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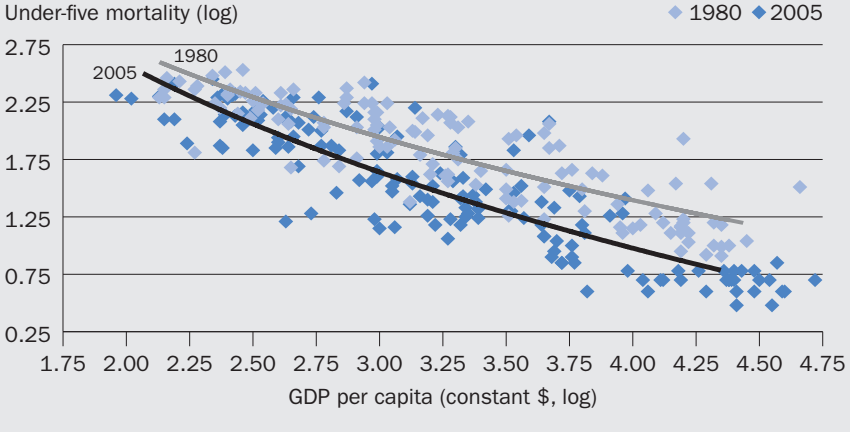
The wide health divide

Advances in technology and knowledge for health and hygiene have transformed life over the past 50 years. In 1960 more than 20 percent of children in developing countries died before reaching their fifth birthday; by 2005 this had fallen to just over 8 percent. The declines are large, even for the poorest countries (figure 2a). But this reassuring picture, painted by rising global averages, obscures substantial disparities among the world's regions and among the poor within countries. For millions of people health services and modern medicines are still out of reach, and many die prematurely from diseases that are easily prevented or cured. More than 25 years after the Health for All declaration, improving the health of the poorest people in developing countries remains a challenge.

What can improve all this? There is no consensus on which determinants are most important across countries. But there is agreement on the need to reduce extreme income poverty, the major risk for poor health and premature death. The World Health Organization (WHO) concurs, noting that a poverty-oriented health strategy requires complementary policies in other sectors (WHO 2003). These include improving access to education, enhancing the position of women and other marginalized groups, shaping development policies in agriculture and rural development, and promoting open and participatory governance.

Priorities in healthcare are also clear: focus on health problems and diseases that affect the poor disproportionately. Health gains require directing program benefits toward the poor and increasing the quality and availability of health services, especially where they are least available. This section looks at the rich-poor health divide between and within countries—and at the factors behind that divide.

Child mortality has fallen in the past 25 years for countries at all incomes **2a**



Source: World Bank estimates.

The divide between rich and poor countries

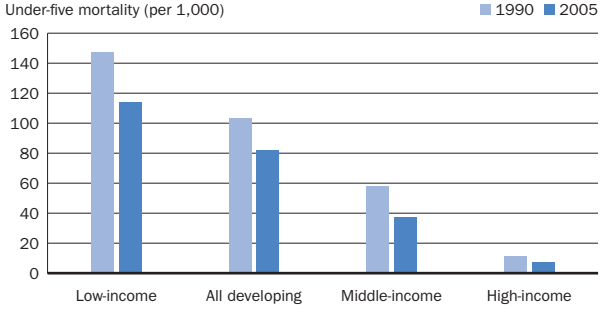
Differences in the health of rich and poor countries remain large and in some cases are increasing. Under-five mortality fell more than 36 percent in high-income countries from 1990 to 2005, but only 20 percent in developing countries, as preventable diseases continue to take a toll on the world's poorest people. But more important than the changes in proportions are the levels: under-five mortality is five times higher in middle-income countries than in high-income countries and 15 times higher in lower-income countries (figure 2b).

What accounts for these disparities? Child mortality from malaria doubled from 1990 to 2001, with the largest increase in Sub-Saharan Africa (Lopez and others 2006). Other increases in child mortality in developing countries came from HIV/AIDS, again with the largest increase in Sub-Saharan Africa, and problems in the first months of life, which depend strongly on the quality and availability of prenatal services. Child deaths from these causes are far less common in high-income countries, just as they are from acute respiratory infections, diarrheal diseases, and measles. But for developing countries, these diseases, along with malnutrition, remain significant causes of avoidable child deaths (figure 2c).

