Impact of Socioeconomic Status

In a country well governed, poverty is something to be ashamed of. In a country badly governed, wealth is something to be ashamed of. - Confucius

Anyone who has ever struggled with poverty knows how extremely expensive it is to be poor. ~ James A. Baldwin

Imagine no possessions
I wonder if you can
No need for greed or hunger
A brotherhood of man
Imagine all the people
Sharing all the world
~ John Lennon
Learning Objectives

• Describe the links between health and education

• Discuss the connections between health, productivity, and earnings

• Describe key relationships between health & the costs of illness

• Discuss connections between health and equity

• Understand cost-effectiveness analysis

• Discuss two-way relationship between health and development
Poverty: Alarming Stats

• **~1 billion** people live in poverty and threat of hunger
  – Live on **less than $1** per day
  – No resources to escape **generational cycle** of poverty
  – Additional 1 billion people live on **less than $2** per day

• **1/3 population** no access to clean water, adequate nutrition, shelter, sanitation, healthcare
  – Or education, employment, protection

• **30,000 deaths per day** (1 every 3 secs) as a result of poverty
GLOBAL AVERAGE INCOME OF THE RURAL POOR*

Daily income per capita (in 1993 international dollars)

1993: $0.76
1996: $0.75
1999: $0.76
2002: $0.77

International Poverty Line ($1.08 per day)

*The rural poor are defined as populations living in rural areas with per capita incomes of less than $1.08 per day

Source: Ravallion et. al. 2007: 38, 42
Poverty Trends

PROPORTION OF PEOPLE ON LESS THAN $1 A DAY, 1990 AND 2004

*Former Russia and Soviet states
** Sub-Saharan Africa, SE Asia, Oceania, E Asia, S Asia, W Asia, Latin America and Caribbean

SOURCE: UN
Percentage population living on less than 2 dollars day 2007-2008
Poverty Cycle

- Poverty impacted by variety of factors, including social, economic & political
- Cycle difficult to break without community & public support to improve health care, financial services, work skills
Health and Education

- Intergenerational links
- Malnutrition and disease
- Prevention of illness
As a country improves its education level, its life expectancy almost always rises. This occurs worldwide, in countries both large and small.

BOX 5.9: UNESCO EDUCATION FOR ALL GOALS

Expand and improve early childcare and education.

Provide free and compulsory universal primary education by 2015.

Ensure equitable access to learning and life-skills programmes.

Achieve a 50% improvement in adult literacy rates.

Eliminate gender disparities in primary and secondary education by 2005 and at all levels by 2015.

Improve all aspects of the quality of education.

Source: UNESCO, 2007a

WE ARE THE FIRST GENERATION THAT CAN END POVERTY.
School User Fees

- Fees for school
  - Abolished in many countries
  - Some still collected illegally
  - Tuition, uniforms, textbooks
- Poorest children could not afford them

BOX 5.12: KENYA – ABOLITION OF SCHOOL FEES

When Kenya abolished school fees in 2003, there was an immediate influx of 1.3 million children into the school system, overwhelming school infrastructure and teachers. School enrolments since 2002 increased by 28% while the total number of teachers increased by only 2.6% between 2002 and 2004; in some areas the ratio rose to one teacher for 100 pupils.

Source: Chinyama, 2006
Increased Enrollment

- Primary school enrollment increased 20% in many countries
- Weak infrastructure cannot handle increased class sizes - quality suffers
Primary School Enrollment (2000-2006)
Out of School

- Latin America/Caribbean: 4.1 million
- East Asia/Pacific: 5.0 million
- Middle East/North Africa: 6.9 million
- Eastern/Southern Africa: 17.4 million
- West/Central Africa: 23.8 million
- CEE/CIS: 1.7 million
- Industrialized countries: 2.7 million
- South Asia: 31.5 million
Poverty Cycle: Child Labor

A family living in poverty cannot afford to send their children to school

They lose their job to younger employees and there are fewer opportunities for adult employment

Children are forced to work

Children receive little or no education

Now they have a number of children to support with little income

Girls marry young and have children

Child labour is accepted as a ‘necessary evil’

Children grow up and without basic skills and education, they remain in low-paying (and often dangerous) work
Where and how do children work?

