Healthcare in developing countries

ASSIGN BUSTER

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For any country to make the transition from developing to developed, there are many factors that must work in unison in order to achieve this transition. These development goals cover a wide spectrum of factors that are simultaneouslyunrelated and interlocked[LL2]with one another. Although there are many different factors that push a country towards development, theprovision, and societal access to, healthcare[LL3]is almostunanimously agreed to be one of the most important signifiers in a countries transition. [LL4]

Most economic problems in developing countries are largely due to a high majority of the population living inpoverty[LL5]. In these countries, there are at least one billion people living on less than one US dollar aday[LL6]. There are two and a half billion people living on less than two US dollars a day. Regarding healthcare, just over one third of the population of the entire world lacks what we consider to be adequate health care (Bale). At its most basic root, the cost, access to, and availability of healthcare, like every other economic signifier we study, is determined by basic supply and demand. Simply put, we[LL7]have a distinct lack of adequate health care being supplied in these developing nations. Not only that, but those that need it most are not seeking out, or demanding, the healthcare they need toflourish[LL8]. There are many factors that lead to theseshortages[LL9]of supply and demand, as well as many theories and policies aimed at correcting these market inefficiencies. Whileeveryone[LL10]is essentially

working towards the same goal, there exist a multitude of different policies and interventions designed to achieve this goal.

The problems on the supply side facing developmental healthcare in these countries can be attributed to a few underlying factors. One of these factors can be boiled down to the same issue that causes most all economic issues: lack of resources (O'Donnell). The problems that face facilitating change without adequate resources inevitably leads to the misallocation of these resources and not utilizing them in the most effective, efficient way possible[LL11]. This misallocation of resources can take many forms, including concentrating said resources in improper geographic areas such as large, urban cities that do not necessarily require these economicinterventions[LL12]. Unfortunately, the majority of public health expenditure is still absorbed through hospital based care, which is virtually impossible for the poor, rural population of these developing countries to utilize (Peabody, Taguiwalo and Robalino). The insufficient resources at play affect the supply side of healthcare in that the capital required to actually get the train rolling is just not available to provide the adequate facilities, medicine, and proper personnel necessary to facilitate radical change in as many locations as needed (Peters, Garg and Bloom). The early years of the fight for improved healthcare worldwide consisted of many different types of policies aimed at reversing this trend, but even though some of them differed, one main goal persisted through each: accessibility of healthcare for the poor. As the years have gone on and the accessibility of these benefits has risen dramatically, the goal has shifted from correcting the lack

of accessibility to improving the inadequate quality of said healthcare (Peabody, Taguiwalo and Robalino).[LL13]

In these developing countries, obtaining and providing the facilities and supplies can go a long way toward achieving our healthcaregoals[LL14], but these issues represent only part of the problem. The real problem is then convincing those in poverty and in need of aid to utilize these resources. Clinics and medicine do no good, and as such represent further insufficient allocation of resources, if these interventions do nothing to foster demand for these services[LL15]. Once again,[LL16]the extreme poverty that these people are forced to live in become i s the main factor that dictates that lack of demand. But besides just that broad, all-encompassing, underlying reason of poverty,[LL17]we can look at two, more specific, factors that can suppress demand of all types across the economic landscape. These two factors are the outside constraints put on the consumer, in this case those without adequate healthcare, that limit their respective ability to consume, as well as the personal preferences of any individual that will lower their a willingness to consume (O’Donnell).

The outside constraints on these families and individuals that limit demand, especially in developing countries, are also influenced by a variety of factors that all work cohesively to make it so that those in poverty remain in poverty. Evidence shows that amount of household income earned has a strong positive relationship between standard of living and utilization of healthcare (Bale). Basically, the more money a family brings in, the more likely they are to utilize healthcare. This all comes back to resources, though this time it is the resources of the family as opposed to those ofthe

intervening party[LL18]. This makes sense though, as it stands to reason with the high price of healthcare, that some may start to view maintaining health and wellness as a luxury more than a necessity.[LL19]When you are living day to day and struggling as it is to put food on the table, certain things become prioritized overothers[LL20]. While relative income plays a large role, the actual price of receiving treatment becomes another huge deterrent in seeking out adequate healthcare (Peabody, Taguiwalo and Robalino). Many of these countries, and especially the poor population, do not have any sort of medical insurance. So all of these visits and trips to the doctor end up coming out of their ownpockets[LL21]. The high price of visits, in addition to a variety of different user fees possibly associated with treatment, make those living in poverty much more price sensitive than those that are better off. So while those that need it most remain in poor health, those that are well off may seek treatment for much less serious ailments. In addition to the actual costs associated with treatment, there exist costs outside of formal charges that may effectively filter out potential patients. Costs[LL22]associated include foregone earnings that would have been made that day, travel costs for treatments, as well as distance, time, effort, and poor road conditions all deter potential patients (O’Donnell). [LL23]

