HEALTH INEQUALITIES IN THE WORLD

INEGALITATI PRIVIND SANATATEA IN LUME

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Abstract: *Global differences appear both in the economy and in health issues. Health inequalities are similar to economic ones, because there is close connection between the state of health, hygiene and the economic and social development. Accordingly differences in economic development reveal dissimilarities in the state of health of different countries. The present study presents leading medical problems and their reasons in the case of developed and developing countries. In our opinion multidisciplinary approximation is required to analyse health and its regional inequalities.*

Key words: *economy, health inequalities, life expectancy at birth, mortality, morbidity*

INTRODUCTION

Health inequalities of world population could appaer not only between areas at a given time, but these are present at the same territory at different terms, too. It means we can examine health inequalities in a certain area or at a certain time. When we study a given territory, we have to concentrate on temporal inequaltites. When we examine a certain period, we have to concentrate on spatial disparities. So first I negotiate in present study the epidemological development, then in connection with spatial inequalities I examine the health differences between develeped and develeping countries.

MATERIAL AND METHODS

Periods of epidemological development

Epidemological development has four periods. First period means the term of epidemics (pandemics) and famines, second period is the phase

of infectious diseases, which are constantly present and do not cause epidemic. Third period is the term of non-communicable diseases, fourth is the phase of delayed non-communicable diseases. This periodity shows the temporal figure of health condition. The mentioned periods signify different development levels in respect of health state. It is interesting that temporal development is distinct in different regions of the world. As a result there are present all periods of epidemiological development at the same time. In the first period of epidemological development there are countries lying South Sahara, in the second phase is India for example. The characteristics of third phase are experienced in Middle East European countries. The forth phase characterized the West European countries, the USA, Canada, Israel, Japan, Australia and New Zealand (Józan 2009, 1231.). Different periods have distinct traits respect of death causes, mortality rate and life expectancy at birth. According to Olhansky et al. (1986) the reason is the economic, social, political and cultural environment, less the natural environment. But it is important to mention that natural environment plays serious role in the forming of economic environment, so it is not immediate, but mediate determining or influencing factor. After analysing the temporal changes of health state we can turn to spatial differences.

Regional differences of population health status

In different regions of the world the economic-social development was variant, regarding its both quantitative and qualitative aspects. As a result health determining factors will be different in developed and developing countries. The final effect represents the regional differences of health state. The following part of study includes the most important indicators of health state, which are life expectancy at birth and mortality. Mortality and morbidity (diseases) will be negotiated together, because diseases cause mortality and the structure of death cause. Between mortality and morbidity is close relationship, it is fairly complicated to separate them. We do not need the particular investigation of them, because I seek after complexity and consistency. I try to approach the indicators of health state using not only the nominal value, I also try to make a comparative analysis. I will illustrate the stature of indicators and the differences between them using tables, maps, diagrams.

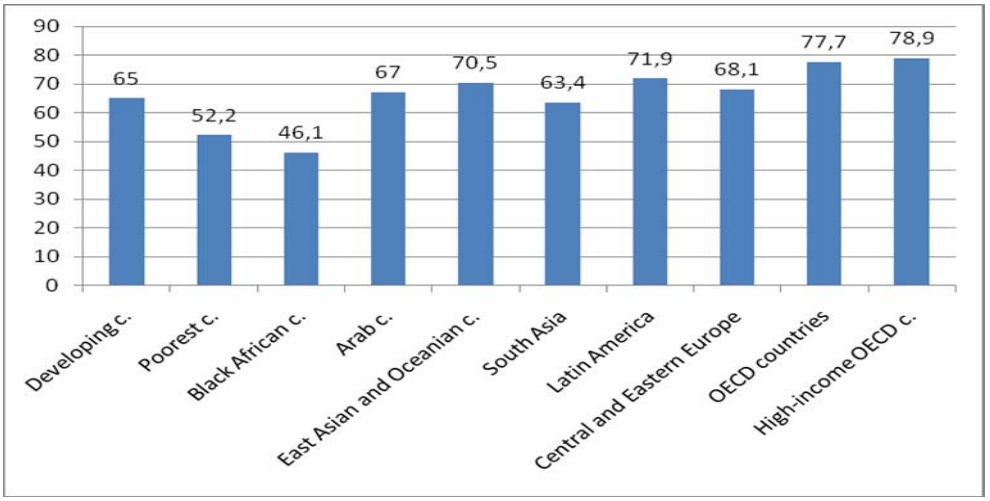
Health status of population living in developed countries

Overall we can say that in developed countries life expectancy at birth is substantially higher than in developing countries (Figure 1., Table

1.) It suggests ”the health state of population living in developed countries is much better than in developing countries” (Pál – Uzzoli 2008, 475.) According to Report 2007 of World Health Organisation the diferrence between developed and developing countries can be experienced not only in life expectancy at birth, but also regarding morbidity (healthy years of life lived) and mortality (especially infant mortality) (WHR 2007).