While the figure of 218 million child labourers is used in official calculations, the actual number of children working is probably much higher. This is due to the invisible and informal nature of child labour and the fact that many children have not been registered because they have no birth certificate and they do not appear on any school or employment records.

GLOBAL ESTIMATES ON CHILD LABOUR
218 million – total number of children working  
Source: ILO 2006

AGE

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 to 17 years</td>
<td>52 million</td>
<td>24%</td>
</tr>
<tr>
<td>12 years and 15 years</td>
<td>58 million</td>
<td>27%</td>
</tr>
<tr>
<td>Under 12 years</td>
<td>108 million</td>
<td>49%</td>
</tr>
</tbody>
</table>

GENDER

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>121 million</td>
<td>54%</td>
</tr>
<tr>
<td>Girls</td>
<td>97 million</td>
<td>46%</td>
</tr>
</tbody>
</table>

WHERE?

<table>
<thead>
<tr>
<th>Region</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian-Pacific</td>
<td>49.3 million</td>
<td>41%</td>
</tr>
<tr>
<td>sub-Saharan Africa</td>
<td>122 million</td>
<td>5.7 million</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
<td>41 million</td>
<td>5.7 million</td>
</tr>
<tr>
<td>Rest of world</td>
<td>5.7 million</td>
<td>5.7 million</td>
</tr>
</tbody>
</table>

INCIDENCE

<table>
<thead>
<tr>
<th>Region</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian-Pacific</td>
<td>150 million</td>
<td>69%</td>
</tr>
<tr>
<td>sub-Saharan Africa</td>
<td>48 million</td>
<td>22%</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
<td>26.4%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Rest of world</td>
<td>5.1%</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

WHAT TYPE OF WORK?

<table>
<thead>
<tr>
<th>Sector</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>150 million</td>
<td>69%</td>
</tr>
<tr>
<td>Industry</td>
<td>48 million</td>
<td>22%</td>
</tr>
<tr>
<td>Services</td>
<td>20 million</td>
<td>9%</td>
</tr>
</tbody>
</table>

Note: while the Asia-Pacific region has the highest number of child labourers, the incidence is highest in sub-Saharan Africa.
Health, Productivity, and Earnings

- Longevity and higher lifetime earnings
- Increased productivity among healthy workers
- Less absence from work due to illness and ability to continue earning
Global Unemployment to Increase in 2009

The ILO’s best case projection shows a rise in unemployment across the globe. Figures show the change in unemployment between 2007 and 2009:

- Developed economies and EU: 5 million more unemployed
- Latin America and the Caribbean: 2 million more unemployed
- South Asia: 2 million more unemployed
- Sub-Saharan Africa: 1 million more unemployed
- Central and South Eastern Europe (non-EU) and CIS: 1 million more unemployed
- East Asia: 4 million more unemployed
- South-East Asia and Pacific: 2 million more unemployed
Wealth = Health

Relationship between household income and fair or poor health status

Working-Age Adults with Health Limits on Activities or Work, by Age, Race/Ethnicity, Household Income, and Insurance Status, 2004

Percent of adults (ages 18–64) limited in any activities because of physical, mental, or emotional problems

<table>
<thead>
<tr>
<th>Category</th>
<th>U.S. average</th>
<th>Top 10% states</th>
<th>Bottom 10% states</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>14.9</td>
<td>11.5</td>
<td>11.9</td>
</tr>
<tr>
<td>Age 18–29</td>
<td>20.1</td>
<td>13.4</td>
<td>11.9</td>
</tr>
<tr>
<td>Age 30–49</td>
<td>24.2</td>
<td>13.0</td>
<td>10.2</td>
</tr>
<tr>
<td>Age 50–64</td>
<td>31.5</td>
<td>19.4</td>
<td>19.0</td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AI/AN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$25,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$25,000–$49,999</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$50,000+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Data were not available for Hawaii in 2004. AI/AN = American Indian or Alaskan Native. Data: B. Mahato, Columbia University analysis of 2004 Behavioral Risk Factor Surveillance System.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006
The Costs of Illness

