

**Bibliographical Alert:
Health, Poverty, and Equity**

Number: 5

January 2003
Bangladesh Health Equity Watch (BHEW)

INTRODUCTION:

This bibliographical alert is a part of the activities of Bangladesh Health Equity Watch (BHEW). BHEW is a joint initiative of four organizations: Bangladesh Bureau of Statistics (BBS), Bangladesh Institute of Development Studies (BIDS), Bangladesh Rural Advancement Committee (BRAC) and ICDDR, B: Center For Health And Population Research. BHEW mainly deals with the equity aspect of the health sector of Bangladesh. It tries to determine whether the health situation of the country is improving and if so whether this improvement is equitable or not. BHEW's activities are designed to advocate policy response to redress inequities in health and health care. BHEW relies upon the three "pillars of action" that are considered to be most essential in eliminating inequity: measurement and monitoring, public participation and advocacy. BHEW will combine its activities around these three pillars in a complementary manner with an aim to stimulate response to tackle existing and emerging inequities. In order to sensitize the society in building strategies to fight inequity BHEW will also disseminate findings among policy makers, programme implementers, researchers, NGO leaders and civil society through mass media, seminars, and conferences, on a regular basis. Broader development issues including poverty and human right are also intended to be covered within the scope of BHEW in near future.

PURPOSE:

To alert all concerned individuals/organizations about health, equity and poverty related literatures.

SCOPE:

This 5th issue of the "Bibliographical Alert" includes a list of related articles published in journals or books till December 2002, with their complete references.

METHODOLOGY:

The most popular databases like popline, medline and other relevant Internet databases and publications of local and international health and development organizations were consulted in building this alert.

FREQUENCY OF PUBLICATION:

This "Bibliographical Alert" is being published quarterly.

AVAILABILITY:

Hard/electronic copies of the alert are distributed among interested individuals and organizations. Every attempt has been made to keep a copy of all the articles in this "Bibliographical Alert" at the BHEW secretariat. Electronic copies can also be obtained from: bhew@icddr.org.

1. Baumann LC, Chang MW, Hoebeke R. **Clinical outcomes for low-income adults with hypertension and diabetes.** *Nurs.Res.* 2002;**51**:191-8.

Ref ID: 1

Keywords: Adult/analysis/Blacks/blood/Caucasoid Race/Community Health Centers/Community Health Services/Comparative Study/Diabetes Mellitus/Diabetic Angiopathies/ epidemiology/ethnology/Female/Health Behavior/Hispanic Americans/Human/Hypertension/Male/Medically Uninsured/methods/Middle Age/Negroid Race/nursing/Outcome and Process Assessment (Health Care)/Poverty/Prevalence/Preventive Health Services/Risk/Risk Factors/standards/statistics & numerical data/United State/United States/Urban Health Services/Whites

Abstract: BACKGROUND: Long-term management of hypertension and diabetes, which are more prevalent in minority and socioeconomically disadvantaged populations, presents challenges for healthcare providers in community health centers. **OBJECTIVES:** The purpose of the study was twofold: to examine health outcomes for persons with hypertension and diabetes and to compare these outcomes for disparities in patients who were Black, Hispanic, or White. **METHODS:** Medical records (N = 280) from an urban community health center that serves predominantly uninsured adults were reviewed for selected clinical outcomes of primary care. Measures included outcomes of hypertension and diabetes control, lifestyle behaviors, preventive care, and patient status. Chi-square tests, t tests, and one-way analysis of covariance were used to analyze racial/ethnic group differences. **RESULTS:** Data revealed significant differences in smoking status, influenza immunization, and blood pressure. Racial/ethnic group differences were minimal compared with the overall high prevalence of risk factors such as smoking and obesity. Regular access to primary care did not result in improved clinical outcomes. **CONCLUSION:** The findings support the need for more effective interventions that promote healthy lifestyle if health disparities in low-income populations with chronic conditions are to be reduced.

2. Bemby JX, Anderson BK, Yaggy EO. **Mental health care for the poor: the Pro Bono Counseling Project.** *J Health Care Poor Underserved* 2002;**13**:273-9.

