

# INEQUALITY, PUBLIC HEALTH, AND ETHICS: THE CASE OF LATIN AMERICA

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## **I. Latin America and Health: A Complex Relationship**

In the new world scenario, key shifts are occurring in how to determine whether a society is making progress and how to measure development. This is related to the deep frustrations that many societies—including several in Latin America—have experienced in recent decades. When measured by the usual indicators of annual growth rate, gross national product per capita, and inflation levels, such societies show all the signs of progress, yet their economic base has been seriously eroded, and a growing portion of their populations is being excluded.

In the emergent thinking, Latin America is a clear example of a region where—according to Joseph Stiglitz (2002), Nobel Laureate in economics—traditional ways of viewing and measuring development have been trumped by reality. Stiglitz argues that we need to reexamine and broaden our understanding of economics of development that we accept as truth while planning the next series of reforms.

This new perspective, which is catching on, significantly broadens the dimensions that should be considered in determining whether a society is making progress. In addition to the usual economic indicators, it includes aspects linked with social and environmental development, access to culture, freedoms, and citizenship-building. We know that with progress comes the growth of what Amartya Sen calls the “degrees of freedom” of choice—the options that every human being has to develop his potential.

This perspective fully enhances the role of public health. The way a society treats its members in this essential field is a critical “seismic indicator” revealing the extent to which a society is truly progressing. Health is a priority goal in and of itself, and at the same time, a strategic underpinning of real freedom.

The new development thought is also giving new meaning to the conventional, to the value of a society’s human resources in

meeting goals for productivity, technological advancement, competitiveness, and growth. The main differences in national performance in today's global economic scene are based on the "quality" of a country's population. Two key expressions of this quality are education and health. Health, greatly influenced by education, is at the same time the foundation of education. In recent decades, the accumulation of education and health capital has provided key leverage in the development of the most successful economies, for example the Scandinavian countries and some countries in Southeast Asia. *Macroeconomics and Health*, a report by the commission of notables chaired by Jeffrey Sachs (WHO, 2002), pointed out that all successful countries have invested a great deal beforehand to improve public health. These improvements are a prerequisite to—not merely a consequence of—development.

Health, increasingly a litmus test that reveals whether real progress has been made, is also a real means to achieving it. Such progress is highly significant. However, at the same time, meeting goals in health is increasingly viewed as a very complex challenge, because the goals are closely tied to wide range of related to the overall operation of each country's society. The characteristics of national conditions--aspects such as poverty, inequalities, the coverage and quality of infrastructure, family conditions, community development, the environment, and more—are relevant. In particular, the critical issue of inequity in health has proven to be extremely complex. Experiences in Latin America show that while overall indicators may improve, the gaps within countries may also continue to grow, seriously impacting broad sectors of society. As Mirta Roses (2003) points out, it is essential to move beyond the tyranny of averages. As she suggests, it may be preferable in terms of life expectancy and other parameters to be born in a country with lower per capita income but greater equity than in a country with higher per capita income but wider income gaps. As several research studies show, the Gini coefficient can be very useful in understanding a population's real health problems. Erick Messias (2003) studied the differences among several states in Brazil (a country with an extremely high level of inequality in health), and estimated that each 0.01 increase in the Gini coefficient represents a decrease of 0.6 years in life expectancy.

A strategic question arises. For public health and its prospects in Latin America, what does it mean to be immersed in the region

unanimously considered to be the most unequal in the world? This critical issue can be viewed in two different ways. Inequities in health appear to be strongly influenced by the profound inequalities in Latin American societies. At the same time, all truly effective strategies to address and overcome these inequalities will have to be based on successfully meeting goals in health.

Democratizing public health determinants is fundamental to addressing the unacceptable levels of inequality in Latin America. Enormous changes are under way in terms of the direction and content of development, opening new climate for struggles in public health. Democratic growth is significant. Civil society is participating more actively and demanding a shift from passive to active democracy. Public pressure is growing for more transparent, decentralized, and open governments. Upward mobilization of social capital has begun. There are new expectations about the very the role of public policy. The exclusionary approaches to public policy have lost credibility due to their poor results, and new ties are anticipated between active public policies, the forces of production, and civil society.

A basic tenet in the agenda of these developments is the complete unacceptability of the current levels of inequality. The World Bank recently reported (2004) that the high levels of inequality are generally unacceptable in most countries, and that 80 to 90% of citizens consider the prevailing levels to be unfair or extremely unfair.

New coalitions of forces are developing in Latin America's democracies, clearly aimed at renewing the development model with a vigorously anti-inequity approach. This is leading to serious programs for change, such as the mandates given to the new presidents of Brazil, Argentina, Uruguay, Chile, and Bolivia. The World Bank (2004) noted that changes are under way, especially at the subnational level, in which the new alliances between the progressive, public officials, the middle class, and the poor are now pushing for the creation of institutions that are more inclusive and efficient.

This is a context full of significant changes, with great risks and challenges for public health. This purpose of this article is to contribute to the search for renewing public health policies, focusing in particular on answering the question posed earlier: what does it mean for public health to be immersed in the region with the greatest inequality on the planet? In an attempt to answer this question, several successive analyses will be examined: first, a

picture of recent regional trends in inequality and their significance for development; second, a brief review of selected indicators of health inequities, noting the influence of some trends observed in general issues of inequality; and finally, some strategic considerations that may be useful in the debate on new courses of action in public health.

## **II. Trends in Inequality**

### **The Income Gap**

A joint report by ECLAC, IPEA (Brazil), and the UNDP (2004) on the Millennium Development Goals and LAC pointed out that in all Latin American countries without exception, the Gini coefficient (a calculation of inequality in income distribution) was higher than the international and OECD averages. In its report on inequality, the World Bank (2004) noted that Latin America suffers from enormous inequality, which permeates every aspect of life, including access to education, health, and public services; access to land and other assets; financing of the credit and formal labor markets; and political participation.

Recent statistics leave no doubt as to the truth of these assertions. Table 1 below compares the Gini coefficients and income gaps in 10 Latin American countries, the United States, and Italy.

**Table 1**  
**Indicators of Inequality for Selected Latin American Countries, the United States, and Italy**

The gaps in Latin American countries are much wider than those in the United States and Italy. Extreme concentration of income is prevalent. In Brazil, the richest 10% of the population receives 47% of the total income, while in Italy that figure is 27%. At the same time, the poorest 20% in Italy shares the same amount of income as the poorest 20% in Brazil. Thus, while in Brazil the richest 10% receives 54 times the amount of income as the poorest 10%, in Italy it is only 14 times higher. The difference is even less in other countries such as Korea and Hong Kong (less than 10 times higher), and in Norway, the richest 10% currently receives only 1.5 times more than the bottom 50%.

