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World Health Report (2010)
Background Paper, 46

HEALTH SYSTEMS FINANCING
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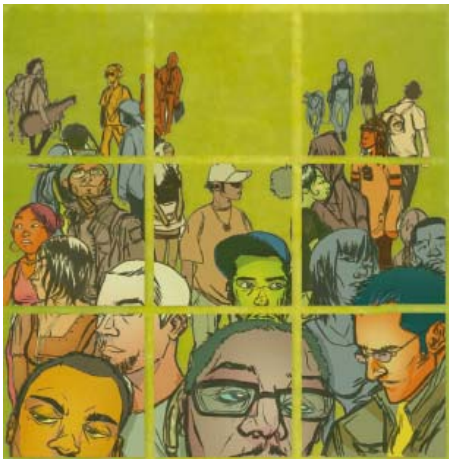

Access and Health Expenditure for Ethnic/Racial Groups in the Region of the Americas

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Cristina Torres Parodi[1], Sergio Munoz[1], and Antonio Sanhueza[1]

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1. Introduction

The Region of the Americas exhibits a high degree of inequality when comparing the indicators of different countries and analyzing health information disaggregated by social determinants such as ethnicity and race within countries. Some 43% of Latin America's population lives below the poverty line. Studies from several sources coincide in the view that certain ethnic/racial groups are over-represented among the disadvantaged. These findings confirm that "belonging to an ethnic group" is a social determinant that limits the possibilities of certain individuals in the job market and access to services. The evidence compiled by PAHO in recent years shows that ethnic populations use the health service less than the rest of the population does and as a result, have worse health indicators.

The demographics of the Region of the Americas are complex from the standpoint of ethnic composition, given its history of conquest, colonialism, and immigration. There are constraints to quantifying ethnic groups in the countries of the Region; current estimates give us an idea of their numerical significance, as they represent 25% of the Region's population--that is, roughly 50 million indigenous people and over 100 million Afro-descendants. The three countries with the largest indigenous populations are Peru, Mexico and Bolivia, followed by Guatemala.

Afro-descendants, in turn, represent over 45% of the population in the English-speaking Caribbean, Brazil, and Haiti, as well as significant percentages in Colombia, the Dominican Republic, Panama, and Venezuela.

Literature review reveals that indigenous people and afro-descendent are overrepresented in the lower income quantity

2. Access to Services

Due to their low income levels and their incorporation in the informal economic sector, these populations generally tend to use the public health services.

Table 1, for Brazil, shows that afro descendent represents 53% of the people with no access to health services. On the other hand, this population has lower access to health service which involves any payment.

Table 1: Health Access Distribution by race and type of service provider in Brazil

	Type of service	Afro	White
Without sources		53	47
With access	**Pharmacy**	43	57
	Emergency Care	42	58
	Community Health Worker	67	33
	Health Posts	53	47
	Private Provider	23	77
	Work outpatient	34	66
	Clinic	35	65
	Hospital outpatient	54	46

Source: PNAD, Brazilian Household Survey, 2003

Even when some services are free, these populations often face other barriers, such as geographical or cultural inaccessibility.

2.1 Access to health services related to the achievements of MDGs

Due to scarcity of information on access to health services disaggregated by ethnic-racial self-reported origins, this report will focus on the analyses of health services related to the achievement of the Millennium Development Goals, such as maternal and child health.

Maternal Health

Few countries in the Region report maternal mortality rates disaggregated by ethnicity, despite cases where this information is available. Nevertheless, inequities unrelated to the country's development level are observed. For example, in 2002, Brazil, a country with a numerically significant Afro-descendant population (around 45%), reported a total maternal mortality rate of 75.5, a maternal mortality rate of 90.4 in Afro-descendants, and a maternal mortality rate of 58.8 in whites. Furthermore, the United States, one of the Region's developed countries, reports that, according to data from the Centers for Disease Control and Prevention, almost 4 times as many African-American women die from problems of pregnancy, delivery, and the puerperium than white women (total mortality rate, 13.1; white mortality rate, 9.8; African-American mortality rate, 36.1).[2]