Ref ID: 2

Keywords: Baltimore/Counseling/economics/Health Services Needs and Demand/Human/Mental Health Services/Personnel Selection/Poverty/Uncompensated Care/United State/United States/Voluntary Workers

3. Bindman J, Tighe J, Thornicroft G, Leese M. **Poverty, poor services, and compulsory psychiatric admission in England.** *Soc.Psychiatry Psychiatr.Epidemiol* 2002;**37**:341-5.

Ref ID: 3

Keywords: Adolescent/Adult/analysis/Commitment of Mentally Ill/Community Mental Health Services/England/Female/Health Services Research/Human/London/Male/Mental Health Services/methods/Middle Age/Multivariate Analysis/Poverty/Quality of Health Care/Regression Analysis/Risk/statistics & numerical data/Support,Non-U.S.Gov't

Abstract: BACKGROUND: Compulsory admission is a central feature of psychiatric systems internationally but the factors determining its use within different legal systems are not understood. Numbers of compulsory psychiatric admissions vary widely between areas in England. We examined the hypothesis that variation in rates of detention is related to social deprivation and also to the functioning of local mental health services. **METHODS:** Rates of detention under sections 2 and 3 of the Mental Health Act (1983) in 1998/9 were obtained in 34 mental health sectors in eight Trusts in England. Measures of socio-economic deprivation and measures of service function were used to conduct an ecological analysis. **RESULTS:** Compulsory admission is associated with measures of deprivation but there is unexplained variation. The range in rates is higher than allowed for by the resource allocation

formula. Some indicators of service quality are independently associated with rates of detention. **CONCLUSIONS:** Variation in detention rates and its relation to service function need further explanation if the use of compulsion is to be reduced.

4. Blair AS, Lloyd-Williams F, Mair FS. **What do we know about socioeconomic status and congestive heart failure? A review of the literature.** *J Fam.Pract.* 2002;51:169.

Ref ID: 4

Keywords: Data Collection/epidemiology/Health Services/Health Services Accessibility/Heart Failure,Congestive/Hospitalization/Human/Income/Morbidity/Mortality/Prevalence/Primary Health Care/Psychosocial Deprivation/Research/Risk/Socioeconomic Factors/therapy/United State/United States/utilization

Abstract: **OBJECTIVE:** To examine and assess the available literature concerning the effects of socioeconomic status (SES) and congestive heart failure (CHF). **STUDY DESIGN:** We examined electronic databases, including: MEDLINE, EMBASE, Social Science Citation Index, Science citation index, the Cochrane Database, and Bandolier. We hand searched recent copies of appropriate journals and scrutinized lists of identified papers. The search terms we used included "heart failure," "cardiac failure," "ventricular dysfunction," "social class," "socioeconomic," "poverty," and "deprivation." Two reviewers independently examined and selected papers for inclusion. A standardized data collection form was used for data extraction. **OUTCOMES MEASURED:** We measured (1) prevalence; (2) differences in care (eg, use of diagnostic tests); (3) morbidity (eg, health care use); and (4) mortality. **DATA SOURCES:** We examined all English-language abstracts or papers concerning human research related to the subject of SES and CHF, including all clinical trials, reviews, discussion papers, and editorials. **RESULTS:** Only 8 clinical studies were identified that specifically examined aspects of the relationship between socioeconomic status and CHF. Key themes included increased hospitalization rates with increasing social deprivation; lower income inversely associated with being placed on a waiting list for transplantation; and that those of lower socioeconomic status had a greater severity of illness on admission. **CONCLUSIONS:** There is a paucity of generalizable high-quality research in this subject area. Crucial issues not addressed include the effects, if any, of socioeconomic status on the behaviors of health care providers. Further investigation, with a more holistic approach, is necessary to inform future intervention strategies aimed at reducing excess mortality from CHF.

5. Boyle P, Norman P, Rees P. **Does migration exaggerate the relationship between deprivation and limiting long-term illness? A Scottish analysis.** *Soc.Sci.Med.* 2002;55:21-31.