<i>Country</i>	<i>Gini coefficient</i>	<i>Share of top 10% in total income</i>	<i>Share of bottom 10% in total income</i>	<i>Ratio of incomes of the 10<sup>th</sup> to 1<sup>st</sup> decile</i>
Brazil (2001)	59.0	47.2%	2.6%	54.4
Guatemala (2000)	58.3	46.8%	2.4%	63.3
Colombia (1999)	57.6	46.5%	2.7%	57.8
Chile (2000)	57.1	47.0%	3.4%	40.6
Mexico (2000)	54.6	43.1%	3.1%	45.0
Argentina (2000)	52.2	38.9%	3.1%	39.1
Jamaica (1999)	52.0	40.1%	3.4%	36.5
Dominican Republic (1997)	49.7	38.6%	4.0%	28.4
Costa Rica (2000)	46.5	34.8%	4.2%	25.1
Uruguay (2000)	44.6	33.5%	4.8%	18.9
United States (1997)	40.8	30.5%	5.2%	16.9
Italy (1998)	36.0	27.4%	6.0%	14.4

Source: World Bank (2004). Inequality in Latin America: Breaking with History? Washington, D.C

The Gini coefficients in Latin American countries (measuring income distribution) are the worst in the world and have been deteriorating steadily since the 1970s, as can be seen in Table 2 below.

**Table 2**  
**Gini Coefficients of the Distribution of per Capita Household**  
**Income: Decade Averages, by Region**

Region	1970s	1980s	1990s	Overall Average
<i>Levels</i>				
Latin America and the Caribbean	48.4	50.8	52.2	50.5
Asia	40.2	40.4	41.2	40.6
OECD	32.3	32.5	34.2	33.0
Eastern Europe	28.3	29.3	32.8	30.1
<i>Changes</i>				
		<i>'70s-'80s</i>	<i>'70s-'90s</i>	<i>'70s-'90s</i>
Latin America and the Caribbean		2.4	1.3	3.7
Asia		0.2	0.8	1.1
OECD		0.2	1.7	1.9
Eastern Europe		1.0	3.5	4.5
<i>Differences in Gini points -- LAC vs.:</i>				
Asia	8.3	10.4	10.9	9.9
OECD	16.1	18.3	18.0	17.5
Eastern Europe	20.2	21.6	19.4	20.4

Source: Calculations based on WIDER 2000, Smeeding, and Grodner 2000, Székely 2001, and estimates for Latin America. World Bank. *Inequality in Latin America: Breaking with History?* Washington, D.C.

In the 1990s, the Gini coefficients in Latin American countries were 19 points higher than in the Eastern European countries, 18 points higher than in the developed OECD countries, and more than 10 points higher than in Asian countries. The table could be evaluated from another perspective if the trend were positive, but the analysis over time shows that the situation has deteriorated. Gini coefficients in Latin America grew between the 1970s and 1990s. Furthermore, the differences between the coefficients in Latin American countries and in Asian and OECD countries were greater in the 1990s than in the 1970s. In the 1990s, the average Latin American Gini coefficient even surpassed that of Sub-Saharan Africa (0.47), one of the poorest regions on Earth.

### **Multiple Inequalities**

Skewed income distribution is the most widely known form of inequality in Latin America, but it is not the only kind of inequality or the gravest. Inequality is found in all basic aspects of daily life in most Latin American countries.

Another expression of inequality is the extreme concentration of ownership of an essential productive asset such as land, from which vast sectors of the rural population are excluded. The Gini coefficients for land distribution, based on the calculations of

Deninger and Olinto (2002) and the UNDP (1993), are compared below:

**Table 3**  
**Gini Coefficients for the Distribution of Land Ownership**

<b>Region</b>	<b>D&amp;O (i)</b>	<b>UNDP (ii)</b>
<b>Latin America</b>	0.81	0.74
Middle East and North Africa	0.67	0.56
North America	0.64	
Sub-Saharan Africa	0.61	0.51
Western Europe	0.57	
Southeast Asia	0.56	0.52

Note: Column (i) shows averages for 1950-1994; Column (ii) shows values *circa* 1981.

Sources: Deininger and Olinto (2002) and UNDP (1993). Mentioned by World Bank. *Inequality in Latin America*. op. cit.

As can be observed, concentration of land is even more extreme than income concentration. The Gini coefficients for land in Latin America are much worse than those for every other region in the world.

A key dimension of inequality is found in the field of education. Significant progress has been made in Latin America in areas such as literacy and enrollment in primary school. Most children start school, but the dropout and repeat rates are high. The resulting low schooling indexes can be observed in Table 4 below.

**Table 4**  
**Schooling in Latin America. 1999.**

Country	Average years of schooling
Argentina	9.4
Bolivia	5.6
Brazil	6.0
Chile	9.8
Colombia	5.6
Costa Rica	7.5
Dominican Republic	6.9
Ecuador	6.4
El Salvador	6.2
Guatemala	4.1
Honduras	5.3
Mexico	5.9
Nicaragua	5.9
Panama	5.3
Paraguay	7.6
Peru	7.6
Uruguay	9.3
Venezuela	7.1

Source: ECLAC, IPEA, and UNDP (2003). Hacia el objetivo del milenio. Hacia el objetivo del milenio de reducir la pobreza en América Latina y el Caribe.

In 2000, the index of average schooling in Latin America was calculated at 5.9 years. This average conceals sharp social stratification. Children who drop out and repeat grades come mostly from disadvantaged sectors. Their low performance is attributable to specific causes, such as: the fact that 22 million children under 14 years of age work; malnutrition; and the incidence of families torn apart by poverty. In countries such as Bolivia, Ecuador, and Peru, 20% of children aged 10 to 14 work. The gaps in schooling are significant. In 2001, the richest 20% in Brazil attained 10 years of schooling, and the poorest 20% only three years. In Mexico, the gap was similar: 11.6 years for the top quintile versus 3.6 years for the lowest.

Added to the inequalities already mentioned are those in the area of health, which will be examined in the following section, and others that have not been investigated in detail but are clearly visible and have a profound impact. One such inequality is in



access to credit. Small- and medium-sized enterprises play a significant role in creating employment in Latin America; estimates indicate that 60 million small- and medium-sized enterprises receive only 5% of the credit offered by financial institutions. Here again is yet another example of extreme concentration.