Even ifone[LL24]is financially able to pay treatment costs, there are a variety of preferential [LL25]factors that may prevent them from doing so. Cultural and gender issues can lead to a lower demand of healthcare, even if readily available. There is a great deal of history and tradition in developing countries, so much so that many people in these countries still utilize

traditional therapies of the culture rather than modern medicine. This trend to use traditional therapies is negatively related to income and education (Peters, Garg and Bloom). Helping these people to gain knowledge and further educate themselvesis[LL26]one of the first steps in solving this issue. Education can assist in just being able to recognize illness and the potential benefit of the modern treatments for these illnesses. Many of these societies culturally do not employ much gender equality, and as such, access to maternal, reproductive, and child health care has proven difficult (O'Donnell). Because so many people are ill, and there is not adequate treatment, rampant illness almost becomes the norm and severe illnesses become harder and harder to recognize[LL27]. A continued push for education would go a long way in alleviating some of these symptoms.

All of these factors regarding inadequate healthcare necessitate the introduction of financial interventions andaid[LL28]. Because there are so many underlying causes, there have been many theories and policies enacted in order to reverse this negativetrend[LL29]. Raising the utilization of effective interventions requires a multitude of different things. First, any raise in utilization is not possible without first introducing morecapital[LL30], and thendirecting[LL31]the spending of this capital towards themost effective programs[LL32]in order to maximize efficiency. These interventions should alsome[LL33]geographically proportional to population and need (Peabody, Taguiwalo and Robalino). Opening up a new facility in a large city thatdoesn't need one does not good.[LL34]Management of these operations must also be reformed to maximizeefficiency[LL35], and regulatory and political incentives must be introduced and provided in order to promote

utilization. Some of the more specific goals include extending health insurance coverage to more users (Bale). Although this is more of a long-term policy, growing this numberwill provide a great incentive for treatment. [LL36]Policies that aid the poor, such as subsidies and fee waivers, will greatly cut back on individualcosts of treatment[LL37]and promote care as well (Peters, Garg and Bloom).

Most of the surface issues associated with healthcare in developing countries can be attributed to an access problem and a quality problem. When we look closer though, we can see that these are just a few factors that can hold us back from achieving our MDG's. We now need to move towards alleviating some of the educational and income disparity issues, and the solving of these two problems, while by no means a clean, absolute fix, can provide great strides we may have yet to evensee[LL38].

Works Cited

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O'Donnell, Owen. " Access to Health Care in Developing Countries: breaking down demand side barriers." (2007).

Peabody, John W., et al. " Improving the Quality of Care in Developing Countries." *Disease Control Prioritites in Developing Countries* . 2006.

Peters, David H., et al. " Poverty and Access to Health Care in Developing Countries." *Annals of the New York Academy of Sciences* 25 July 2008.

Word Count: 1513

[LL1]Good start. But a few issues linger.

Grammar (esp. overuse of commas) makes following some of your writing challenging.

Missing some opportunity for critical/economic analysis.

Grade: 75 – 10 (late): 65

[LL2]These seem like opposites. How is this possible?

[LL3]Grammar/punctuation is not right

[LL4]Strong claim… citation?

[LL5]Citation?

[LL6]Which countries? Citation

[LL7]We?

[LL8]Why do you suppose? Citation?

[LL9]Is there a shortage? Sounds like you just said supply is low, but so is demand.

[LL10]?

[LL11]Wording?

[LL12]Examples? Why is this bad? Isn’t this where most of the people live?

[LL13]Why the switch in objectives? What were the results?

[LL14]Which are what?

[LL15]Really really strong claim… citation?

[LL16]? Does this tie into the previous supply discussion?

[LL17]wording

[LL18]?

[LL19]Not sure about this luxury vs necessity language…

(also Discussion from Poor Economics applies here)

[LL20]Yes

[LL21]Who ultimately pays when insurance is involved?

[LL22]Opportunity costs

[LL23]Possible solutions to the problems (and can you clarify… what are the problems? High prices? What if the costs or provision are high. Are high prices a problem?)

[LL24]Who?

[LL25]?

[LL26]Is? Citation?

[LL27]?

[LL28]Strong claim… Citation?

[LL29]Examples?

[LL30]From where?

[LL31]Who will direct it? Where?

[LL32]How will we know what these are?

[LL33]?

[LL34]?

[LL35]What do you mean by efficiency?

[LL36]What do you mean?

[LL37]Subsidies lower the costs? TANSTAAFL.

[LL38]More (economic) discussion is warranted… What are the incentives resulting in the status quo? The discussion regarding education is good, but can you be any more specific about how to address it?

Are the advantages and disadvantages for the solutions or only advantages?