The differing patterns of mortality and well-being reflected in the age distributions of death for developing and high-income countries show their impact on life expectancies at birth (figures 2d, 2e, and 2f). In developing countries, where deaths of children under age five are still the major health issue, average life expectancy at birth is 65 years. But several countries—such as Lesotho, Zambia, and Zimbabwe, with high AIDS-related mortality—have life expectancies of less than 40 years. In high-income countries, by contrast, noncommunicable illnesses—such as cardiovascular diseases, diabetes, and related conditions of high blood pressure, high cholesterol, and excessive body weight—cluster deaths at older ages, and the average life expectancy at birth is 79 years. Indeed, in Canada, France, Japan, Norway, Sweden, and Switzerland life expectancies of 80 years and above are the norm. So any efforts to improve health and increase life expectancy in developing countries will have to focus on diseases that kill children.

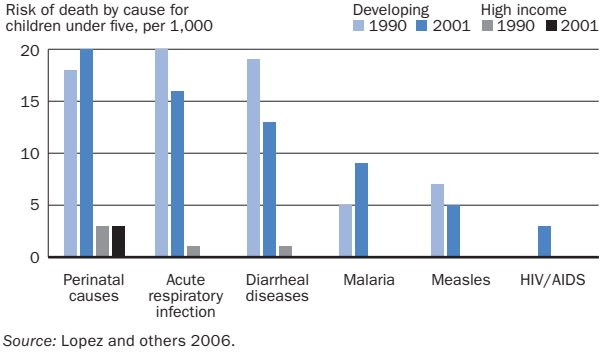
Why are there health gaps between rich and poor countries? Poverty makes people in developing countries more vulnerable to disease. Nearly a third of the people in South Asia and half those in Sub-Saharan Africa lived on less than $1

Under-five mortality is 15 times higher in low-income countries than in high-income countries **2b**



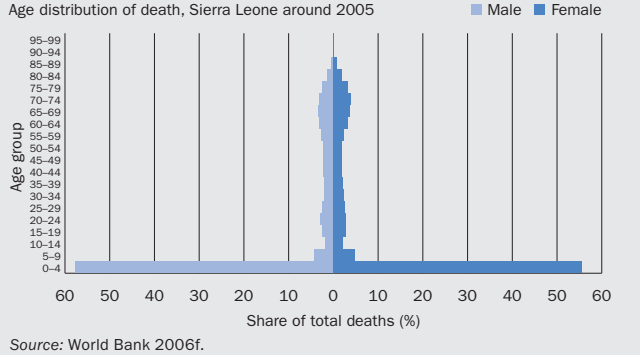
Source: Harmonized estimates from WHO, UNICEF, and World Bank.

Little reduction in risks for poor children **2c**



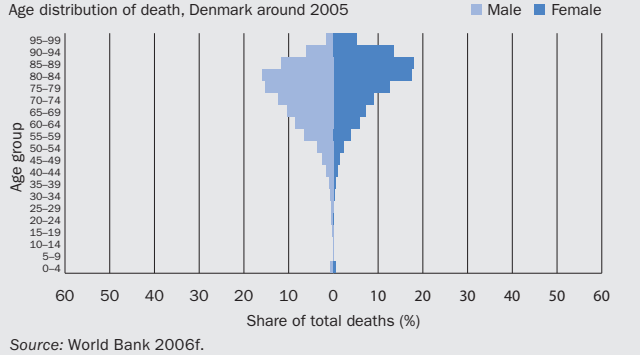
Source: Lopez and others 2006.

In Sierra Leone most deaths occur before age 5 **2d**



Source: World Bank 2006f.

A child born in Denmark can expect to live to be 78 **2e**

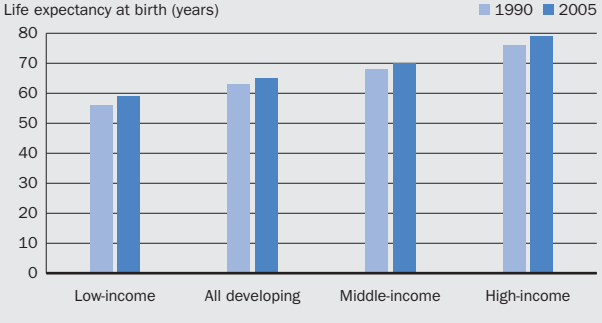


Source: World Bank 2006f.

a day in 2002. The majority of them typically lack access to safe drinking water and adequate sanitation, food, education, employment, health information, and professional healthcare. Almost half the people in Sub-Saharan Africa cannot obtain essential drugs (Jamison and others 2006). Many developing countries experienced little increase in immunization coverage between 1990 and 2005, and in 2005 only 75 percent of children ages 12–23 months were vaccinated against measles and diphtheria, pertussis, and whooping cough, compared with almost 95 percent for high-income countries.