Ref ID: 5

Keywords: Adolescent/Adult/analysis/Censuses/Child/Child,Preschool/Chronic Disease/Confounding Factors (Epidemiology)/Cultural Deprivation/Emigration and Immigration/England/epidemiology/Female/Health Services Research/Health Status Indicators/Human/Infant/Infant,Newborn/Logistic Models/Male/Middle Age/Poverty Areas/Public Housing/Residence Characteristics/Scotland/Socioeconomic Factors/statistics & numerical data

Abstract: Few epidemiological studies of the links between health and environmental variables account for the potentially confounding effects of population migration. Here we explore the relationship between self-reported limiting long-term illness and material deprivation, using individual-level 1991 census data extracted for Scotland. The aim is to investigate whether the migration patterns of ill individuals influences the relationship between limiting long-term illness and material deprivation. Specifically, we seek to determine whether individuals who are well are more likely to migrate away from deprived areas and whether ill individuals are more likely to migrate towards deprived areas. If true, this would suggest that the apparent relationship between deprivation and limiting long-term illness is exaggerated by the

effects of migration. We then examine the issue controlling for individual-level characteristics expected to influence limiting long-term illness and pay special attention to the role of public housing in these relationships.

6. Braveman P., Tarimo E. **Social inequalities in health within countries: not only an issue for affluent nations.** *Social Science and Medicine* 2002.

Ref ID: 6

Keywords: inequalities/ affluent nations/ health/ disparities/ primary health care

Abstract: While interest in social disparities in health within affluent nations has been growing, discussion of equity in health with regard to low- and middle-income countries has generally focused on north south and between-country differences, rather than on gaps between social groups within the countries where most of the world's population lives. This paper aims to articulate a rationale for focusing on within- as well as between-country health disparities in nations of all per capita income levels, and to suggest relevant reference material, particularly for developing country researchers. Routine health information can obscure large inter-group disparities within a country. While appropriately disaggregated routine information is lacking, evidence from special studies reveals significant and in many cases widening disparities in health among more and less privileged social groups within low- and middle- as well as high-income countries; avoidable disparities are observed not only across socioeconomic groups but also by gender, ethnicity, and other markers of underlying social disadvantage. Globally, economic inequalities are widening and, where relevant information is available, generally accompanied by widening or stagnant health inequalities. Related global economic trends, including pressures to cut social spending and compete in global markets, are making it especially difficult for lower-income countries to implement and sustain equitable policies. For all of these reasons, explicit concerns about equity in health and its determinants need to be placed higher on the policy and research agendas of both international and national organizations in low-, middle-, and high-income countries. International agencies can strengthen or undermine national efforts to achieve greater equity. The Primary Health Care strategy is at least as relevant today as it was two decades ago; but equity needs to move from being largely implicit to becoming an explicit component of the strategy, and progress toward greater equity must be carefully monitored in countries of all per capita income levels. Particularly in the context of an increasingly globalized world, improvements in health for privileged groups should suggest what could, with political will, be possible for all.

7. Ewart CK., Suchday S. **Discovering how urban poverty and violence affect health: development and validation of a Neighborhood Stress Index.** *Health Psychol.* 2002;21:254-62.

Ref ID: 7

Keywords: Adolescent/Affect/Blood Pressure/Cities/Depressive Disorder/education/epidemiology/Female/Health Status Indicators/Hostility/Human/Male/Poverty/Questionnaires/Research/Residence Characteristics/Social Desirability/Socioeconomic Factors/statistics & numerical data/Support,U.S.Gov't,P.H.S./United State/United States /Urban Health /Violence

Abstract: Health problems of the urban poor have been attributed to psychosocial effects of environmental stress. Testing such models requires an ability to measure neighborhood characteristics that make life stressful. The City Stress Inventory (CSI) uses self-report to assess perceived neighborhood disorder and exposure to violence. Data from an interracial sample of urban adolescents show the CSI to be internally consistent, stable, and correlated with census indices of social disadvantage. Validity for stress research is indicated by correlations with trait depression, anger, hostility, self-esteem, and mood changes during a debate with an unfamiliar peer. The CSI can be completed by persons with an 8th-grade education.

8. Fallon PR and Lucas RE. **The impact of financial crises on labor markets, household incomes, and poverty: a review of evidence.** World Bank Research Observer. 2002.