- Treatment and drugs
- Absence from work
- Transportation to and from provider
- Cost of living with disability
## Medical Costs

### Surgical Costs By Country

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>US</th>
<th>INDIA</th>
<th>THAILAND</th>
<th>SINGAPORE</th>
<th>NEW ZEALAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart bypass</td>
<td>$130,000</td>
<td>$10,000</td>
<td>$11,000</td>
<td>$18,500</td>
<td>$19,000</td>
</tr>
<tr>
<td>Heart-valve</td>
<td>$160,000</td>
<td>$9,000</td>
<td>$10,000</td>
<td>$12,500</td>
<td>$17,500</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>$20,000</td>
<td>$3000</td>
<td>$4500</td>
<td>$6000</td>
<td>$6500</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>$40,000</td>
<td>$8500</td>
<td>$10,000</td>
<td>$13,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Spinal fusion</td>
<td>$62,000</td>
<td>$5500</td>
<td>$7000</td>
<td>$9000</td>
<td>$7500</td>
</tr>
</tbody>
</table>

*Source: American Medical Association, June 2007 and Medtral*
Medical Tourism

Medical tourism by country

Five of the countries visited most often for medical treatment:

- Estimated annual number of medical tourists from the U.S. — '000s *
- Approximate cost relative to the U.S. — percent

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated Number</th>
<th>Cost Relative to U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexico</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td>Thailand</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>India</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Singapore</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

* Estimates are rough; most patients are not tracked.
Sources: Deloitte, Josef Woodman (consultant and author of Patients Without Borders)

Reuters graphic/Stephen Culp
Global pharma sales and growth

Source: IMS Health

Reuters graphic/Scott Barber
Counterfeit Drugs

• Global concern
• Random mixtures:
  – harmful toxic substances
  – inactive, ineffective preparations
• Unreliable, treatment failure or even death
• May appear so similar to genuine product & deceive health professionals and patients
# Bad Medicine

## Table: Examples of counterfeit medicines

<table>
<thead>
<tr>
<th>Counterfeit medicine</th>
<th>Country/Year</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-diabetic traditional medicine (used to lower blood sugar)</td>
<td>China, 2009</td>
<td>Contained six times the normal dose of glibenclamide (two people died, nine people hospitalized)¹</td>
</tr>
<tr>
<td>Metakelfin (antimalarial)</td>
<td>United Republic of Tanzania, 2009</td>
<td>Discovered in 40 pharmacies: lacked sufficient active ingredient²</td>
</tr>
<tr>
<td>Viagra &amp; Cialis (for erectile dysfunction)</td>
<td>Thailand, 2008</td>
<td>Smuggled into Thailand from an unknown source in an unknown country³</td>
</tr>
<tr>
<td>Xenical (for fighting obesity)</td>
<td>United States of America, 2007</td>
<td>Contained no active ingredient and sold via Internet sites operated outside the USA⁴</td>
</tr>
<tr>
<td>Zyprexa (for treating bipolar disorder and schizophrenia)</td>
<td>United Kingdom, 2007</td>
<td>Detected in the legal supply chain: lacked sufficient active ingredient⁵</td>
</tr>
<tr>
<td>Lipitor (for lowering cholesterol)</td>
<td>United Kingdom, 2006</td>
<td>Detected in the legal supply chain: lacked sufficient active ingredient⁶</td>
</tr>
</tbody>
</table>

## Internet sales

In over 50% of cases, medicines purchased over the Internet from illegal sites that conceal their physical address⁷ have been found to be counterfeit.

