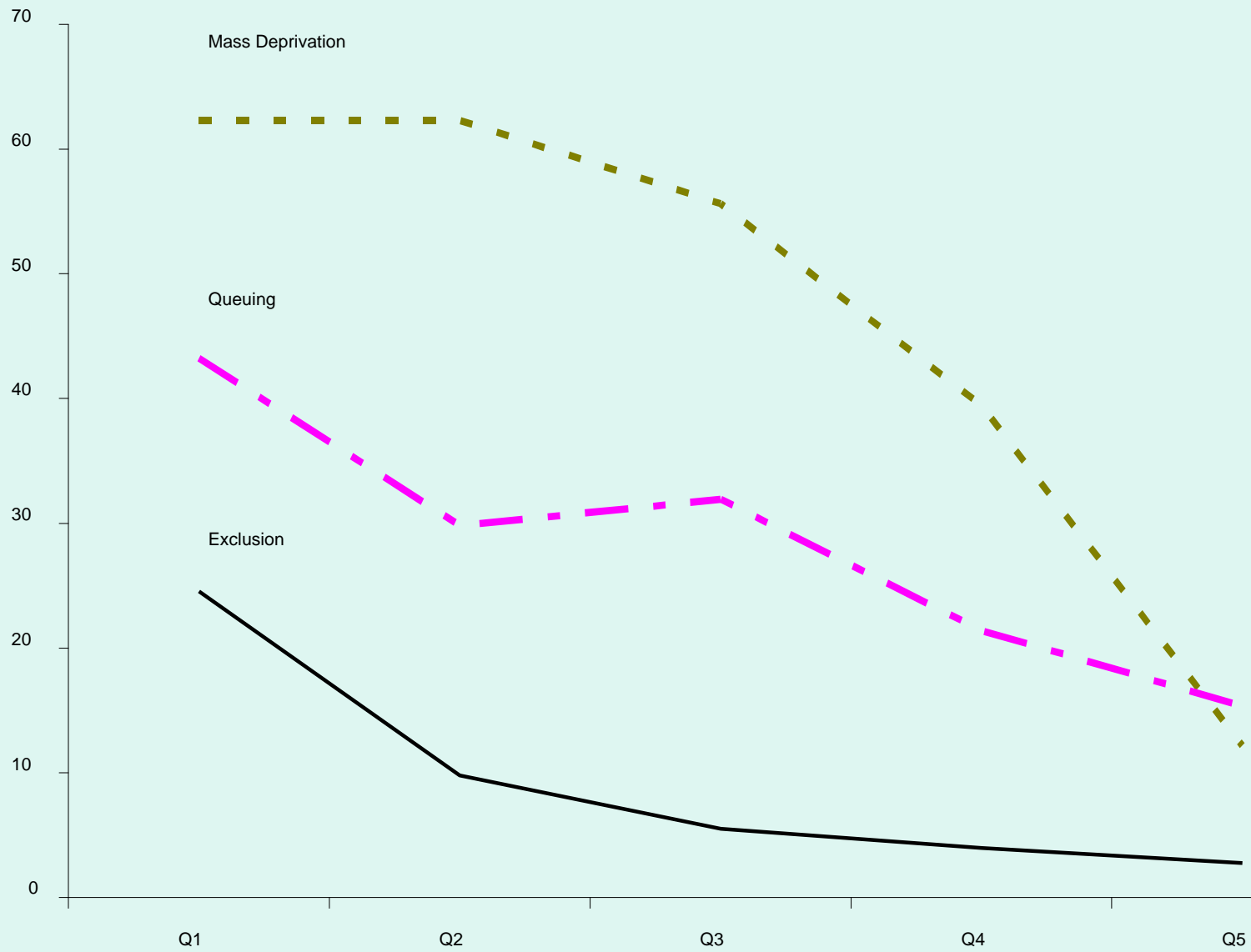
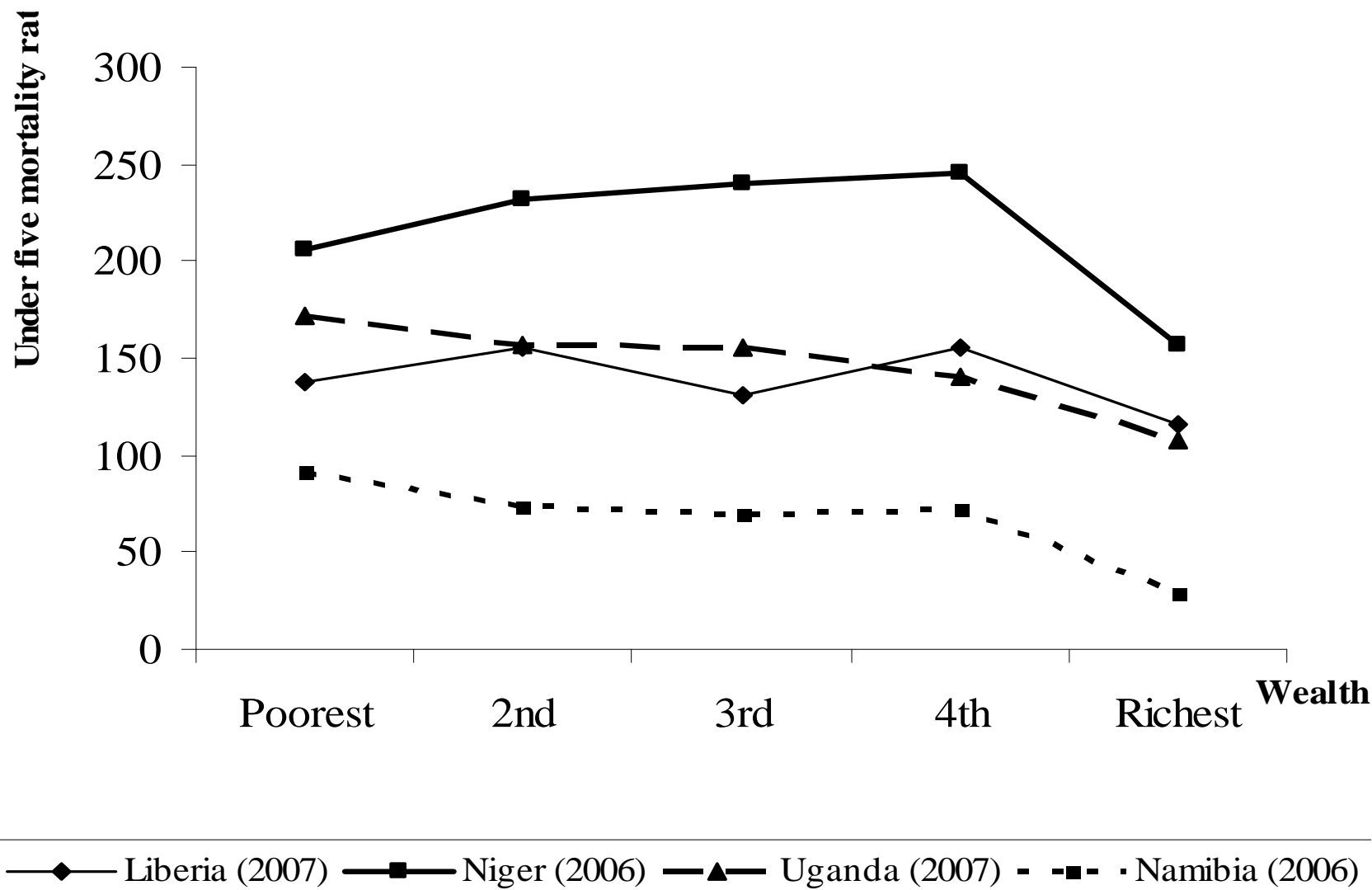