A new inequality is emerging with respect to access to advanced technologies. The number of people with access to the Internet is strongly concentrated in the upper strata. Only 3% of Latin America's population is connected to the Internet, compared to 20% in Spain and 40% in the United States. When the numbers are disaggregated by income bracket in Argentina, for example, 8 out of 10 people in the top sectors have Internet access, compared to only one out of every 10 in the lower-income brackets (Clarín, 2004). Repeated warnings have been made about the stealthy creation of a wide "digital divide" in Latin America, and a large sector of "cyber-illiterates."

Inequalities in Latin America are at their peak when it comes to ethnicity and color. More than 80% of the 40 million indigenous people in the Region are estimated to be living in extreme poverty. There are also striking disparities between the basic indicators of the white population and Afro-descendant population. And to all this should be added the persistence of gender discrimination in the job market and other areas.

### **The Cost of Inequality**

All these inequalities and others interact daily, negatively reinforcing one another. They mark people's path for life. If one is born into a poor family, the chances of good health care and education are limited. The level of schooling will be low, access to stable employment limited, and income sporadic and extremely limited, with a high probability of creating a family with similar problems. In fact, in some of the Region's more socially advanced societies (Uruguay, for example) studies show that the schooling of children from poor families tends not to exceed the low levels of their parents. Lack of opportunity creates an unending circle.

A few years ago, many "establishment" economists adamantly defended the "functionality" of inequalities. They argued that that inequalities are a necessary step toward progress, that inequalities help certain groups accumulate capital, which will then be reinvested and help accelerate growth. Today, given the obvious dysfunctions, the consensus is clearly shifting. The World Bank, a frequent locus of

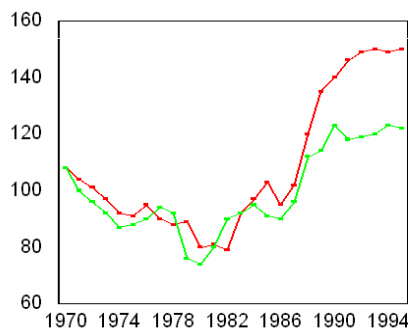
controversy, recently reported that most economists and other social scientists now regard inequality as a potential brake on development (World Bank, 2004).

Indeed, many studies show what these levels of inequality are costing the region, and how seriously they hinder the chances of sustained growth. Studies in Latin America often mention that there is poverty and there is inequality. Actually, research shows a different situation. There is poverty *because* there is inequality. This relationship is key to understanding how a Hemisphere rich in natural resources and with great potential in all fields has such high levels of poverty.

According to ECLAC data, the current poverty level is higher than in 1980 in both relative and absolute terms. In 1980, 40% of the population was poor; today the figure is over 44%. It is estimated that between 1997 and 2002, the number of poor grew by 20 million. The percentage of extreme poverty rose from 17.8% in 2000 to 20% in 2002.

Birdsall and Londoño (1997) attempted an econometric calculation to measure the impact of inequality on poverty. They constructed the following simulation:

**Figure 1**  
**The Impact of Inequality on poverty in Latin America, 1970-1995**



Source: Birdsall, N. and J. L. Londoño. "Asset inequality matters: an assessment of the World Bank's approach to poverty reduction", *American Economic Review*, May, 1997.

The first curve in the figure plots the poverty trend in Latin America, which, as can be observed, has risen steadily, with minor

variations, since the early 1980s. The second simulates what the poverty level would have been had inequality remained at the same level as in the 1970s (before the military dictatorships and orthodox policies), and not continued to grow. It was already considerable, but increased further in the last two decades. According to these estimates, poverty today would be half of what it has actually been. An “excess of poverty” has been caused by the increase in inequality, which doubled poverty. Along the same lines, in comparisons made across regions, it can be seen that if Latin America had the same pattern of inequality as Southeast Asia, poverty would be greatly reduced.

Albert Berry (1997) reaches similar conclusions in his research, identifying the existence of a wide sector of so-called “unnecessary poverty” in Latin America caused by the severely limited income share of the two lowest quintiles of the population. Both Berry and Altimir, as well as other researchers, see the rise in inequality as being closely linked to policies from the last two decades that generate effects of that order. The case of Argentina clearly exemplifies the disadvantages of such policies. Their rigidly orthodox implementation in the 1990s led to brutal social polarization. In that decade, 7 million people, 20% of the population, fell from the middle class into poverty, and the Gini coefficient rose 0.05 from 0.42 in 1992 to 0.47 in 1997.

Chris Patten (2004), the European Union’s Commissioner for External Relations

“If income distribution in Latin America had followed the patterns in Southeast Asia, poverty would be one-fifth of what it is now.”

He went on to add that this is important not only on humanitarian grounds, but also as a piece of practical, self-interested politics. Halving the population of poor people means doubling the size of the market.

Nancy Birdsall (1998) viewed inequality as the major obstacle to economic growth in Latin America. She pointed out that growth rates in Latin America may not be able to surpass 3 or 4%, as long as societies cannot rely on the participation and contribution of the half of the population that is struggling in the lowest income brackets.

In an effort to find out why Latin America is so far from being able to achieve the Millennium Develop Goal in poverty reduction,

ECLAC, IPEA, and UNDP (2004) identified inequality as the main reason. Through detailed econometric simulations, they concluded that reducing inequality would have more of an impact on poverty than increasing growth. Growth is necessary, but in the current climate of inequity, growth does not actually reach the poor. Assuming that Brazil grows at the same rate as in the 1990s, it is estimated that it would take 48 years to reduce poverty by two points if it does not reduce its inequality. Mexico would take 44 years to reduce poverty by 3.2 points. The results of these projections show that in the majority of countries examined, lowering the Gini coefficient by one or two points would reduce the incidence of poverty as much as several years of positive economic growth would. Efforts to reduce poverty in Latin America and the Caribbean have been discouraging largely because it has been impossible to control the high levels of inequality in the region.

This scenario of acute and persistent inequalities and widespread growth in poverty, difficulties in sustaining growth, and the impact of the needs afflicting daily life in most of Latin America is the context in which public health in the region is unfolding. Inequality affects the determinants of health and is one of the most powerful forces in creating the conditions that give rise to a fundamental problem, inequity in health, which will be addressed in the following section.

### **III. Public Health in the Most Inequitable Region on Earth**

#### **Beyond the Averages**

Public health has made great strides in Latin America. Bold efforts by democratic governments and various sectors in society—in which model institutions like the Pan American Health Organization (PAHO) have played a pioneering role and exercised strong leadership—have laid the groundwork for steady progress. However, inequity in health remains a serious and widespread problem, one that is almost “unsolvable”.

