INEQUALITIES IN HEALTH
– AN EMERGING CHALLENGE FOR MEDICAL MISSIONS

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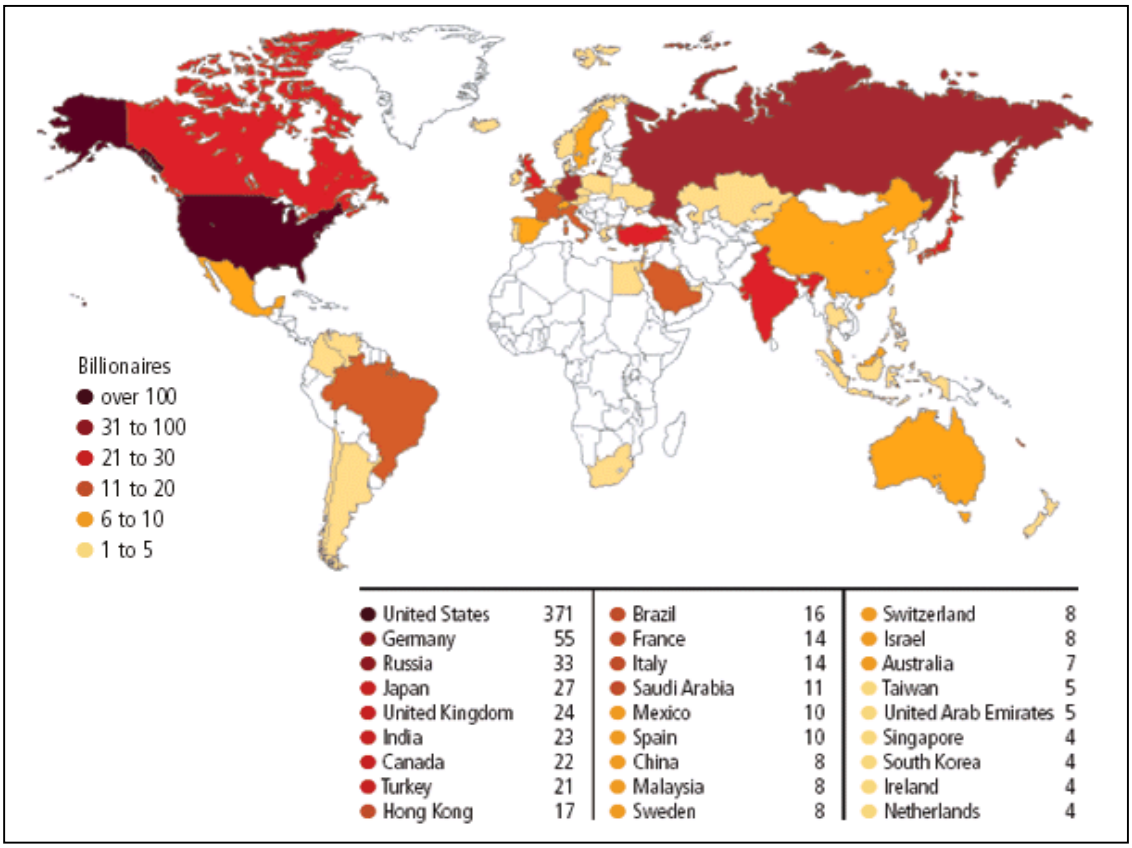
The following text is an extract from Dr Philip's talk and PowerPoint presentation to the Global Connections Healthcare Forum o 11th May 2006. The full PowerPoint, with graphs, is available to members of the healthcare forum on request.

1. INEQUALITY AND ITS CONSEQUENCES.

The map below shows the number of billionaires in the world.



The following factors should be noted:

- The process of globalization is unprecedented in newly opened economies such as India and China = note where India is on the list of billionaires
- There is a rapid production of neo-millionaires and neo-billionaires
- The distance between the richest and the poorest is increasing exponentially
- The number of people becoming marginalized is growing

a) Why inequality is not good for societies?