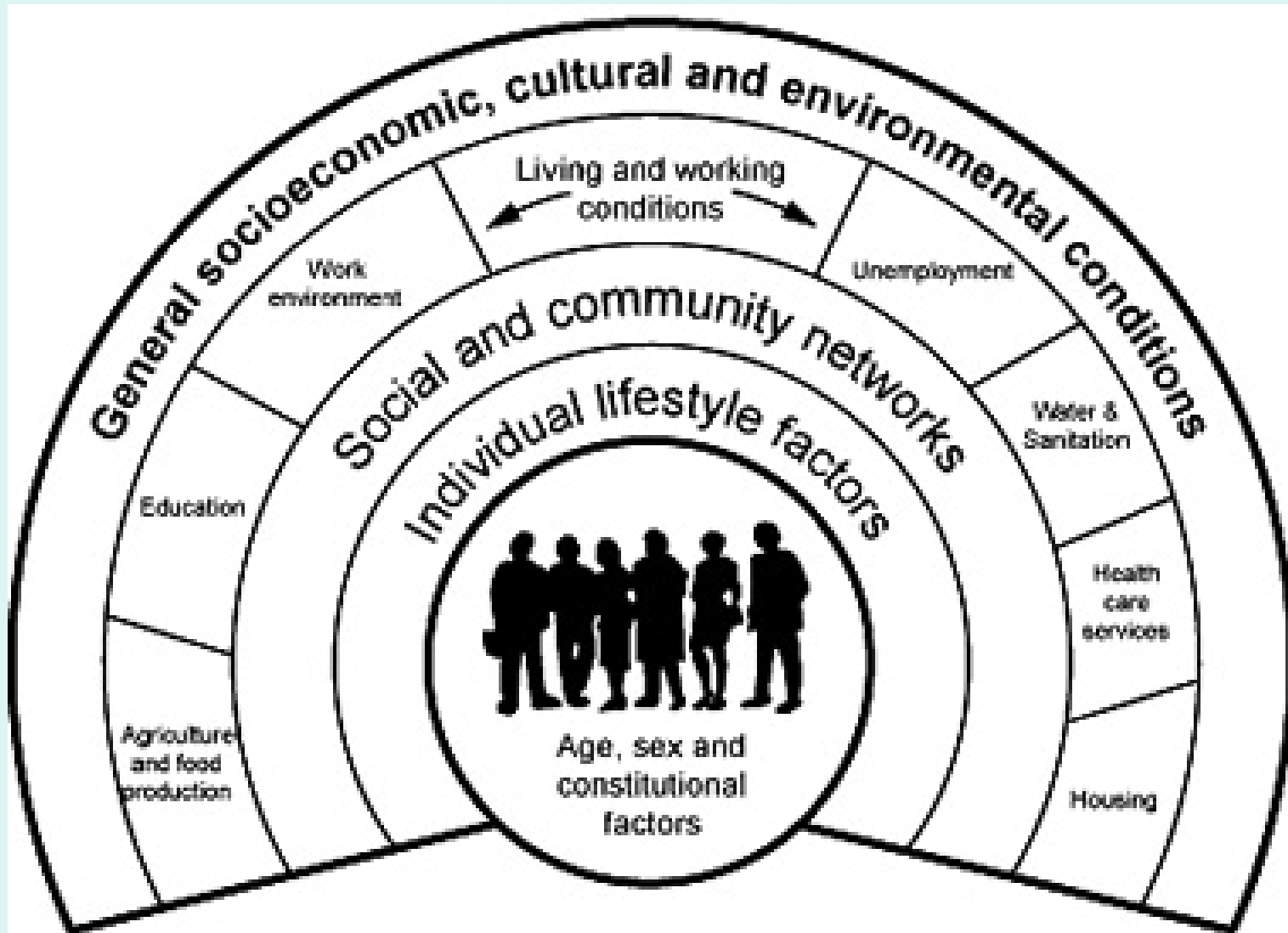