For the moment the issue is cloudy. National studies on health often emphasize only the general progress in averages. This facilitates comparisons and makes it possible to calculate degree of inequity between countries. But this is just “the tip of the iceberg.” Basic inequities underlie those averages and are revealed when Roses’ healthy recommendation (2003) is practiced, to move beyond the “tyranny of averages.” As she notes in reference to child mortality in Latin America, although a decrease in the overall

magnitude of the risk of dying in the first year of life was evident and consistently observed across all country groups in recent decades, inequalities in infant mortality did not change significantly in the same time period. These results show that great achievements may be made with measurements of central tendency (means and medians) for a given health indicator, without having a corresponding impact on the relative magnitude of the gaps (distributions) between and within population groups.

As Alleyne (2002) emphasized, the spirit of the Declaration of Alma-Ata addresses this same problem when it calls for “health for all” instead of focusing solely on achieving good averages. When in-country health statistics are disaggregated by socioeconomic strata, geographic location, gender, ethnicity, color, and age, among other things, a panorama unfolds revealing very dissimilar access to this essential right that is part of human dignity.

#### **Health Inequities in Action**

Ongoing research on inequities is revealing the scope of the problem. The following findings are highly illustrative. The average number of children who die before the age of 5 in Latin America is 71 per 1,000, surpassing the average in East Asia and the Pacific, which is 57.1. Major differences exist among countries: in Haiti the average is 140.6 and in Bolivia 99.1. Differences are found across the different social levels, as can be seen in Table 5.

**Table 5**  
**Mortality in Children under 5**

Country/region	Mortality rate for children under 5 (in thousands)					
	1	2	3	4	5	Average
Bolivia	146.5	114.9	104.0	47.8	32.0	99.1
Brazil	98.9	56.0	39.2	26.7	33.3	56.7
Colombia	52.1	37.1	30.7	34.9	23.6	37.4
Dominican Republic	89.9	73.0	60.1	37.3	26.6	61.0
Guatemala	89.1	102.9	82.0	60.7	37.9	79.2
Haiti	163.3	150.1	137.1	130.6	105.6	140.6
Nicaragua	68.8	66.6	52.5	48.5	29.7	56.0
Paraguay	57.2	50.0	59.0	39.4	20.1	46.6
Peru	110.0	76.2	48.0	44.1	22.1	68.4
<b>LAC</b>	<b>97.3</b>	<b>80.8</b>	<b>68.1</b>	<b>52.2</b>	<b>38.8</b>	<b>71.7</b>
East Asia, Pacific	84.0	62.9	53.7	41.1	27.1	57.1
Central Asia	82.5	64.5	69.8	57.5	40.2	64.9
Middle East, North Africa	140.6	117.8	92.2	80.1	50.4	100.3
South Asia	144.2	152.6	136.1	110.8	71.7	126.6
Sub-Saharan Africa	191.7	190.9	174.3	156.6	112.4	168.4
<b>Total Countries</b>	<b>148.3</b>	<b>140.8</b>	<b>126.8</b>	<b>110.0</b>	<b>77.4</b>	<b>124.2</b>

Source: World Bank (2004). Op.cit.

In the richest 20% of Bolivia's population, 32 out of every 1,000 children die before reaching 5 years of age. In the poorest 20%, the figure is five times higher: 146.5 per 1,000. This sobering reality reflects a very concrete ethnic bias, basically against indigenous population. The same holds true in Peru, where under-5 mortality for the poorest 20% is five times higher than for the richest 20% (111 versus 22.2); and three times higher in Brazil (98.9 versus 33.3).

Statistics on chronic malnutrition in children also reveal significant disparities by ethnic group, location (rural versus urban), and income bracket. See the following table with data from four Andean countries:

**Table 6**  
**Incidence of Delayed Growth in Children (%) by Country,**  
**Place of Residence, Ethnicity, Region, and Socioeconomic**  
**Status, in Four Andean Countries**

	Country			
	Colombia	Ecuador	Peru	Bolivia
<b>Place of residence (1)</b>				
Large city	12.7	20.7	13.2	18.5
Small city	10.9	22.4	20.1	20.3
Village	14.0	28.2	27.2	22.4
Rural area	19.3	35.2	40.8	37.2
<b>Ethnicity</b>				
Nonindigenous	(2)	24.2	22.5	23.7
Indigenous	...	58.2	47.0	50.5
<b>Region</b>				
Highlands	...	33.3	38.5	31.2
Other regions	...	22.2	18.2	23.9
<b>SES Deciles (3)</b>				
1 (child)	26.8	38.5	49.6	42.2
2	24.1	51.8	46.8	39.9
3	17.1	30.6	39.6	38.7
4	14.9	27.6	32.5	32.8
5	16.3	17.9	23.4	31.8
6	15.2	24.4	19.9	25.0
7	11.0	19.0	18.3	22.7
8	11.7	19.1	12.8	18.2
9	6.3	15.8	12.6	13.5
10 (and over)	5.4	11.9	5.2	9.7
<b>Concentration index (4)</b>	<b>-0.221</b>	<b>-0.223</b>	<b>-0.311</b>	<b>-0.223</b>
<b>Total countries</b>	<b>14.9</b>	<b>26.5</b>	<b>26.1</b>	<b>26.9</b>

(1) According to DHS surveys (in Colombia, Peru, and Bolivia), large cities include national capitals and cities with more than 1 million inhabitants; small cities have a population ranging from 50,000 to 1 million. According to LSMS surveys (Ecuador), small cities have a population ranging from 5,000 to 1 million.

(2) The (...) indicates that no information is available.

(3) SES deciles computed for children and do not correspond to population deciles, due to socioeconomic differences in fertility.

(4) The concentration index measures social inequality in delayed growth. The concentration index is a generalization of the Gini coefficient, and ranges from -1 to 0. Values closer to -1 indicate greater social inequality.

Source: Larrea, Carlos, and Wilma Freire (2002). Social inequality and child malnutrition in four Andean countries. *Pan American Journal of Public Health*. May-June.

Child malnutrition rates in the Andean countries are high (exceeding 21% in Bolivia, Ecuador, and Peru). However, they also show clear economic gradients. In general, chronic malnutrition rates are three times higher in the poorest deciles than in the richest. For example, in the richest 10% in Ecuador, only 11% of children suffer from malnutrition, while in the poorest

10%, the figure almost quadruples. In the indigenous population, the figure rises to 58%.

Maternal mortality claims a significant number of victims in Latin America. As PAHO (2004) recently reported, 23,000 women die during pregnancy or childbirth, mostly due to “avoidable causes that are routinely prevented in developed countries.” The risk of dying in childbirth in Latin America is 25 times higher than in Western Europe (1 in 160 compared to 1 in 4,000). While in the United States, 17 mothers die annually per every 100,000 live births, in Haiti 600 die and in Colombia 100.