According to Illés Dési (2001) the most important reason for improvement of health state and increase of life expectancy at birth is the transformation of life circumstances and life style. Actually we can explore major coherence between input and output factors of health, because life circumstances and life style are input factors of health. Life circumstances are the environmental, social and economic factors, and lif style means the personal factors. Most important reason for improvement of life circumstances and life style are rapid economic and technical development, rising standard of living and growth of consumption. Among the reasons mentioned the root cause is the economic development, (as consequence of technical development).

Figure 1. Life expectancy at birth (years) in particular groups of countries (2005)



Source: According to Human Development Report 2005, own work

In developed countries the improvement of health state accompanied the substantial transformation of leading causes of death. Spatial differences

can be explored in respect of leading causes of death, too (Pál – Uzzoli 2008, 476.). Chronic and degeneratíve diseases cause most deaths. In order the most important death causes are the followings: diseases of circulatory system, cancer deaths, respiratory and digestive diseases, external causes of death (accidents, injuries). Diseases of circulatory system are responsible for 50 percent of deaths, cancer causes 20-25 percent of deaths. Five leading death causes result in the more than 90 percent of deaths. In developed countries infectous diseases result less than 1 percent of deaths (WHR 2007). Cardiovascular diseases (diseases of circulatory system) are specific for older population. Leading risk factors of mentioned diseases are presence of other cardiovascular and metabolic diseases or so-called civilizing influences (for example stress, unhealthy diets, sedentary lifestyle. Among risk factors most important is hypertension, one billion people are affected by hypertension and it is responsible for approximately one million deaths annually (Pál-Uzzoli 2008). Cancers cause mortality of about 56 million people annually in the world. Cancer deaths in order are following: lung-, colon-, rectum-, breast-, stomach- and prostate cancer. Less death is caused by respiratory diseases: asthma, allergic rhinitis, chronic inflammatory lung diseases (COPD) (Pál-Uzzoli 2008).

Most important reasons for prevalence of chronic and degenerative diseases are very varied. One of them is the so-called epidemiological and demographic reason. It means that people live longer than before, so the rate of elderly population increases, and it results more chance for emergence of chronic diseases. Second group of reasons for predominance of chronic and degenerative diseases are welfare, growth of consumption, spread of harmful habits and the lifestyle associated with these (risk factors) (Pál-Uzzoli 2008). Third group of reasons is the group of environmental hazards, due to industrial development and urbanization. It can be observed not only in developed countries, but also in developing countries.

Health status of population living developing countries

Life expectancy at birth in developing countries is lower than in develeoped countries. The causes of difference were detailed in the previous section of present paper. Following table shows spatial and temporal differences of life expectancy at birth between developed and developing countries.

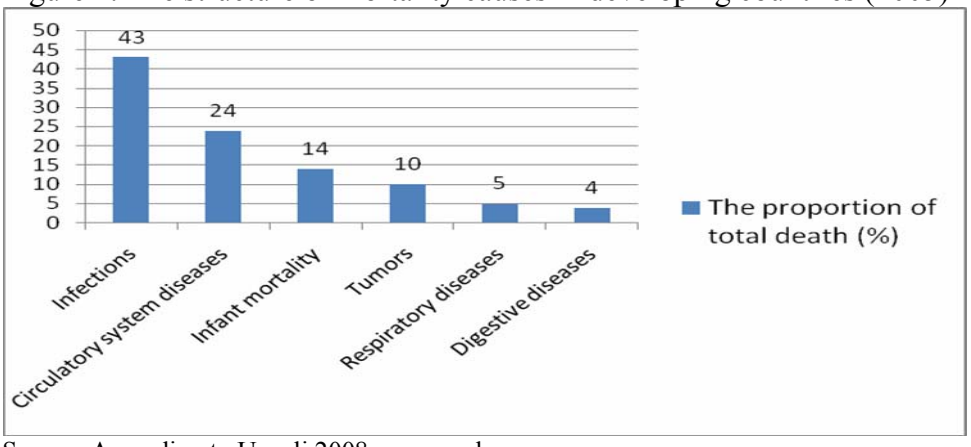
Table 1. The comparison of life expectancy at birth

Group of countries, gender	**1950-55**	**1995-2000**	**2045-50**
Developed countries			
- Both genders (years)	66,1	74,8	81,9
- Male (years)	63,5	70,1	78,6
- Female (years)	68,5	78,5	84,5
Developing countries			
- Both genders (years)	41,0	62,5	73,1
- Male (years)	40,2	60,9	71,0
- Female (years)	41,9	64,3	75,3

Source: Birg 2005, 93. p.