Source: WHO
Lost Income: Chronic Disease

Figure 5.15: Economic Burden of Diabetes in Canada*, by Sex and Cost Component, 1998

- Hospital Expenditures
- Drug Expenditures
- Mortality Costs
- Long Term Morbidity Costs

* Only 99.8% of drug expenditures could be distributed by sex.
Health Care: Blue Light Special?

Are Today’s Shoppers Creating Lifelong Health Care Habits?

- Put off trips to physician for routine examinations: 34%
- Utilize medical services in drugstores or super centers: 40%
- Try OTC meds to avoid cost of going to physician: 43%
- Use Internet for basic health care information including diagnosis and treatment: 52%

Source: Dissecting the Downtown Generation, IRI, April 2009
Health and Equity

• Access to health services

• Responsiveness to the needs of the people

• Extent to which financing of health systems is fair

HEALTH INEQUITY IN ALL COUNTRIES

“There are no conditions of life to which a man cannot get accustomed, especially if he sees them accepted by everyone around him.” (Tolstoy, 1877)
INEQUITY IN HEALTH CONDITIONS

LEB among indigenous Australians is substantially lower (59.4 for males and 64.8 for females in the period 1996-2001) than that of all Australians (76.6 and 82.0, respectively, for the period 1998-2000) (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005).

In Europe, the excess risk of dying among middle-aged adults in the lowest socioeconomic groups ranges from 25% to 50% and even 150% (Mackenbach, 2005).

Health inequalities are observed among the oldest old. The prevalence of long-term disabilities among European men aged 80+ years is 58.8% among the lower educated versus 40.2% among the higher educated (Huisman, Kunst & Mackenbach, 2003).

In the United States of America, 886 202 deaths would have been averted between 1991 and 2000 if mortality rates between whites and African Americans were equalized. This contrasts to 176 633 lives saved by medical advances (Woolf et al., 2004).

Cardiovascular diseases (CVDs) are the number one group of conditions causing death globally. An estimated 17.5 million people died from CVDs in 2005, representing 30% of all global deaths. Over 80% of CVD deaths occur in low- and middle-income countries (WHO, nd,a).

Of people with diabetes, 80% live in low- and middle-income countries. Diabetes deaths are likely to increase by more than 50% in the next 10 years without urgent action (WHO, nd,c).

Mental health problems will become increasingly important. It is estimated that unipolar depressive disorders will be the leading cause of the burden of disease in high-income countries in 2030, and it will be number two and three in middle- and low-income countries, respectively (Mathers & Loncar, 2005).

The lifetime risk of maternal death is one in eight in Afghanistan; it is 1 in 17 400 in Sweden, (WHO et al., 2007).

Maternal mortality is three to four times higher among the poor compared to the rich in Indonesia (Graham et al., 2004).

Every day, over 13 500 people worldwide die due to tobacco. The total number of smoking deaths will increase from 5 to 8 million in the next 20 years. Soon, it will become the leading cause of death in developing countries (as it is in high-income countries) (Mathers & Loncar, 2005).

Worldwide, alcohol causes 1.8 million deaths (3.2% of the total). Unintentional injuries alone account for about one third of the 1.8 million deaths (WHO, nd,b).
Inequity: Access & Coverage

- **Shortage** of physicians & health services in poor, rural areas
- Serves large populations & may require sick people to travel long distances
- Leads to inequity in access to care

Access to healthcare in Sub-Saharan Africa

**Percent of Population with Access to Health Care**

Access to health care is defined as the percent of the population that can reach appropriate local health services by the local means of transportation in no more than one hour.

City Slums

• Rapid urbanization is taking place in Africa 
  – Kenya: 85% population growth between 1989-1999 was in densely packed slums of Nairobi and Mombasa

• Overcrowded small dwellings, poor sanitary conditions, widespread contagious diseases, conflicts due to fusion of different cultures

In Nairobi, where 60% of the city’s population live in slums, child mortality in the slums is 2.5 times greater than that in other areas of the city.

In Manila’s slums, up to 39% of children aged between 5 and 9 are already infected with TB – twice the national average.
Figure 2.2: Under-5 mortality rate per 1000 live births by level of household wealth.