Lack of institutional medical care is one of the causes of such poor statistics. Approximately 24% of expectant mothers do not receive medical care during pregnancy, and one-third have no medical care during childbirth. The figures show significant biases according to the economic gradients, as seen in the table below:

**TABLE 7**  
**Basic Prenatal Care and Deliveries Attended by Medically Trained Personnel**

Country/region	Basic prenatal care rate (by medically trained personnel)							Medically attended delivery rates (by medically trained personnel)						
	1	2	3	4	5	Average	CI	1	2	3	4	5	Average	CI
Bolivia	38.8	57.8	70.4	88.6	95.3	65.1	0.17	19.8	44.8	67.7	87.9	97.9	56.7	0.28
Brazil	67.5	87.7	93.4	96.9	98.1	85.6	0.08	71.6	88.7	95.7	97.7	98.6	87.7	0.07
Colombia	62.3	81.1	89.8	95.4	95.9	82.5	0.09	60.6	85.2	92.8	98.9	98.1	84.5	0.09
Dominican Republic	96.1	98.2	99.0	99.2	99.9	98.3	0.01	88.6	96.9	97.3	98.4	97.8	95.3	0.02
Guatemala	34.6	41.1	49.3	72.2	90.0	52.5	0.19	9.3	16.1	31.1	62.8	91.5	34.8	0.42
Haiti	44.3	60.0	72.3	83.7	91.0	67.7	0.14	24.0	37.3	47.4	60.7	78.2	46.3	0.21
Nicaragua	67.0	80.9	86.9	89.0	96.0	81.5	0.07	32.9	58.8	79.8	86.0	92.3	64.6	0.19
Paraguay	69.5	79.5	85.6	94.8	98.5	83.9	0.07	41.2	49.9	69.0	87.9	98.1	66.0	0.18
Peru	37.3	64.8	79.1	87.7	96.0	67.3	0.17	13.7	48.0	75.1	90.3	96.6	56.4	0.31
<b>Latin America and the Caribbean</b>	<b>57.5</b>	<b>72.3</b>	<b>80.6</b>	<b>89.7</b>	<b>95.6</b>	<b>76.0</b>	<b>0.11</b>	<b>40.2</b>	<b>58.4</b>	<b>72.9</b>	<b>85.6</b>	<b>94.3</b>	<b>65.8</b>	<b>0.20</b>
East Asia, Pacific	64.9	80.7	86.9	91.4	96.2	81.9	0.08	30.5	53.0	68.4	80.6	93.4	60.8	0.22
Central Asia	78.2	84.7	86.8	93.3	96.3	86.9	0.05	82.7	92.3	95.1	98.6	99.7	92.8	0.04
Middle East North Africa	13.7	21.1	33.4	49.3	73.0	35.2	0.32	12.8	21.7	37.7	58.6	82.2	38.5	0.36
Southeast Asia	16.8	23.2	28.8	43.0	70.9	34.6	0.30	5.3	8.1	11.7	21.9	49.3	17.7	0.46
Sub-Saharan Africa	61.1	69.5	74.9	84.2	93.6	75.7	0.10	24.6	32.9	41.2	59.2	82.1	46.2	0.26
<b>ALL COUNTRIES</b>	<b>55.0</b>	<b>64.8</b>	<b>71.1</b>	<b>80.6</b>	<b>91.0</b>	<b>70.8</b>	<b>0.13</b>	<b>31.2</b>	<b>42.1</b>	<b>51.6</b>	<b>66.2</b>	<b>84.0</b>	<b>52.5</b>	<b>0.25</b>

Source: World Bank (2004). Op. Cit. Demographic and Health Research (DHS) 2002.

In the richest 20% of the population, more than 90% receive institutional medical care during both pregnancy and childbirth. In



the poorest 20%, the deficits are severe. In Bolivia, 60% lack prenatal care, and 80% lack medical care during delivery. In Brazil, almost one-third of the poorest quintile lack medical attention in both cases. In Peru, in the poorest 20%, 60% lack care during pregnancy and 86% during childbirth.

Inequity among children is also prevalent in two key areas, in comprehensive vaccination coverage and the incidence of diarrhea. As can be seen below, the poorest 20% in Latin America have serious problems in both areas compared to the richest 20%. In terms of complete vaccination coverage, while 56% of the richest quintile is fully covered, only 39% of the poorest quintile receives coverage, which is 17% less. In Brazil, Bolivia, and Peru, the incidence of diarrhea in children more than doubles in the poorest 20% compared to the richest 20%.

**TABLE 8**  
**Comprehensive Immunization Coverage and Incidence of Diarrhea**

Country/region	Immunization coverage							Incidence of diarrhea (%)						
	1	2	3	4	5	Average	CI	1	2	3	4	5	Average	CI
Bolivia	21.8	24.9	21.0	33.4	30.6	25.5	0.08	21.8	19.8	20.5	17.9	11.7	19.2	-0.07
Brazil	56.6	74.0	84.9	83.1	73.8	72.5	0.07	18.3	12.9	12.7	9.3	7.4	13.1	-0.16
Colombia	53.8	66.9	68.2	70.6	74.1	65.5	0.06	18.4	19.8	16.8	14.9	10.0	16.7	-0.09
Dominican Republic	28.0	30.2	46.9	42.6	51.7	38.7	0.12	17.9	16.4	17.8	14.1	10.1	15.7	-0.08
Guatemala	41.2	43.0	47.2	38.3	42.5	42.6	0.00	22.8	21.5	23.3	17.7	16.0	20.9	-0.06
Haiti	18.8	20.1	35.3	37.9	44.1	30.2	0.17	30.9	27.1	24.4	31.6	20.4	27.4	-0.04
Nicaragua	61.0	74.6	75.3	85.7	73.1	72.6	0.05	16.1	14.0	14.2	14.4	8.7	14.0	-0.07
Paraguay	20.2	30.8	36.4	40.7	53.0	34.2	0.18	9.8	8.5	9.2	7.4	4.6	8.1	-0.11
Peru	55.3	63.8	63.5	71.7	66.0	63.0	0.04	21.4	20.3	18.6	14.1	9.3	17.9	-0.11
<b>Latin America and the Caribbean</b>	<b>39.6</b>	<b>47.6</b>	<b>53.2</b>	<b>56.0</b>	<b>56.5</b>	<b>49.4</b>	<b>0.09</b>	<b>19.7</b>	<b>17.8</b>	<b>17.5</b>	<b>15.7</b>	<b>10.9</b>	<b>17.0</b>	<b>-0.09</b>
East Asia, Pacific	48.3	56.8	60.3	64.6	72.9	59.3	0.08	10.5	9.9	9.9	8.6	6.3	9.3	-0.08
Central Asia	64.2	67.9	71.8	75.7	77.4	70.9	0.04	19.0	15.6	15.0	14.6	13.7	15.8	-0.02
Middle East	42.2	53.3	62.5	73.2	81.1	61.0	0.17	21.0	20.3	19.1	17.2	14.7	18.7	-0.06
North Africa														
Southern Asia	29.8	31.4	41.6	49.8	64.4	42.0	0.17	17.0	14.4	14.3	15.3	12.4	14.9	-0.04
Sub Saharan Africa	33.6	42.0	44.4	53.1	66.9	47.3	0.17	24.5	23.3	22.5	22.6	18.2	22.3	-0.05
<b>ALL</b>	<b>38.3</b>	<b>45.8</b>	<b>50.3</b>	<b>57.2</b>	<b>66.6</b>	<b>50.7</b>	<b>0.14</b>	<b>21.2</b>	<b>19.6</b>	<b>19.1</b>	<b>18.5</b>	<b>14.8</b>	<b>18.9</b>	<b>-0.05</b>