Several barriers beyond low income exclude people in developing countries from getting appropriate care, and these can be related to services, clients, and institutions. Service factors include the high cost of care and transportation, poor quality and inappropriate care, and negative staff attitudes. Client factors include social and cultural constraints on women's movements and limited information about their health needs and availability of services. And institutional factors include men's control over decisionmaking and budgets, local perceptions about illness and treatment norms, and discrimination in health settings.

A health gap becomes a life gap **2f**



Source: World Bank estimates.

Health inequalities by social, cultural, and geographic factors **Box 2g**

Inequalities in health go beyond income to such sociocultural, demographic, and geographic factors as sex, race, religion, ethnic group, language, and residence. In parts of India and China infant girls are more likely to die than infant boys because the cultural preference for male children puts girls at a disadvantage in nutrition and healthcare early in life. Women and girls also face discrimination in healthcare because cultural norms restrict them from traveling long distances, especially alone.

Poor communities—rural, remote, and in urban slums—typically face multiple health risks related to gaps in infrastructure, services, and trained personnel. For example, ethnic minorities, especially in isolated regions in Bangladesh, were less likely to be vaccinated for childhood diseases.

Source: Carr 2004; Ashford, Gwatkin, and Yazbeck 2006.

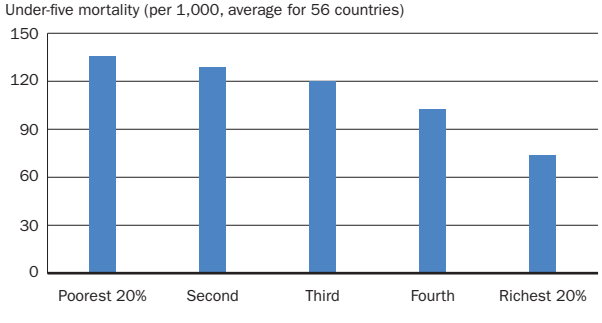
The health divide within countries: the rich-poor gap

Inequalities in health within countries are pervasive. Even in healthy countries such as Finland, the Netherlands, and the United Kingdom, the poor die 5–10 years before the rich (Carr 2004). But the inequalities are most apparent in poorer developing countries. Studies from many developing countries show that the poorest 20 percent of the population fares far worse than the richest 20 percent on a range of health outcomes, including child mortality and nutritional status (box 2g, figures 2h and 2i). On average a child in the poorest 20 percent is twice as likely to die before age 5 as a child in the richest 20 percent. The disparity is similar for maternal nutrition, with women in the poorest 20 percent almost twice as likely to be malnourished as those in the richest 20 percent.

Severe malnutrition among children reveals more pronounced inequality, with children in the poorest 20 percent more than three times as likely to be underweight as children in the richest 20 percent. The inequality is largest in South Asia, where 21 percent of children in the poorest 20 percent were underweight, compared with 6 percent in the richest.

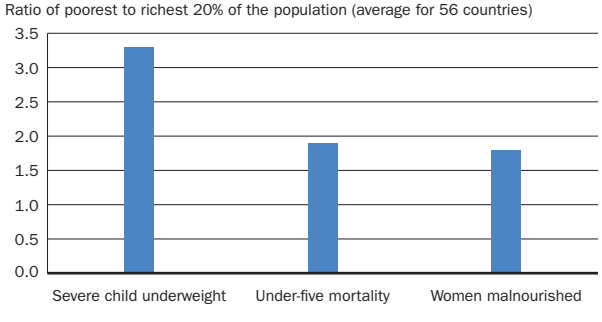
Demographic and Health Surveys find that gaps in the use of health services are closely related to economic

Under-five mortality falls with rising income **2h**



Source: Gwatkin and others 2007.

Health inequalities in developing countries **2i**



Source: Gwatkin and others 2007.

status (box 2j and figure 2k). On average, children ages 12–23 months in the richest 20 percent of the population are more than twice as likely as those in the poorest 20 percent to have received basic immunizations. Inequality in immunization is especially high in Sub-Saharan Africa: only 32 percent of children in the poorest 20 percent have been fully immunized, compared with 60 percent in the richest 20 percent.