Current health problems in developing countries are similar to health problems in developed countries in the first half of the twentieth century. In respect of structure of mortality causes (Figure 2) are specific prevalence of infectious diseases in developing countries. There the major problems are malnutrition, starvation and in many cases lack of healthy drinking water. Health infrastructure is underdeveloped than health infrastructure in developed countries. Probably the economic and social development can alleviate the mentioned problems. Paradoxically these factors are the main obstacles of economic and social developing. Socio-economic development of a given area is closely linked to health state of population living there (Towsend-Dawidson 1982).

Figure 2. The structure of mortality causes in developing countries (2005)



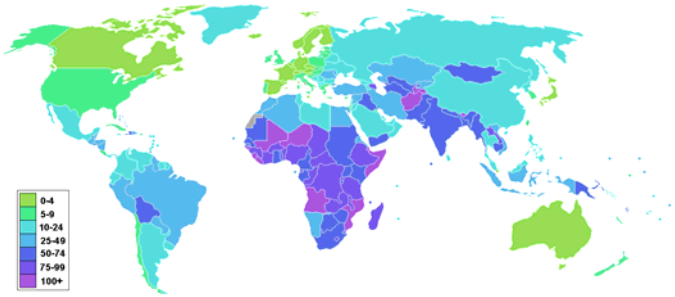
Source: According to Uzzoli 2008, own work

In developing countries the infectious diseases play important role, but in developed countries cause less deaths. 95 percent of infectious diseases cause deaths in developing countries, particularly tuberculosis and malaria (Pál-Uzzoli 2008). The second main problem in developing countries is the high rate of infant and child mortality (Figure 2) and maternal death in childbirth. At the beginning of the twenty-first century deaths of child under 5 years have decreased by 60 percent compared to 1960 (Oumeish-Paris 2000). But most of this decrease was observed in developed countries.

In developing countries the malnutrition and the problem of starvation play an important rule. These can be traced back to overpopulation, so the mentioned problems are specific in regions where the degree of overpopulation is the highest and the growth of population is higher than the economic growth. It means that some of the reasons have social and economic aspects, but in addition the natural environment influences the food endowment in a given region too. Thus we can experience the combined and interactive presence of environmental spheres (society, economy, natural and infrastrucure environment) (Tóth 2002).

Synthesizing the themes of health and economy in developing countries we can conclude that some regions in developing countries started to develop respect of both economic and health status. It suggests that there is hope for developing countries. Developing economy results the development of health status, but the development of economy could not be realized with population having health problems or unsatisfactory health status.

Figure 3. Differences in mortality rate worldwide (2006)



Source: http://commons.wikimedia.org/wiki/File:Infant_mortality_rate_world_map.PNG according to CIA Factbook

RESULTS AND DISCUSSION

Overall in most developing countries the indicators measuring the level of economic development (GDP per capita/year, GNP, HDI) and health status (life expectancy at birth, mortality) are significantly worse than in developed countries. Differences in mortality structure between developed and developing countries remained the same. The following table illustrates the discrepancy in indicators of health status between developed and developing countries.

Table 2. The comparison of developed and developing countries (2005)

Main health indicators	Best country in the world	Index	Worst country in the world	Index
Life expectancy at birth (years)	Japan	83,1	Zimbabwe	36,2
Life expectancy at birth, male (years)	Japan	79,1	Liberia	33,9
Life expectancy at birth, female (years)	Japan	86,5	Zimbabwe	38,2
Child mortality under 5 years, male (per thousand capita)	Sweden	4	Sierra Leone	296
Child mortality under 5 years, female (per thousand capita)	Finland	3	Niger	269
Adult mortality, male (per thousand capita)	San Marino	66	Zimbabwe	857
Adult mortality, female (per thousand capita)	Iceland	45	Zimbabwe	849

Source: According to Uzzoli 2008, own work

CONCLUSIONS

At the same time the examination of temporal and territorial differences of state of health claims a complex approach. In our opinion multidisciplinary approximation is required to analyse health and its regional inequalities. Emphasising that health has a special character, the author wishes to outline its correlation with economic, natural and social environment.

According to World Health Organization there is necessary to achieve three main objectives in order to reduce global health inequalities.

The first objective is that the differences between the countries having best and worst life expectancy should be reduced with 10 years until 2025. Second objective is to reduce the differences between the countries having best and worst mortality indicators by 10 percent. Third objective is to reduce the infant mortality below 20 per thousand in the poorest countries of the world as well (WHO 2007).

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