Source: World Bank (2004). op. cit. Demographic and health research (DHS) 2002.

### **The Relationship between Economic Inequality and Inequality in Health**

These and other health inequities are deeply intertwined in “perverse circles” that are fueled by the severe socioeconomic inequalities in Latin America. The result is that the most disadvantaged sectors have the slimmest probabilities in terms of health, which in turn sharply reduces their chances for economic improvement.

The connections between the general context of inequalities in Latin America and specific inequities in health are complex, and are manifested in many ways. In certain areas they are direct and almost brutal; in others more indirect but with a high impact nevertheless. Much research on these interactions remains to be done to achieve a better understanding of the operant mechanisms and reveal the most silent effects. The presence of these dynamics is an indisputable and fundamental fact. As emphasized by Wagstaff (2002), among others, what we know suggests that inequalities in health, and most likely in service utilization, in large measure reflect inequalities in variables at the individual and household level, such as education, income, location and housing characteristics.”

Understanding the “operant modes” of inequalities can prove highly relevant for designing policies, building partnerships in public health, and defining clear roles for the different stakeholders. Here we will present some examples, given the breadth of the issue, of how macro inequalities impact health determinants.

A key area of inequality that directly impacts health is the level of education. Many studies show that the accumulation of educational capital has a direct impact on areas such as infant mortality rates, the handling of infant feeding, children’s weight, disabilities, and life expectancy. Schkolnik (1998) provides the following table on the relationship between infant mortality and education levels in six Latin American countries.

**Table 9**  
**Differences in Infant of Mortality, circa 1990, according to**  
**Several Indicators in Selected Countries**

Socioeconomic indicators	Infant mortality rate					
	Guatemala	Honduras	Nicaragua	Peru	Panama	Chile
Total country	60	64	82	64	31	16
Rural	68	62	98	90	-	19
Urban	51	43	67	48	-	14
Indigenous population	64	-	-	-	80	45
Nonindigenous	53	-	-	-	23	-
Poor	76	68	88	66	-	-
Nonpoor	53	34	66	37	-	-
	Guatemala	Bolivia	Colombia	Peru	Mexico	Dom.Rep.
No schooling	82	124	60	124	83	102
Primary incomplete	86	108	40	85	64	76
Primary complete	61	65	-	42	46	57
High school and more	41	46	28	22	27	34

Source: Schkolnik, Suzanne (1998). Schkolnik, Susana (1998). Tendencias demográficas en América Latina: desafíos para la equidad en el ámbito de la salud. Celade. Santiago de Chile.

Infant mortality rates in households where the mothers did not finish primary school are much higher than in households where the mothers graduated from high school. The rates are double or more in Guatemala, Bolivia, Mexico, and the Dominican Republic, and they quadruple in Peru.

A study in Brazil (University of São Paulo, 1996) revealed close correlations between low weight of children and the educational level of their mothers. The low weight-for-age rates were 19.9% when the mothers had completed less than 3 years of formal education, and dropped to 3.35% when the mothers had completed 11 years or more. The low weight-for-height rates went from 24% for mothers with less than 3 years of education to 7% for mothers with 6 or more years.

Detailed studies in both Chile and Brazil indicate the robust correlation between educational levels and life expectancy. The table below presents statistics from Chile (Vega et al., 2003), showing life expectancy as a function of age or temporary life expectancy, for men and women aged 20 to 69, by education level.

**Table 10**  
**Temporary Life Expectancy of Adults Aged 20 to 69 by**  
**Educational Level: Chile, selected years 1985-1996**

Years of enrollment	1985-1987	1990-1992	1994-1996	Change 1985-1996
<i>Men</i>				
0	41.5	40.7	39.5	-2.0
1-8	44.8	44.7	44.7	-0.1
9-12	45.1	45.4	45.6	0.5
13 or more	47.7	47.8	48.1	0.4
Total	45.1	45.4	45.6	0.5
Difference between groups with higher and lower education levels	6.3	7.2	8.7	2.4
<i>Women</i>				
0	44.9	44.5	44.6	-0.3
1-8	47.3	47.5	47.6	0.3
9-12	47.9	47.9	47.9	0.0
13 or more	48.5	48.7	49.1	0.6
Total	47.4	47.5	47.8	0.4
Difference between groups with higher and lower education levels	3.6	4.2	4.5	0.9

Source: National Statistics Institute, Chile. Vega, Jeannette et al. (2003) in "Desafío a la falta de equidad en salud". PAHO, Rockefeller Foundation. Washington, D.C.

The lower the education level, the shorter the life expectancy. Furthermore, this gap is increasing. Life expectancy in men decreased by 2 years for men without education between 1980 and 1996, while it increased by 0.4 years for men with the highest education. Life expectancy in women declined by 0.3 years in the same period for women without education, while it increased by 0.6 years for women with high levels of education.

Comparative analysis of all data from Brazilian states (Messias, 2003) shows a clear correlation between years of schooling and average life expectancy in the state. It is estimated that a 10-unit increase in the illiteracy rate translates into 2.2 years less in life expectancy. The wide gaps in education in Latin America arrest or enhance opportunities in health and play a major role in keeping the most disadvantaged groups from benefiting from the "gains" in health resulting from progress in medicine.