Use of professional healthcare during childbirth also varies by income. Rich women are four times more likely to use modern methods of birth control than their poorer counterparts and nearly five times more likely to be attended by a skilled health professional during childbirth. Several countries, such as Benin, Morocco, Nicaragua, and Vietnam, have reduced inequalities and increased the coverage of trained medical staff attending childbirths for the poorest women (figure 2l). Childbirths attended by trained staff among the poorest 20 percent more than doubled in Nicaragua from 1997 to 2001, from 33 percent to 78 percent. In a few countries, such as Chad and Ghana, inequalities increased because of lack of progress in coverage among poor women.

Why do the poor receive and seek less health care than the rich? Box 2j

According to *World Development Report 2006: Equity and Development* (World Bank 2005d), inequities occur when some groups of people have less say and fewer opportunities to shape events and institutions around them, resulting in institutions that favor the privileged, who are often the rich. In health this translates into a lower likelihood of the poor taking preventive measures and seeking and using healthcare.

Government actions affect the health of poor people. Public spending on health can influence the type and quality of services available to the poor. Governments may allocate high proportions of their health budgets to urban hospitals, leaving rural residents without adequate health facilities. Income is another important constraint. In South Africa people in the poorest 20 percent have to travel an average of nearly two hours to obtain medical attention, compared with 34 minutes for those in the wealthiest 20 percent.

Additional barriers that lower demand for health services include a lack of knowledge about hygiene, nutrition, and the availability of treatment options, particularly among the uneducated. This can keep people from seeking care when they need it, even when price is not an issue. In India immunization rates are low, even though immunization is free: mothers cited lack of knowledge of the benefits of vaccination and of the clinic location as the main reasons why their children had not been immunized.

Lack of knowledge can also lead people to pay for inappropriate healthcare. Unqualified providers can overprescribe treatment to patients who do not know what is in their best interest. For example, instead of effective and inexpensive oral rehydration therapy, a poor child in Indonesia gets more than four (often useless) drugs per diarrhea episode.

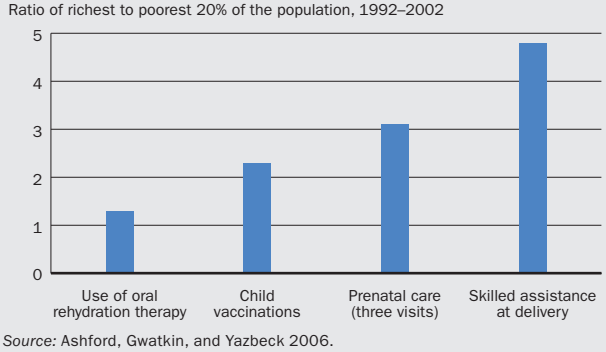
Poorer members of a community often have less say in whether to seek care than wealthier members, and this can affect the level of resources used in their interest. Similarly, within a family, women and children have less voice than men and older family members.

Main determinant of health status: health spending

Differences in health spending contribute to global disparities in health outcomes (figure 2m). In rich countries, total health spending, at 6 percent of GDP, is almost twice that of developing countries, and childhood vaccinations, skilled attendants at birth, and access to effective health interventions are almost universal. In developing countries, where access to free health services is seen as a basic human right, public spending on health is less than 3 percent of GDP. In low-income countries the annual per capita spending on healthcare in 2004 was just $32, well below the $60 that the WHO deems sufficient for an adequately performing health system (WHO, *World Health Report 2000*). By contrast, annual per capita health spending in high-income countries was $3,724.

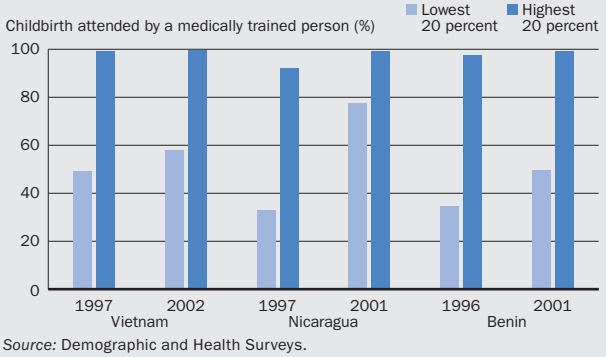
The most obvious barrier to expanding health coverage in developing countries is the current low level of spending. Expanding access to successful interventions will require more funds, a situation made more difficult as HIV/AIDS spreads and more spending is allocated to the treatment of AIDS and AIDS-related opportunistic infections, such as tuberculosis and pneumonia. As public funds for general health shrink, the

Rich people use health services more than poor people 2k



Source: Ashford, Gwatkin, and Yazbeck 2006.