Rwanda is a chronicle of inequality. Some background:

- 1950s: Tutsis (10 – 15% of population) own most of land and 95% of chiefs and 88% of bureaucrats are Tutsis
- 1959: Hutu revolution. Land redistribution. Subsequently agriculture becomes unsustainable
- 1989: 2/3rd of the population not able to meet minimum food energy requirement
- 1990: Representatives of the peasant association declare: "It is only the peasants who are bearing its impacts while the 'educated' [the elite] are enjoying its side effects. Those who should assist us in combating famines are of no use to us, It will require no less that a revolution similar to that of 1959".
- 1991: "….it is time to fear the Malthusian effects that could derive from the gap between food supply and the demand of the population, and social disorders which could result from there." –*Report of the National Agriculture Commission (1990-1991), chaired by James Gasana*
- 1991-92: World Coffee market collapses from $ 60 to $ 13 per capita income

After the collapse of the coffee price, violence broke out in many communes. However where the calorie intact each day was more than over 1,500, no violence occurred. (Chart available detailing this). Not soon after in 1994, the Hutu Presidents of Rwanda and Burundi were killed in a plane crash. We all now the result with 800,000 Tutsis and moderate Hutus slaughtered in 100 days

b) Consequences of Inequality Greater Income Inequality

- Increased social distances between income groups
- Less sense of common identity
- Appearance authoritarian values
- Discrimination
- Carelessness of other's welfare
- Aggressive exploitation
- Poorer quality of social relations
- Acts of sporadic violence, theft, rape etc
- Mass violence and uprising

c) What is the link between Social Inequality & Health inequality?

	Bangladesh		India	
	1970	**2003**	**1970**	**2003**
GDP/capita	n/a	376	n/a	564
Annual Growth rate	1.9	3.1	3.1	4
Infant Mortality Rate	145	46	127	63
Under 5 Mortality Rate	239	69	202	87
Life expectancy	45.2	62.6	50.3	60.1
Maternal Mortality Rate	n/a	380	n/a	540

As can be seen, the health indicators in Bangladesh are better than India, despite the better overall ecomonic situation if one looks at GDP/capita and growth rate. Some suggested reasons are:-

- Society in Bangladesh in the 1980s, was not rigidly stratified… Social class distinctions were mostly functional, and there was considerable mobility among classes" - US library of congress
- Egalitarian principles of Islam in Bangladesh – strong sense of 'brotherhood'
- Socialist ideology in Bengal
- Less economic differential between the rich and poor in Bangladesh
- Empowerment of Women - years ago more women were dependent on their husbands. If their husbands fed them, they ate." Asmat, Grameen Bank member for ten years, owner of milk-giving cows, currently building grocery store in Savar, mother of two.
- Emphasis on Primary Health care in BangladeshInvestment in preventative and promotion of health care
    - Implementation of Essential Service Package
    - Major change in health seeking behaviours of women
    - First country to implement essential drug list so that prices were controlled and there was a limited number of drugs. However now modified to some extent under pressure from MNCs

So what lessons can be learnt from Bangladesh

- Extent of inequality in health is a good indicator of social inequalities
- Persistent, structured social inequalities fail to improve the health of communities and may be the most important reason for countries like India falling behind in making progress with health improvements.
- "Deep structural inequalities in human capabilities, opportunities and income act like a brake on the Millennium Development Goals" – UNDP

d) **Why is health equality important?**

- Health is the most basic of all human endowments to experience fullness of life
- Without health little else is possible!
- Exploring one's 'opportunity range' and reaching one's potential is only possible if there is adequate health

So what are the different kinds of health inequalities?

- Biological – genetics and vulnerability
- Environmental factors
- As a result of choices made – behaviour and lifestyle choice
- As a result of having NO choice. Issues that socially & culturally determined, result of social arrangements and structures, and general inequity.

So why is inequity injustice

- Denial of humanity being made in the image of God – dignity of all humans
- Denial of God as father of all humanity and thus equality of all humans
- Inequity denies the common humanness or fraternity or our common future

- Denial that each person as the creative work of God and the redemptive work of Christ
- Humans tend to find true identity in society –inequity and its consequent exclusion from participating in the society is an attempt to destroy his true identity.

2. WHAT IS THE WAY FORWARD?

a) Can markets achieve social justice or equity?