Factors in the relationship between income level in different population strata and the quality of health care are multiple. They range from the most elementary aspects such as self-exclusion from medical care due to lack of income, to the correlation between income and heart disease found by some research studies (Marmot, 2001).

In a region with such unequal income distribution as Latin America, the repercussions of the skewed gap invade many aspects of health. Among other manifestations, PAHO research on exclusion in health in six Latin American countries (PAHO, 2003) found a consistent pattern of lack of demand for services despite perceived needs, in which the basic obstacle is income levels. In Paraguay, 51% of the population reported they had been sick or injured in the past three months but had not sought medical attention. When the data was stratified by income level, the percentage of people in the richest 20% that sought care was twice as high as the percentage in the poorest 20%. Furthermore, average per capita health expenditure in the latter group is six times lower than in the richest; however, out-of-pocket expenditures are higher for the poor. Income strongly affects consultations. This explains the high sensitivity of the poor to fees for public medical care. In Latin America and other places in the world, there have been “forced” decreases in demand by the most disadvantaged, leading to greater inequity in health.

In other areas, research in Brazil (Messias, 2003) has shown correlations between the minimum wage and infant mortality, causes of death and income, and social inequalities and violence. A basic right such as access to necessary medication is deeply affected by these inequalities. Evaluating the situation worldwide, the World Health Organization (WHO, World Health Report, 2003) estimates that 15% of the world’s population consumes 91% of the world’s pharmaceutical products.

Income level and participation in the formal or informal economy strongly influence access to health insurance. This has a major impact in a region where workers in the informal sector, who represented 40% of active nonagricultural labor in 1980, came to represent 60% in 2000. A basic characteristic of informal employment is its lack of social protection networks, including health protection.

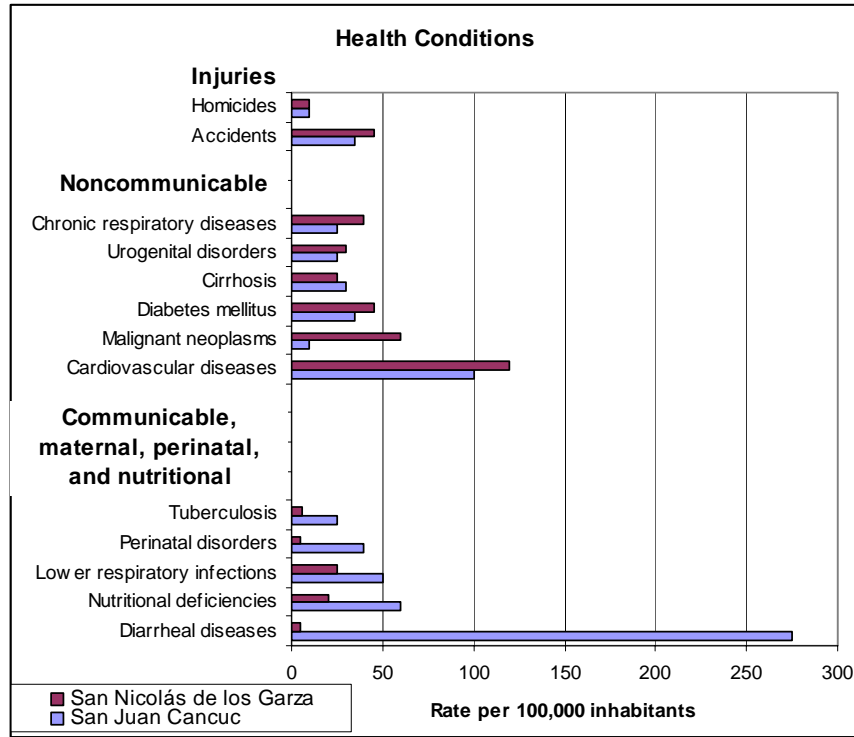
Income inequalities greatly influence the situation of senior citizens, who are at a critical stage in terms of their medical protection needs. Recent estimates indicate that 40% of adults over 65 years of age in Latin America receive neither a pension nor social security coverage.

Along with education and income, another relevant factor is the situation of the municipio. Gaps observed between municipios in good situations, average situations, and poor situations can be large and strongly influence health determinants.

Research in Mexico (Lozano et al., 2003) shows how very different community environments lead to widely divergent health indicators. The figure below compares a typical poor municipio in Chiapas with a richer one in Nuevo León.

**Figure 2**  
**Sociodemographic and Health Conditions in two municipios,**  
**Mexico, 1990-1996**

<b>Indicator</b>	<b>San Juan Cancuc (Chiapas)</b>	<b>San Nicolás de los Garza (Nuevo León)</b>
<b>Sociodemographic indicators</b>		
Exclusion	Very high	Very low
Population, 1995	27,750	436,603
Indigenous population as a percentage of the total	100	0.1
Illiteracy rate (percentage)	67	2
Average education (years)	4.2	8.2
Households with access to running water (percentage)	4	95
Households with access to sewage services (percentage)	45	92
Life expectancy (years) 1990-1996	62	71
<b>Economic indicators</b>		
GNP per capital (US\$), 1990	3	43.6
Health expenditure per capita (US\$), 1995	3	79



Sources: Authors' calculations

Lozano, Rafael, et al. (2003). In: "Desafío a la falta de equidad en salud". PAHO. Rockefeller Foundation. Washington, D.C.

The two municipios differ markedly in the main health determinants. Water supply, sewerage services, education levels, degrees of poverty and other variables are very dissimilar. All this leads to a higher mortality rate in San Juan Cancuc than in Nicolás Garza for all ages, and to a 13-year difference in life expectancy (58 years versus 71 years in 1993). The types of diseases found in each also vary greatly. In the poorer municipio, for example, diarrhea is common among children.

A study on 198 communities in Chile (Arteaga et al., 2002) found substantial differences in health, depending on the characteristics of the municipio. These included differences in health investment, coverage of basic services such as drinking water and wastewater disposal, and housing quality. One observation was that in some municipios, the use of primary health care services was 2.8 higher, emergency care 3.9 times higher, and hospital discharges twice as high.

A critical dimension of inequalities in the region, with all sorts of implications for inequity in health, is access to drinking water. Beneath the improving averages, significant gaps are evident when the statistics are disaggregated, as seen below.



