

CROSSROADS: WHERE MEDICINE AND THE HUMANITIES MEET

A Perspective on Health Inequities and the Need for Universal Healthcare

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INTRODUCTION

We don't often think of health disparities as a theme unifying communities across the world, regardless of geography or level of economic development. Still, poor levels of health come as little surprise in the midst of endemic poverty, with 40% of the world living on less than \$2 a day and great slices of African and Asian populations living on less than \$1 a day (1,2). While the global perspective is that healthcare tends to be the province of the world's richer countries, often the division between accessible healthcare in affluent, developed countries relative to poorer, developing countries is erroneously presumed. Even amongst wealthy nations, people's human right to health and wellbeing, and specifically to medical care, is categorically denied (3,4). Some 45.8 million Americans, or 15.7% of the population, were uninsured in 2004, and this number continues to grow (5). It is this denial of people's most basic human right, usually, but not necessarily alongside significant poverty, that links together diverse communities in developing and developed countries alike. Ultimately, these shared experiences of health inequity – either in the form of gaping health disparities in developed countries or inaccessible care in developing countries – point to the pervasive need for universal healthcare systems as one of the pillars to rectifying such injustices.

As healthcare providers, bearing witness to these disparities has become routine. The dearth of universal access to care is evident in settings across the world, but all too often accepted in several medical spheres. During my own clerkship practicum as a medical student, I came face to face with these inequities working in clinics in rural Lake Atitlan, Guatemala and a part of inner-city Chicago I began to call the "Other Chicago," the greatest reason being it's inhabitants' uneven access to healthcare services relative to other

citywide demographics. Though these two communities were contextually different to an extreme, both were comprised of medically underserved and disenfranchised populations, where independently funded clinics responded to local healthcare needs by attempting to provide safety nets in areas without reliable access to care. However, an important distinction existed in terms of universal healthcare coverage: while the United States had no formal universal healthcare policy at the time, Guatemala had recently adopted such policy and it was slowly beginning to reach rural areas.

PERSONAL PERSPECTIVE AND COUNTRY-SPECIFIC EXPERIENCES: THE UNITED STATES AND GUATEMALA

Appreciating the burden of healthcare inequities in Chicago and Guatemala, as well as the circumstances in which they existed, demonstrated a need for change. In Chicago, the health status of the population that attended the independent clinic where I worked was unmistakably related to poverty levels that were among the highest within the city. The clinic site was located in an African American neighborhood composed of blocks of dilapidated housing projects. Residents of the Henry Horner Homes, an infamous urban ghetto, formed the mainstay of the patient body. Since its inception in the late 1960s, patients heavily utilized the clinic mainly for primary care services such as prenatal, well-child, dental and psychiatric care, as well as midwife visits, nutritional counseling and diabetes and lactation education. Their health needs were particular; devastatingly poor nutrition was a huge culprit, with rampant obesity and diabetes inflicting major morbidity across the community. Hypertension and pediatric asthma were commonplace, and children were categorically tested for lead poisoning due to substandard housing conditions. During my time at the clinic, we detected latent tuberculosis—a disease that should otherwise be eradicated in developed countries such as the United States—in an HIV negative, non-

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immigrant patient without obvious risk factors for infection other than being poor, of low social status and without regular healthcare (6).

In a city with large disparities in access to healthcare, vulnerable groups were especially hard-hit. Therefore offering healthcare not only to those neglected by the private-payer American healthcare system, but also to some of the most marginalized people within the city formed the clinic's operational mandate, given the lack of publicly funded infrastructure to treat such patients. For the bulk of these patients, the clinic was one of the only sites in the area where they could access free care, or care at all. As a federally qualified health center, Medicaid and Medicare patients were treated on a regular basis, in addition to uninsured patients who were otherwise excluded from the conventional healthcare system. However, the clinic absorbed only a tiny fraction of the estimated 784,930 people who, in 2005, were without health insurance in Chicago's greater Cook County area (7). Across the state of Illinois, in 2005 there was also a stark discrepancy between Caucasian uninsured rates of 9.7-12.3% and those of African Americans, which were nearly double around 20.1-24.0% (7).