There is a consensus among experts that the causes of maternal mortality are primarily related to: hemorrhage, sepsis, unsafe abortion, preeclampsia and eclampsia, and obstructed labor. These causes are all preventable through the delivery of quality services, including family

[2] CDC. National Vital Statistics Report, Vol. 55, Number 19, pg. 103, 2007.

planning, prenatal care, and skilled delivery and postpartum care. Analysis the data for selected countries with information on institutional delivery care disaggregated by ethnicity shows a lack of access to these services by indigenous women (see Table 2).

Table 2: Percentage of Institutional Delivery Care

Country	Year	Indigenous Population	Non-indigenous population	Difference (non-indigenous vs. indigenous)
Bolivia	2003	46.5	76.8	30.3
Ecuador	2004	30.3	79.6	49.3
Guatemala	2002	19.6	57.9	38.3
	2009	29.2	70.0	40.8
Mexico	1997	44.6	86.7	42.1
Nicaragua	2001	34.9	67.5	32.6
Paraguay	2004	58.4	84.2	25.8
Peru	2000	14.4	85.2	70.8

Source: Authors, with data produced within the framework of the PAHO/ECLAC agreement.

These same sources report that a very high percentage of indigenous women deliver at home (Bolivia, 52.3%; Ecuador, 69.1%; Guatemala, 80.4%; Mexico, 54.3%; Nicaragua, 64.3%; Paraguay, 38.6%; and Peru, 84.5%)[3] with the consequent risks to their health and that of the newborn. This is compounded by the limited access of indigenous women to prenatal health care. As seen in Table 3, at least 8% of pregnant indigenous women had no prenatal check-ups, and in some countries, the figure may exceed 25%.

Table 3: Percentage without Prenatal Care

Country	Year	Indigenous Population	Non-indigenous population	Difference (indigenous vs. non-indigenous)
Bolivia	2003	25.9	11.7	14.2
Ecuador	2004	38.6	15.8	22.8
Guatemala	2002	18.7	13.7	5.0
	2009	7.6	6.5	1.1
Nicaragua	2001	27.2	13.2	14.0
Paraguay	2004	10.6	2.7	7.9
Peru	2000	21.7	14.4	7.3

Source: Authors, with data produced within the framework of the PAHO/ECLAC agreement.

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Another relevant indicator for maternal health that can be analyzed in terms of women's access to services, disaggregated by ethnic origin is postpartum care. The data from Maternal and Child Health Surveys show differences consistent with those mentioned above; in some cases, such as that of Bolivia, Ecuador, and Nicaragua, 8 out of every 10 indigenous women did not receive postpartum care for the last live birth prior to the survey.

[3] Census data from the 2000 round for selected countries. Authors' calculations within the framework of the PAHO/CELADE agreement.

In addition, access to family planning services affects maternal health, since the number of children and integenesic interval can pose health risks for the mother. In this regard, Table 4 shows very marked differences in access to contraceptives.