Figure 2: Under five mortality rates per 1000 children by wealth quintile



Health outcomes and inequalities reflection of many conditions



Most important source of inequalities lie in general socio-economic inequalities

- *'In order to address health inequities and inequitable conditions of daily living, it is necessary to address inequities ... in the way society is organised. (WHO: 2008: 2).*
- *What matters in determining mortality and health in society is less the overall wealth of that society and more how evenly wealth is distributed. The more equally wealth is distributed the better the health of that society. (Editorial in British Medical Journal, April 20th, 1996).*

Major source of health inequalities – mostly outside health sector

- Social stratification
- Educational inequalities
- Distribution of water/sanitation infrastructure
- Health behaviours (tobacco, alcohol, diet..).
- Occupational hazards
- Discrimination

Global action for health

- Much beyond the health sector.
- GHPs
- ‘Normal’ aid activities in support of aid
- Price of drugs

The global crisis: impact on health?

- Output decline:
 - Public revenue and expenditure decline on health expenditure and educational expenditure. Yet in 1980s some countries protected health and educational expenditures
 - Employment decline, negative impact on health (via stress), and on private health expenditures
 - Evidence of long run negative impact of economic instability on health.
- Aid?

Conclusions

1. Inequality matters for achieving goals of global public health: numerical targets can be mechanically met while many are left behind, the less privileged members of society can be often bypassed.
2. Inequality within a country worsens overall health.
3. The health status of a given population is the result of the complex interaction of a wide range of factors.
4. Equality of access to health services, appropriately designed to meet the needs of the disadvantaged, is critical.
5. However, many critical factors lie outside the actual health services. Most important are general socio-economic inequalities in society. Educational and behavioural factors are important, often associated with socio-economic status.

Recommendations

- Support conclusions of WHO Commission on Social Determinants of Health. Commission priorities :
 1. To improve living standards of poor.
 2. Tackle inequities in power and resources in society.
 3. Measure and understand the problem and assess the impact of action.

CDP recommendations for international action, by governments and NGOs for health sector

- *Adjust the aggregate MDG health goals to address existing inequalities and to improve the health of the poor and disadvantaged.*
- *Introduce inequality impact assessments for interventions in the health sector including for all GHPs.*
- *Take action to ensure access to low cost pharmaceuticals. This will require a review and reform of the patent and property rights regulations; and support for developing country capacity to evaluate and negotiate for appropriate drug access.*

Specific recommendations for national action in the health sector, supported by aid

- *Assure universal access to health services, including:*
 - *Removing user charges for basic health facilities.*
 - *Improving the distribution of services across regions and groups*
- *Emphasise the provision of preventative health education and health services.*
- *Provide financial support for the disadvantaged using preventative health services*
- *Improve the balance between primary health and secondary health care*
 - *this may involve restructuring the education of medical personnel*
- *Identify and correct all sources of discrimination, including racial, ethnic, gender and age discrimination*

Specific national areas of policy to promote health and reduce health inequalities that need global support

- *Promote female education*
- *Promote the use of smoke-free cooking stoves and fuels*
- *Tax items that cause ill health using revenue to support health sector, including:*
 - *‘Junk’ food and drink*
 - *Tobacco*
 - *Alcohol*

Reacting to the crisis

- Adjustment policies to protect access to health, education and employment for the disadvantaged.
- Learn from the experience of developing countries in the 1980s and the transition countries in the 1990s. Sustain expenditure on health and education, especially basic services.
- Sustain ODA supporting health and education.

Monitoring: with global support

- Essential to monitor health inequalities by income group, region, ethnic/race, age and gender.
- Choose small set of key indicators for global monitoring.
- This requires support for national data collection and analysis.