Therefore, an overt reference to the "Other Chicago" was warranted, because for all intents, the clinic site was another Chicago – one of poorer, disenfranchised minorities who faced substantial barriers to accessing healthcare. It was the counterpart to the more habitable homes speckling nearby affluent, predominantly Caucasian neighborhoods, where residents received private health insurance through some of the city's more prestigious, exclusive hospitals. The consequences of two separate worlds living side by side within the confines of a single city, one side easily accessing healthcare while the other not, was evident in the city's health statistics: The maternal mortality rate of 31.8 deaths per 100,000 live births for African American women in Chicago was five times higher than the national rate for Caucasian women in the 1980's, which was only 6.1. (8). The infant mortality rate in 2004 was more than twice as high for African American babies in Chicago, at 14.8, compared to Caucasian babies (9). Through the 1990's, African Americans were upwards of four times more likely to die of asthma in Chicago than Caucasians (10,11). Pediatric and young adult African Americans in Chicago had a nine fold greater risk of dying from Type 1 Insulin-Dependent Diabetes during the 1990's (12). In 2003, Chicago's African American women had a 68% higher death rate from breast cancer relative to Caucasian women (13). The list went on unendingly. The health issues affecting the clinic's population strongly conveyed the effects not only of socioeconomic imbalances and other social

determinants of health at work, but also the direct outcome of denying universal access to healthcare to the lowest classes within a heavily stratified, unequal society (14).

Yet much further south, in the highlands of rural Central America, the Guatemalan community of Santa Cruz La Laguna existed in what seemed like another dimension compared to the "Other Chicago." As a small mountainside town heavily rooted in indigenous K'achiquel Mayan culture, people lived in mud brick one- and two-room homes, and within the past decade had only begun to receive domestic electricity and running water. Though seemingly different, the threads of poverty, disenfranchisement and the inaccessibility of healthcare gave way to parallel themes in the everyday lives of people in Santa Cruz and the "Other Chicago." Malnutrition was an outstanding problem, and diets devoid of necessary protein and fat resulted in stunted physical and cognitive development within the community. Infectious diseases ranging from scarlet fever and viral diarrhea to scabies and tuberculosis were among the most pressing health needs. And much like in Chicago, the majority of the community had never known what it meant to have regular access to healthcare. However, that was changing.

Access to care had recently improved for people in Santa Cruz since the creation of an independent clinic four years ago, which operated as a healthcare safety net similar to the clinic in the "Other Chicago." During the past year, the Ministry of Health had also bolstered the clinic's capacity by opening a collaborative facility. This was done as part of the government's pledge to provide extended universal healthcare coverage to the entire country, as was specified in the 1997 post-civil war Health Code of the Peace Agreement (15).

Therefore, healthcare services were in the process of transitioning from being practically unavailable in this distant town to relatively accessible with what had become an expanded 24-hour primary care service. Notwithstanding these advances, the new national healthcare system was still a long way off from achieving sustainable care of high quality and accessibility for the community-at-large. Despite political will and progressive steps towards universal coverage—including an increase in healthcare coverage from 46% of Guatemalans in 1996 to 81% by 2000 – the effectiveness of healthcare coverage was marred by severe resource constraints (15). One example of this was that while some medications were subsidized, it was often difficult to predict whether they would be available at the collaborative facility. In addition, other essential medications were never covered, so that even when healthcare visits and procedures were readily accessible and performed free-of-charge, much needed

treatment often came at a hefty cost to patients (16).

UNIVERSAL HEALTHCARE OUTCOMES

The conclusions to be drawn are that both in Santa Cruz and the “Other Chicago,” a multi-pronged approach to resolving health disparities is aptly needed, with universal healthcare as the centerpiece of such a plan. In only one of these locations, however, such a plan is beginning to be enacted; the U.S. remains in a perpetual state of inability to create universal healthcare policy. Although poverty reduction in both locales also seems like an obvious approach, gains in economic status do not necessarily translate into accessible healthcare if there is no framework for universal coverage. Given the wealth of the United States, economic standing alone is not enough to guarantee that people – some outstanding 15% of the population in this case – have access to basic healthcare services. As a result, the American uninsured and underinsured, and poor and underserved minorities, experience health outcomes on par or even worse than people in developing countries despite much greater levels of relative economic development (17).

Perhaps even more alarming is that given the major shortcomings of the current American system, it is also the most costly in the world. The U.S. spent 16% of the country’s gross domestic product, or \$6697 per capita, on maintaining its healthcare system in 2005 (17). On the other hand, countries such as Canada, France, Germany, Japan and the United Kingdom have spent only half of what the U.S. spent per capita on their healthcare systems (17). Not only is the U.S. healthcare system expensive – it also underperforms. When the Commonwealth Fund compared the U.S. system to several other universal healthcare systems around the world using 37 indicators of high performance such as Infant Mortality and Healthy Life Expectancy at Age 60 years, it found that the U.S. ranked last of all countries on issues of access to care – such as “health insurance coverage, ability to see a physician and obtain needed medical attention,” or “short waiting times for doctor appointments” – while Germany’s healthcare system ranked first (17). The U.S. also ranked last on equity due to health disparities encountered by low income, uninsured and various racial and ethnic groups, specifically African Americans (17). Overall, the U.S. healthcare system fared woefully in other indicators as well. It received an aggregated score far lower than other benchmark healthcare systems (17). The consensus was that the U.S. system’s performance was categorically poor.