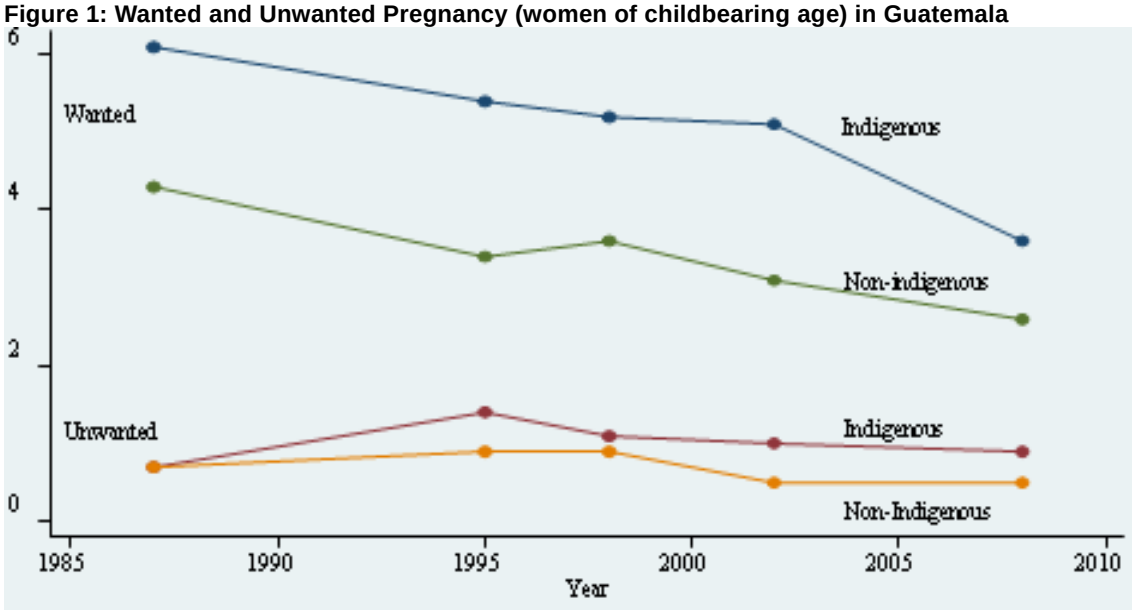
Table 4: Percentage of Access to Contraceptives

Country	Year	Indigenous Population	Non-indigenous population	Difference (non-indigenous vs. indigenous)
Bolivia	2003	54.3	64.8	10.5
Ecuador	2004	47.4	74.6	27.2
Guatemala	2002	23.9	53.0	29.1
	2009	40.2	63.3	23.1
Mexico	2003	51.2	77.3	26.1
Nicaragua	2001	27.5	69.4	41.9
Paraguay	2004	64.7	77.0	12.3
Peru	2000	53.1	70.9	17.8

Source: Authors, with data produced within the framework of the PAHO/ECLAC agreement.

It is possible that, for cultural reasons, indigenous women do not visit the family planning services. However, according to the available statistical information, in Guatemala for example, almost 30% of indigenous women indicate an unmet need for family planning. This information is consistent with the steady decline in the fertility rate of indigenous women. As seen in figure 1 below, the wanted pregnancy rate among indigenous women has fallen by almost 2 children over the past two decades, indicating their desire to reduce the number of children to a maximum of 4.

Figure 1: Wanted and Unwanted Pregnancy (women of childbearing age) in Guatemala



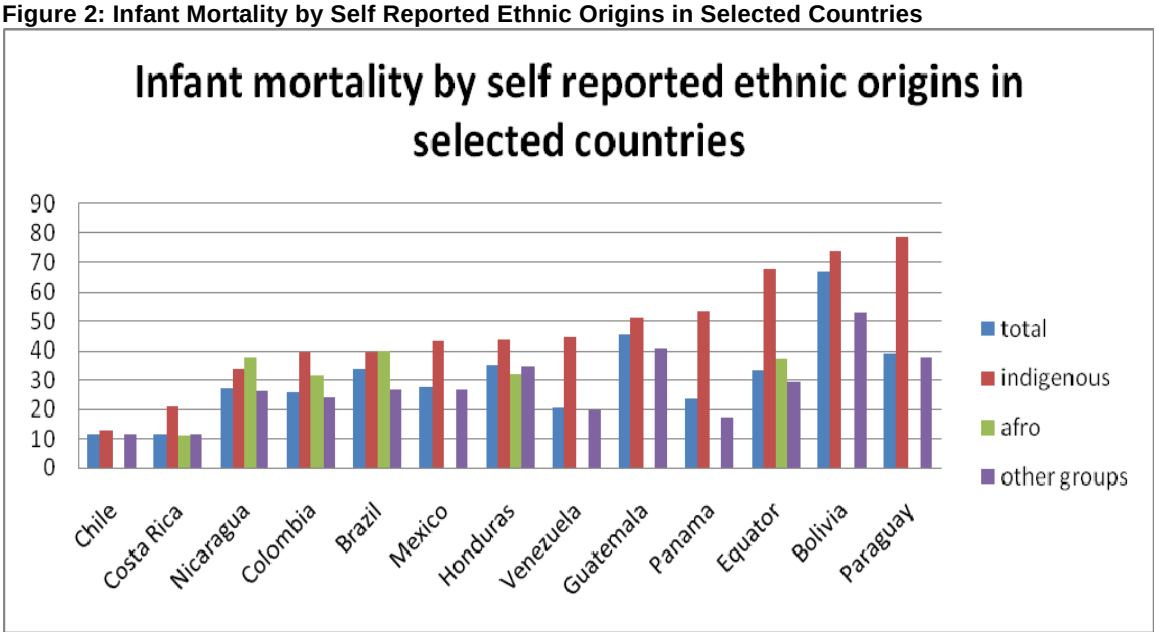
Source: Authors, with data produced within the framework of the PAHO/ECLAC agreement.