Source: Gwatkin et al. (2007), using DHS data.
Health Equity: Between Countries

Figure 2.4: Under-5 mortality rates per 1000 live births, selected countries, 1970 and 2006
EXHIBIT 1
Whitehall Twenty-Five-Year Mortality (British Civil Servants), By Employment Grade

<table>
<thead>
<tr>
<th>Rate ratio</th>
<th>Professional/executive</th>
<th>Clerical</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.9
1.6
1.3
1.0

All causes
Coronary heart disease
Neoplasms\(^a\)
Non-neoplasms\(^a\)


**NOTE:** Ratios are relative to the administrative grade, which equals 1 and is not shown.

\(^a\) Not related to smoking.
Risk of Death by Income

EXHIBIT 2
Risk Of Death According To Household Income, Shown As Odds Ratios With And Without Adjustment For Education, Persons Ages 45–64

<table>
<thead>
<tr>
<th>Odds ratio</th>
<th>Adjusted for age, sex, race, family size, and period</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Adjusted for education</td>
</tr>
</tbody>
</table>

Average household income, 1993

More than $70,000
$50,001–$70,000
$30,001–$50,000
$20,001–$30,000
$15,000–$20,000
Less than $15,000

Reverse Inequality: Thailand

REducing Health Inequalities in Thailand

Between 1990 and 2000, Thailand significantly reduced its level of child mortality and at the same time halved inequalities in child mortality between the rich and the poor. These impressive results can be explained partly by substantial economic growth and reduced poverty over this period. However, there were a number of other important strategies that contributed, many of which began to be put in place before 1990 but which were extended and maintained. These include improved insurance coverage and more equitable distribution of primary health care infrastructure and intervention coverage.

From the 1970s onwards, a series of pro-poor health insurance schemes improved health service coverage. The initial step was to waive user charges for low-income families. This was followed by subsidized voluntary health insurance, then the extension of the government welfare scheme in the 1990s to all children under 12, the elderly and disabled, and to universal coverage from 2001. Also from the 1970s, health infrastructure and services were scaled up with a particular focus on Primary Health Care and community hospitals targeting the poorer, rural populations. Increased production, financial incentives and educational strategies led to a more equitable allocation of doctors in rural areas in the 1980s. This combination led to increased utilization of health services. For example, vaccination coverage rose from 20%-40% in the early 1980s to over 90% in the 1990s; skilled birth attendance rose from 66% to 95% between 1987 and 1999.


Health Equity Goals

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.

2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.

3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.
Cost-Effectiveness Analysis

- Method to compare cost of investment with amount of health purchased with it
- Depends on:
  - cost of intervention
  - extent it can reduce morbidity, mortality, and disability
  - how effectively it can be implemented
- Best intervention is cheaper & more effective than current strategy
- Carefully consider interventions that are less effective (why change?)

FIGURE 2: COST PER DALY GAINED FOR SELECTED HEALTH INTERVENTIONS

- Coronary bypass graft: $37,000
- Drug and psychosocial treatment of depression: $1,699
- Polypill to prevent heart disease: $409
- Improved emergency obstetric care*: $127
- Tuberculosis treatment**: $102
- Basic childhood vaccines: $7

(IN US$)

*Refers to South Asia only; includes measures to address life-threatening pregnancy complications
**Directly observed treatment short-course (DOTS) for epidemic infectious tuberculosis

Notes: The cost per DALY represents an average for low- and middle-income countries, except where noted. The width of the bars represents the relative burden of disease that could be averted by the intervention (or package of interventions) shown if applied to everyone who needs it.

The horizontal scale is logarithmic and thus the length of the bars is not proportional to the dollar values.

Copenhagen Consensus 2004

- Project that prioritizes interventions to advance global welfare by cost-effectiveness
- Panel of economists determine good vs. bad projects

How to Spend $50 Billion
Most effective ways to help the world’s poor.