**Table 11**  
**Percentage of Households With Running Water, by Deciles**  
**(First and Tenth), Income, and Geographical Area. Eleven**  
**countries in Latin America and the Caribbean, circa 1999**

Country		Percentage of households with running water		
		1st Decile	10th Decile	Total population
Bolivia	Urban	82.1	99.1	90.6
	Rural	14.3	41.5	23.0
Brazil	Urban	53.5	97.3	89.6
	Rural	2.6	32.3	19.3
Chile	Urban	96.8	99.7	98.8
	Rural	27.7	43.1	36.0
Colombia	Urban	91.1	99.2	97.4
	Rural (a)	71.4	91.8	78.2
	Rural (b)	29.6	41.0	31.2
Ecuador	Urban	56.2	90.8	75.3
	Rural (a)	42.3	49.4	46.3
	Rural (b)	11.2	26.3	18.5
El Salvador	Urban	39.3	88.8	70.5
	Rural	16.2	39.6	25.5
Jamaica	Kingston	95.7	100.0	97.4
	Urban	62.7	89.5	79.4
	Rural	23.2	54.8	38.8
Nicaragua	Urban	58.3	96.4	83.9
	Rural	7.3	53.3	30.5
Panama	Urban	84.0	100.0	95.4
	Rural	55.8	92.8	79.9
	Rural (c)	16.7	45.5	24.4
Paraguay	Indigenous	39.0	34.4	37.1
	Urban	35.0	87.7	66.9
Peru	Rural	1.8	30.6	13.3
	Urban	57.7	97.0	85.0
	Rural	35.0	34.4	41.9

**Source:** Informe Regional sobre la Evaluación 2000 en la Región de las Américas. Organización Panamericana de la Salud (HEP), 2001.

(a) Rural villages

(b) Scattered rural populations

(c) Remote rural areas

Access to water is radically different in rural and urban areas. Only 19% of households in rural Brazil have running water, in comparison with 89% of households in urban areas. To be part of a rural community anywhere on the continent means the likelihood of major difficulties in this respect. Furthermore, clear socioeconomic segmentation exists in access to potable water, in both rural and urban areas. In Brazil, only 53% of the poorest

decile has potable water, in comparison with 97% of the richest decile. In Peru, the figure is 57% versus 97%; and in Ecuador, 56% versus 90%.

The poor have difficulty accessing drinking water, are forced to purchase it at higher prices in some cases, and the cost of water has come to represent a proportionately higher percentage of their limited budget in comparison with the richest 20%. Expenditure on water among the poorest 10% in urban centers of Brazil and Ecuador is triple that of the richest 10%, and quadruple that of Colombia.

Not only do the poor have less access to water and pay more for it, but the water they ultimately obtain also tends to be of poorer quality. Recent research (Soares et al., 2002) summarizes inequity in drinking water in Latin America as follows: Families without household water supply spend a great deal of time getting water. For poorer families, this implies additional costs. Low-income families without household water connections spend as much money on water as do families with better incomes. Access to the means of household water disinfection is very limited among poor families, due to its relatively high cost, resulting in poorer quality drinking water for the lower-income population.

Inequalities also exist in access to household electricity and bathrooms, both factors in health.

### **An Overview**

In the most unequal region on Earth, the costs to major sectors of Latin America's population owing to these levels of social polarization are very high. Possibly one of the highest is the impact of disparities on health inequities. Roses (2003) acknowledged the importance of this for relevant issues such as years of life expectancy lost compared with potential averages. In Latin American countries with low income levels and narrow gaps, the figure is 13.2, while in countries with a relatively high income and wider gaps, the figure rises to 19.1. To address this problem, steps must be taken to put the discussion of these inequities at the center of public debate. As Roses says, inequities can only be eliminated when they are made visible.

#### **IV. Conclusions**

The Hemisphere greatly needs to return to an ethical approach to development. The ultimate test of whether a society is making progress is the relationship between its indicators and the main ethical values it holds. Latin America clearly has problems in this area. All of society proclaims its absolute support for mothers, children, families, and the elderly, whose well-being is an essential ethical value. Yet, health statistics reveal gross inequities that harm large groups in these sectors. It is essential to actively link ethics, economics, and health. The economy, as Pope John Paul II stressed (2000), should be ruled by ethics and guided by codes of ethics. It should ensure development with dignity for human beings. Health is a pillar of this development. Discussions on how to create a truly ethical economy should include guaranteeing universal access to public health.

Accepting ethics as a framework for goals and for evaluating economies leads to specific outcomes. All stakeholders should assume the resulting ethical responsibilities, addressing relevant issues such as ethical public policies, the aforementioned ethical performance of the private sector, and responsibilities in unions, universities, NGOs, the media, and other stakeholders. The challenges for health in Latin American are very specific. Jiménez and Romero pointed out in 2004 that forecasts predicted 400,000 child deaths in Latin America, most of them avoidable, including 127,000 in Brazil and 70,000 in Mexico. This is ethically unacceptable. Nothing is worth more than the lives of those children. Societies should maximize their efforts to decrease child mortality rates.

In this case as in others, opting for health cannot be delayed. If not resolved, health threats may become irreversible. It is indefensible to argue that we should wait until such-and-such a phase in the trickle-down model is reached and only then tend to children or the maternal mortality rate. Later will be too late. In health, we must apply what we call an “ethics of urgency.”

One argument, used repeatedly, is that we lack the resources. The more abundant the resources, the better. It is desirable and necessary to increase the gross national product, economic stability and achieve high levels of productivity, technological progress, and competitiveness. But all this cannot happen without improving the fortunes of the poor. Many similar experiences in Latin America underscore this, such as the doubling of the percentage of

poor in Chile during the military dictatorship, despite high growth rates; or the spread of poverty and inequality in the 1990s in Argentina, despite apparent macro advances.

Growth is necessary, but the issue of priorities in resource allocation will always exist. Poorer societies may achieve much better health outcomes than richer societies, because it is a real priority for them, and they implement high-level policies to achieve the outcomes. Furthermore, as Amartya Sen states (1999), the cost of establishing important health programs in poor countries is much lower. These programs require labor-intensive professional and paraprofessional workforces that cost much less than in rich countries. With much smaller investments, similar coverage levels can be provided. As Sen noted in the keynote address to the 52nd World Health Assembly, the issue is how to use resources even under financially conservative policies. In his words:

“massive expenses ... now go into the military in one poor country after another...It is an indication of the topsy-turvy world in which we live that the doctor, the school teacher, or the nurse feels more threatened by financial conservatism than does the general....”

Public opinion in Latin America—through surveys, electoral mandates, and various other evidence—is clamoring for ethics to rule and guide the economy. Public health in the Hemisphere in the 21<sup>st</sup> century should be one of the first issues to be examined in an ethical review of priorities, with real influence on resource allocation. There should be no further delay because an ethics of urgency is demanding accountability daily for the countless avoidable deaths and suffering.

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