Some countries have reduced inequalities in use of professional healthcare in childbirth 2l



Source: Demographic and Health Surveys.

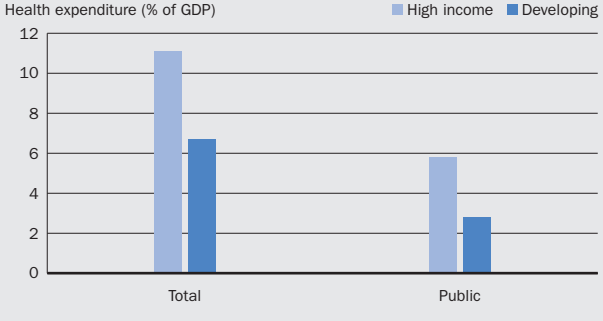
costs are borne more by households and the private sector. In 2004 more than 80 percent of the people in developing countries paid out of pocket for health services, compared with just 37 percent in high-income countries.

Greater public spending is not, however, always associated with better outcomes, and performance varies across countries based on the capabilities of government and health systems. In many countries staff ostensibly delivering services do not, and absenteeism is high (figure 2n). Corruption in the form of informal payments, coupled with the low technical quality of service providers and the poor attitudes of health staff, especially to the poorer population, often discourage a second visit. According to *World Development Report 2006: Equity and Development* (World Bank 2005d), more than 70 percent of patients in Azerbaijan, Poland, and the Russian Federation, and more than 90 percent in Armenia, made "informal payments" for services.

To improve health conditions among the poor and vulnerable in developing countries, governments support free or subsidized health services, often as part of a national policy to reduce poverty. Government spending on health is thus designed to give everyone equal access to care, and this rationale is typically invoked to justify direct government involvement in service provision. In reality, equal access is elusive, and research confirms that publicly financed healthcare benefits the rich more than the poor (figure 2o). In 21 countries the richest 20 percent received more than 26 percent of government health spending, compared with 16 percent for the poorest 20 percent. Even health programs that address illnesses affecting the poor tend to favor the rich. In Sub-Saharan Africa the rich benefited more (53 percent) from prophylactic treatment for malaria than did the poor (34 percent).

Primary healthcare is often free in the public health system, but treatment for major illnesses can be costly if payment is required for drugs and services on top of transport costs and time off from work. Indeed, health shocks can push a high proportion of households into poverty because of out-of-pocket health expenditures (figure 2p). This underscores the need for policymakers to maintain and improve the health status of the poor through effective interventions—and to protect households from falling into poverty.

Differences in healthcare spending contribute to global disparities 2m



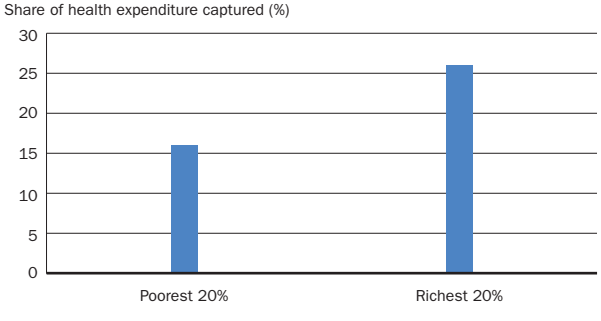
Source: WHO and World Bank.

Where are healthcare workers hiding? 2n

Country	Absence rates among healthcare workers in primary health facilities (%)
India (14 states)	43
Indonesia	42
Bangladesh	35
Uganda	35
Peru	26
Papua New Guinea	19

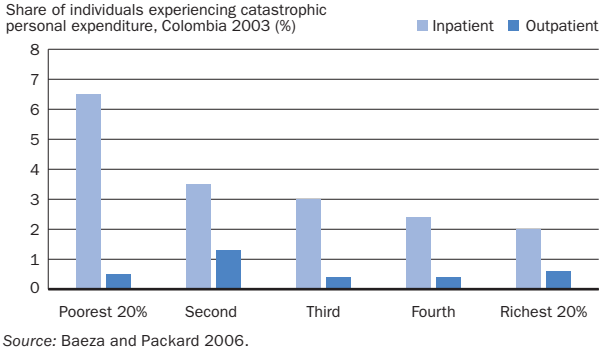
Source: World Bank 2003c.

Public health spending benefits the rich most 2o



Source: Filmer 2003.

Health shocks can push households into poverty 2p



Source: Baeza and Packard 2006.