There is a consensus that achieving Goal 5 is a human rights issue and that improving access by indigenous and Afro-descendant women to sexual and reproductive health information services, including family planning, will make it more feasible to fulfill the commitments assumed in the Millennium Declaration, with the added value of reducing the levels of discrimination and exclusion suffered by these populations.

Child Health

When one of the indicators most sensitive to poverty and health service access barriers, infant mortality, is disaggregated by the ethnicity/race of the population and analyzed, major inequities are revealed whose only explanation is sustained exclusion. As seen in figure 2 below, infant mortality is higher among indigenous peoples than other segments of the population.

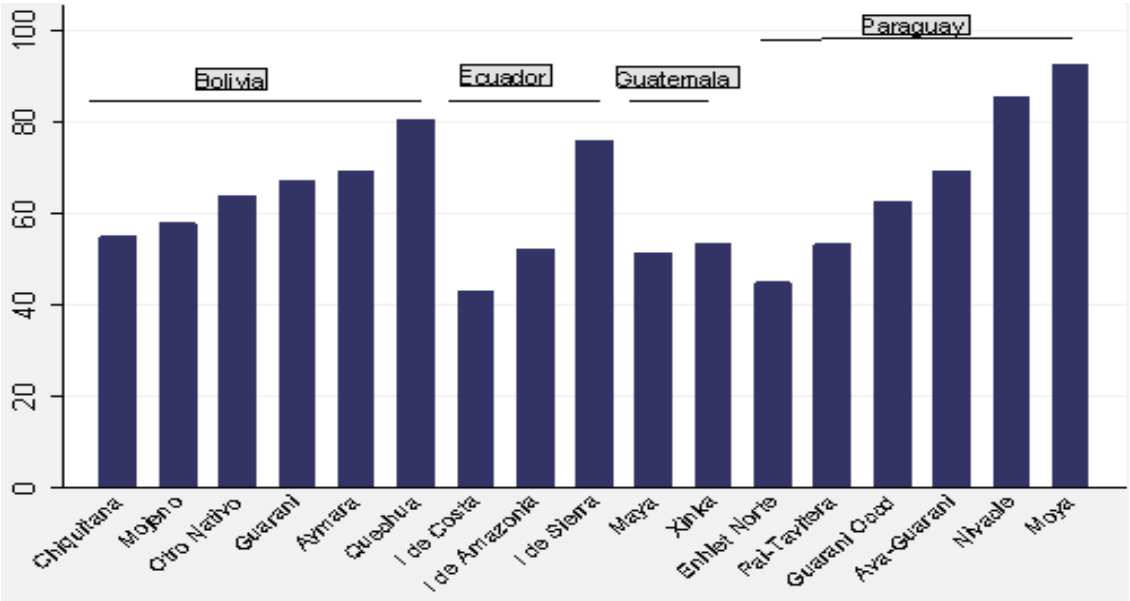
Figure 2: Infant Mortality by Self Reported Ethnic Origins in Selected Countries



Source: PAHO/ECLAC/CELADE, special processing of census microdata.