**Very Good**
- Control of HIV/AIDS
- Providing micronutrients
- Trade liberalization
- Control of malaria

**Good**
- New agricultural technologies
- Small-scale water technology
- Community-managed water supply and sanitation
- Research on water productivity in food production
- Lowering the cost of starting a new business

**Fair**
- Lowering barriers to migration for skilled workers
- Improving infant and child nutrition
- Reducing the prevalence of low birth weight
- Scaled-up basic health services

**Bad**
- Guest-worker programs for the unskilled
- Kyoto Protocol/carbon taxes

Source: Copenhagen Consensus
Health and Development

- Good health promotes economic development at the level of societies
- Investment by local and foreign investors is less likely in low-income countries with high burdens of communicable disease
- Higher levels of economic development promote better health at individual and societal levels
Human Development Index

- Measures **3 dimensions** of human development
  - Living a long and healthy life, knowledge, & standard of living
- Measures of:
  - life expectancy
  - school enrollment
  - literacy
  - income
- Broader view than just income (GDP)
Net Aid as a Percentage of Gross Domestic Product (2008)

Based on aid numbers and GDP in current U.S. dollars, as reported by the OECD.
Total expenditure on health per capita, 2004
(in US$)

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: National Health Accounts unit, Evidence and information for policy, World Health Organization
Map Production: Public Health Mapping and GIS, Communicable Diseases (CDS), World Health Organization

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Consider the global priorities in spending in 1998

<table>
<thead>
<tr>
<th>Global Priority</th>
<th>$U.S. Billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetics in the United States</td>
<td>8</td>
</tr>
<tr>
<td>Ice cream in Europe</td>
<td>11</td>
</tr>
<tr>
<td>Perfumes in Europe and the United States</td>
<td>12</td>
</tr>
<tr>
<td>Pet foods in Europe and the United States</td>
<td>17</td>
</tr>
<tr>
<td>Business entertainment in Japan</td>
<td>35</td>
</tr>
<tr>
<td>Cigarettes in Europe</td>
<td>50</td>
</tr>
<tr>
<td>Alcoholic drinks in Europe</td>
<td>105</td>
</tr>
<tr>
<td>Narcotics drugs in the world</td>
<td>400</td>
</tr>
<tr>
<td>Military spending in the world</td>
<td>780</td>
</tr>
</tbody>
</table>

And compare that to what was estimated as additional costs to achieve universal access to basic social services in all developing countries:

<table>
<thead>
<tr>
<th>Global Priority</th>
<th>$U.S. Billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic education for all</td>
<td>6</td>
</tr>
<tr>
<td>Water and sanitation for all</td>
<td>9</td>
</tr>
<tr>
<td>Reproductive health for all women</td>
<td>12</td>
</tr>
<tr>
<td>Basic health and nutrition</td>
<td>13</td>
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</tbody>
</table>

Questionable Priorities

- Funding for **prevention is always cheaper** than paying for disease
- **Additional cost** to educate, provide clean water, basic health services **minimal to other spending**
- By taking care of basic needs, we can accomplish **major improvements in health** & decrease determinants of **poverty**
Practice Questions

• What is the generational cycle of poverty?
• How many people live on less than $1 per day? What 2 regions have the most people in this category?
• How is education linked to SES? Health?
• How is wealth linked to health?
• How does income influence health disparities within countries?
• Describe the 3 health equity goals.
• Define cost-effectiveness analysis.
• Name 2 very good interventions based on the Copenhagen Consensus. Name 2 fair interventions.
• What does the human development index measure?
In Summary...

- Education and health are closely linked
- Health status is a major determinant of school enrollment and success in school
- Health is strongly associated with productivity and earnings
- Health is an important contributor to productivity
- Health care costs can result in large out-of-pocket expenditures and push people into poverty
- Inequity in health and access to health care is found in all countries—rich & poor
- Inequity in health is found within countries between a nation’s rich & poor people (i.e. wealth = health)
- Health is a major national expenditure in all countries