- Pro Market argument: 'tide raising all the boats' ('trickle down'!)
- Tools of Capitalist philosophy – Markets, globalisation - are based on – competition, self interest & greed
- Evidence to show that a liberal market approach tends to exacerbate and increase inequalities
- Health & Education – basic human capabilities – markets skew the distribution – further exacerbation of inequalities
- Distributive justice is possible only if there are adequate controls by a fairly strong state.

b) We need to have a biblical framework for understanding

- Creation story:
  - Humanity in God's image – dignity of all people
  - Creation and all things in it for all people
  - Participation of all groups of people in creation
- Old TestamentGod of Justice
  - An indicator of Justice - How the poor and the unprotected, vulnerable (orphans, widows, aliens) are treated
  - Jubilee: – a periodic 'equalising' and an obligation of those who have rather than the rights of those who do not haveJesus and New TestamentUniqueness of Kingdom of God: All inclusive – 'Go out quickly into the streets and alleys of the town and bring in the poor, the crippled, the blind and the lame. No special privilege of discrimination: 'There is neither Jew nor Greek, slave nor free, male nor female, for you are all one in Christ Jesus' Exclusion possible only by one's own choice: 'If any man…'
  - Cross: Ultimate symbol of justice and love – 'This is my blood of the new covenant poured out for many…'
  - Finally: Reconciliation of everything & everyone to himself

c) Principles for action for Medical Missions in developing countries There seems to be confusion about which direction to take. There is a decline so many are asking what is the future for Mission Hospitals. There is also apprehension about the future for mission hospitals?

There is a need for changes in theory. We need to rediscover what Medical Missions stood for and can stand for:

- Value of life
- Equality and eternal worth of every human being
- Emphasis on marginalised groups

We need to look at moving from a 'medical model' or 'technological model' to a 'social model' for health

- Inequity in health is a social problem
- Limitation of 'technological' and 'medical' solutions

We need to find a way to engage positively with market forces

- Traditionally suspicious of market but there are opportunities as well as challenges in such an engagement
- Turning markets to the advantage of Medical Missions
- 'Business as mission'; 'socially responsible business'

3. THE CHALLENGES OF ENGAGING WITH MARKET FORCES

If we are to engage with market forces, the basis of the model must be that of including the poor and marginalised groups. This is a strong ethical argument here. These are a few thoughts on issues that need to be addressed.

a) Framework of Justice

We must base our work on a framework of justice

- 'Follow justice and justice alone' - Deut 16:20
- Positive discrimination or affirmative action of Marginalized groups

b) Participation

We need to ensure participation by

- Targeting participation of disadvantaged groups
- Demystifying technology and technical know how: Village level workers are key via training, supporting and an expanding roleDevolving responsibilities lower down the decision making structures

c) Low cost solutions Solutions that are low cost are often more effective

- The best health interventions:
  - Target major causes of death, disability and illness in developing countries;
  - Cost-effective
  - Can be scaled up easily
- Best Buys in Health (www.dcp2.org): "Countries do not have to be rich to be healthy"
- Diffusion of available low cost solutions to village & household levels

d) Advocacy

We need to be more active in advocacy on issues such as

- Helping the state to do what it should be doing.
- Ensuring Health or Welfare spending vs. Defence spending is sensibly made

We need to set aside a budget allocation for advocacy

e) Future of Hospitals

Models which are unsustainable:

- Small hospitals located in remote locations. We need another model in rural areas
- Hospitals unable to provide quality care
- Donor dependent hospitals

Models which are sustainable:

- Medium to large teaching hospitals with reasonable infrastructure
- Able to provide quality care
- Able to attract and keep specialists
- Able to attract large number of patients

f) Investing in People

We need to consider building Medical Missions around talent and passion, rather than institutions and buildings. Dream peddlers are wanted! We need to look at:

- What is person's vision?
- What is the person interested in doing with his/her life?
- What is a person capable of?

4. QUESTIONS FOR DISCUSSION

I leave you with two major questions to take forward.

a) Engaging with markets – Is it realistic? What are the possibilities?

b) Is building mission around people better than investing in institutions? How can this be promoted?

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