In the case of Afro-descendants, for the six countries studied, the mortality pattern differs from that of non-Afro-descendants. There are clear inequities in Brazil, Colombia, Ecuador, and Nicaragua, but not in Costa Rica and Honduras, where Afro-descendant children's likelihood of survival is similar that of other children. PAHO-ECLAC/CELADE)

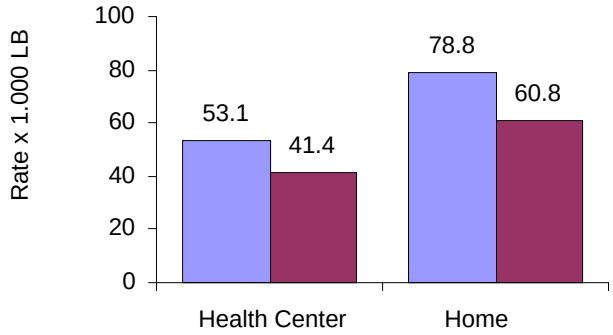
Figure 3: Infant mortality for different indigenous populations in selected countries



Source: *PAHO/ECLAC/CELADE, special processing of census microdata.*

The majority of causes of infant mortality are preventable, and the risks generally diminish when the mother has access to prenatal care, ensuring adequate nutrition to prevent low birth weight. In the case of Bolivia, (see Figure below), infant mortality is lower in children born in a health center, whatever their ethnic background. However, regardless of where the birth occurs, indigenous children have a 30% higher risk of dying before the age of 1 year than non-indigenous children. This could be an expression of cumulative harm that extends beyond the moment of birth (PAHO-CELADE/ECLAC).

Figure 4: Indigenous and non-indigenous infant mortality rate in Bolivia, by place of delivery (1995-2000)



Source: PAHO/CELADE-ECLAC Population Censuses, Round 2000, based on special processing of census microdata

3. Transborder Territories

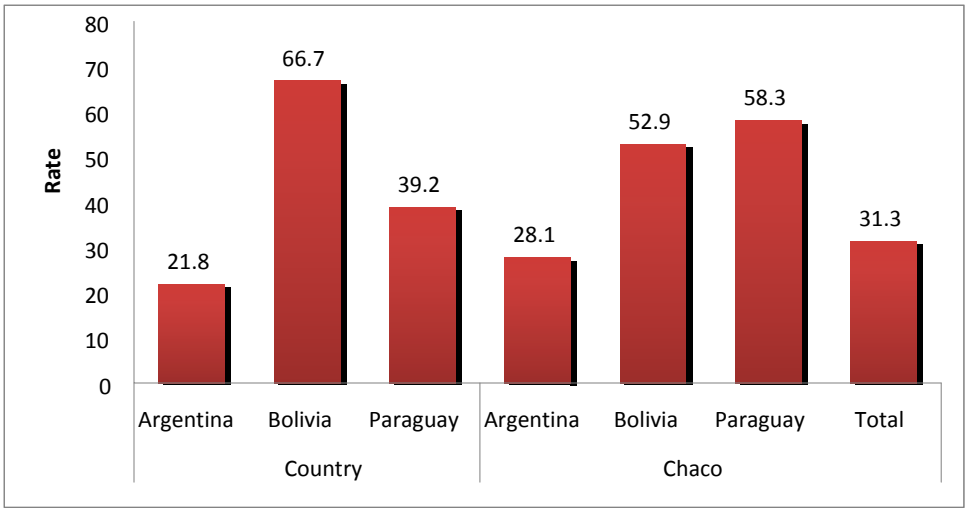
The geographical location of ethnic/racial groups often crosses national boundaries, since their historical development occurred in border territories marked by similar conditions of exclusion and vulnerability.

The Chaco region is a transnational territory populated by different Argentina, Bolivian and Paraguayan indigenous groups: the Charrua, Lule, Mbya-Guarani, Mocovi, Pilaga, Toba, Tonocote, Vilela, and Wichi peoples of Argentina; the Guaraní, Tapiete, and Weenhayek peoples of Bolivia; and the Ayoreo, Nandeva, and Guarayo peoples of Paraguay.