On a consistent basis, countries that out-performed the United States and were deemed to be “well-functioning health systems” were ones that offered universal

coverage to all residents for a specified set of health services (17). Many of these countries had established single-payer systems, such as Canada, the United Kingdom, Japan and Taiwan, while others such as Australia, Belgium, Denmark, France and the Netherlands had mixed public-private healthcare systems (17). That Taiwan was included as a country of comparison, and assessed to be well-functioning relative to the United States, lends additional weight to the argument in favor of adoption of universal coverage.

Only recently, in 1995, did Taiwan become a country boasting universal healthcare policy. Given Taiwan’s late transition to a universal healthcare system, understanding trends in the health status of the country, in addition to changes in access to care, sheds light on the effects of adopting a national healthcare plan. After the changeover, healthcare coverage dramatically jumped from 57% to 98% of the population (18). In the period following the establishment of a national healthcare system, gains in life expectancy in Taiwan were greater than in the period before universal healthcare coverage, and were more substantial in lower health class groups deemed to be of the ‘worst health’ before the transition (19). Reductions in the disparities of life expectancy between higher health class groups and lower health class groups were also visible across both genders. Despite not being as large as had been hoped for, these gains in life expectancy were unmissable; the disparity gap in life expectancy shrunk 6% for men and 13% for women (19).

Those that appeared to benefit most from expanded coverage in Taiwan were the elderly and the vulnerable, both of whom tended to fall into the lowest health class (19). Groups that were known to be the least healthy in society were the ones that experienced the greatest gains from these reforms (18). Yet the cost of implementing national healthcare policy in Taiwan occurred at only one seventh the equivalent spending rate on healthcare in the United States, or \$926 per capita in 2004, with the end result of life expectancy in Taiwan being similar to life expectancy in the U.S (19). These findings reveal that not only is health equity better served by a system that guarantees universal coverage, but that such coverage can be maintained at low costs and continue to be of high quality when compared to the current system in place in the United States.

CONCLUSION

That health inequity is reduced when governments promote human rights through the provision of universal healthcare is a well-made argument, and supported by the experience in Taiwan (20). Particularly for countries with vulnerable and medically underserved populations, such as African Americans in

Chicago, adopting universal healthcare improves health outcomes and reduces health inequality, as was demonstrated with analogous populations in Taiwan. In countries lacking such policy, and especially in the United States, these inequities amount to nothing short of human rights grievances. With ample evidence to demonstrate the payoffs of universal coverage, adopting a universal healthcare system is a real solution to addressing gaping health disparities and creating equitable, accessible healthcare systems that deliver on basic human rights. It is unreasonable for safety net clinics of the kind seen in Chicago or Guatemala to have to fill in for deficient healthcare systems lacking universal coverage, especially in the United States.

Therefore, the stories of clinic populations in the "Other Chicago" and Santa Cruz are ones of a shared experience of health inequity. The commonalities between a sub-segment of Chicago and a rural Guatemalan locale convey how both of these communities have historically experienced the inaccessibility of healthcare, albeit in different contexts. They exemplify the plight of populations around the world without recourse to healthcare. Yet in Guatemala there is a glimmer of hope. Rural Guatemalans are poised to begin receiving care in an evolving universal healthcare system attempting to function despite severe economic constraints. It will be interesting to witness how indicators of health status change over the next decade, and whether trends in Guatemala are similar to those experienced in Taiwan. However, in the United States, improvement of ongoing health inequities seems less promising within the current healthcare paradigm. Americans without private-payer or other forms of health insurance will continue to be denied access to medical care – and it is this denial of their human right to health that is fundamentally unacceptable. Yet this grievance extends to any country, not just the United States, where private insurance trumps universal access to healthcare.

It is society's responsibility to safeguard the health of individuals and to fight against rampant health inequities. Ultimately, the onus of correcting these health inequities rests on the governments elected by societies without universal healthcare systems, and on the active participation of members of those societies advocating for the adoption of universal healthcare reform. In the United States, such reform must be on the forefront of the political agenda. The rhetoric of the new administration under President Obama does little to reshape the current healthcare system, and makes no real provisions for universal access to healthcare in the United States at this time. Given the evidence, universal healthcare coverage is fundamental to any attempt at overturning health inequities, whether in the

United States or other countries throughout the world. It is long past time to cut the ties of health inequity that have unfavorably bound global communities, and instead unify people across the world under the banner of universal access to healthcare.

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