Studying the Chaco region by unmet basic needs (UBN), we can see that nearly half its population (41.53%) has UBN and that 76.95% of its indigenous population has unmet needs. This indicates that indigenous peoples are over-represented in lower income quintiles, since they represent 1 out of 10 inhabitants in the Chaco but 1 out of 5 five poor people in that region (21.6%)

The Guaranís, who have inhabited this region since the days before the conquest, (Chaco means “hunting lands” in Guaraní), reside in border areas of the three countries and are found largely in Ramón Lista in Argentina, Charagua and Yacuiba in Bolivia, and General Eugenio Garay in Paraguay, where they account for some 30% to 60% of the population of each municipal entity. The Guaranís in these territorial entities have UBN figures of over 90%, and this high vulnerability is also reflected in their health status. The infant mortality rate among the indigenous populations of the Chaco is above the total rate for the country in the case of Argentina and Paraguay.

Figure 5: Infant Mortality Rate 2001-2002 in Selected Countries and the Chaco, by Country



Source: Census data processed within the framework of the PAHO/ECLAC/CELADE agreement

In the case of Bolivia, the figure is slightly below the infant mortality rate for the country, since the Quechua and Aymara peoples have rates of 82 and 70 per 1,000, respectively (Source: CELADE), which are higher than THE infant mortality rate of the Guaranis and other indigenous groups in the Bolivian Chaco.

4. How can we take advantage of the window of opportunity opened by the MDGs to reduce these inequalities?

MDG 5 establishes the governments' commitment to work to reduce maternal mortality by three-quarters by the year 2015. A case study has been conducted using maternal mortality data from the PAHO Mortality System for the period 2000-2007 for women of childbearing age in Brazil to project the maternal mortality ratio (MMR) to 2015 using a linear model based on the MMR logarithm. This methodology is used to forecast the total MMR and the ratio for Afro-descendant- and white women (see figure below) and identify the best strategies for the time remaining until 2015.

Figure 5: MMR trend in women of childbearing age in Brazil, by race and total (2000-2015)

Source: PAHO Mortality System

The MDGs use 1990 as the base year for calculating the three-quarter reduction. Since Brazil reported a ratio of 108 per 100,000 live births in 1987 (OPS, 1994), that figure can be used as the country baseline, which means that the value to attain in 2015 is less than 30 per 100,000 live births. Towards the end of the 1990s, the country began to collect data disaggregated by ethnicity/race, and the available maternal mortality data for 2000-2007 reveal a gap between Afro-descendant- and white women. In 2000, the MMR ratio between Afro-descendants and whites was 1.52, remaining relatively constant up to 2007 (1.46).

Today, we observe, moreover, that the trend for total MMR is stable and that the ethnic/racial gap, as measured by the MMR, decreased very slightly to 1.46 in 2007.

Projecting the values to 2015, we observe that:

The TMMR will reach a value of 77.2, signifying that the country will have achieved a reduction that is nearly 30% lower than what is needed to reach the goal.

The second observation is that the ethnic/racial gap in 2015 would drop to 1.23, which reflects the country's efforts to reduce discrimination.

In short, Goal 5 is unattainable in the time remaining, since it took 20 years (1987-2007) to achieve a 30% reduction in the MMR. Nevertheless, the country can improve outcomes if it works to systematically and effectively reduce the ethnic gap, with a view to eliminating the differences between the MMR of Afro-descendant- and white women. In this case, in the next eight years the MMR of Afro-descendant women should be reduced by 21%, which is relatively possible given the health authorities' knowledge about the design of maternal health programs and the experience with affirmative action in other fields.

Such an effort would result in the elimination of inequity and a lowering of the MMR to 66 per 100,000 live births. This would represent a gain, given the projections for 2015 (77.2 per 1,000 live births) if a firm policy intervention to promote racial equity is not adopted.

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