Ref ID: 8

Keywords: income/poverty/East Asia/Mexico/employment/

Abstract: The 1990s have witnessed several financial crises, of which the East Asia and Mexico tequila crises are perhaps the most well known. What impact have these crises had on labor markets, household incomes, and poverty? Total employment fell by much less than production declines and even increased in some cases. However, these aggregates mask considerable churning in employment across sectors, employment status, and location. Economies that experienced the sharpest currency depreciations suffered the deepest cuts in real wages, though deeper cuts in real wages relative to GDP were associated with smaller rises in unemployment. To some extent, families smoothed their incomes through increased labor force participation and private transfers, though the limited evidence available suggests that wealthier families were better able to smooth consumption. The initial impact of the crises was on the urban corporate sector, but rural households were affected as well and in some instances suffered deeper losses than did urban families. School enrollment declined, especially among poorer families, as did use of health facilities, but the impact on children's nutrition levels appears to vary. Crises have typically proved short-lived, but whether households plunged into poverty during a crisis are able to recover as the economy does remains an open question.

9. Fone D, Jones A, Watkins J, Lester N, Cole J, Thomas G *et al.* **Using local authority data for action on health inequalities: the Caerphilly Health and Social Needs Study.** *Br.J Gen.Pract.* 2002;**52**:799-804.

Ref ID: 9

Keywords: Cross-Sectional Studies/England/Health Services Needs and Demand/Health Status/Human/Needs Assessment/organization & administration/Poverty Areas/Primary Health Care/Support,Non-U.S.Gov't/Wales

Abstract: BACKGROUND: Primary care organisations in the United Kingdom have been given new and challenging population health responsibilities to improve health and address health inequality in local communities through partnership working with local authorities. This requires robust health and social needs assessment data for effective local planning. **AIM:** To assess the use and value of local authority data shared through partnership working between Caerphilly Local Health Group and Caerphilly County Borough Council. **Design of study:** Cross-sectional analysis of aggregate electoral division data. **Setting:** Caerphilly County Borough, south-east Wales. **Method:** Local authority datasets identified were categorised into one of six domains: income, unemployment, housing, health, education, and social services. Data were presented at electoral division level as rates in thematic maps and correlations between the variables within and between each domain were explored using Spearman's rank correlation coefficient, with particular focus on children in families. Local planning documents were scrutinized to ascertain the use and value of the data. **Results:** A broad range of data described a comprehensive picture of health and social inequalities within the borough. Multiple deprivations tended to cluster in electoral divisions, particularly for data relating to children, painting an overwhelming picture of inequality in life chances. The data were used in a wide range of local partnership planning initiatives, including the Health Improvement Programme, Children's Services Plan, and a successful Healthy Living Centre bid. **Conclusion:** Local authority data can help primary care organizations in a population approach to needs assessment for use in local partnership planning targeted at reducing health inequalities.

10. Frisby W, Hoeber L. **Factors affecting the uptake of community recreation as health promotion for women on low incomes.** *Can.J Public Health* 2002;**93**:129-

33.

Ref ID: 10

Keywords: Canada/Community Health Services/economics/Female/Health Promotion/Human/Income/Interviews/methods/physiology/Poverty/Recreation/Research/Support,Non-U.S.Gov't/Women/Women's Health

Abstract: **BACKGROUND:** There have been repeated calls for research on the factors that promote the spread of successful local health promotion initiatives from one community to another. We examined the factors that affected the uptake of an initiative designed in one community to improve the health of women living below the poverty line through increased access to community recreation. **METHODS:** Workshops were held in three other communities and uptake efforts were tracked for one year through follow-up site visits and telephone interviews with workshop participants. **RESULTS:** Making the issue a priority, actively involving the women in planning, pooling resources, sharing responsibility through partnerships, and addressing the structural dimensions of poverty were factors that enabled uptake. Factors that inhibited uptake included an emphasis on revenue generation, professionally led planning, inadequate attention to structural barriers, the undervaluing of certain resources, and an over-reliance on one idea champion. **CONCLUSION:** A shift in how municipal recreation departments view their role as partners in community health promotion is required if programs are to promote health and be accessible to under-served populations.

11. Greene ME, Rasekh Z, Amen KA, Chaya N, Dye J. **Republic of Mali: poverty and poor health slow progress.** *Population Action International* 2002.

Ref ID: 11

Keywords: Mali/ poverty/ poor/ health

12. Guendelman S, Wyn R, Tsai YW. **Children of working poor families in California : the effects of insurance status on access and utilization of primary health care.** *J Health Soc.Policy* 2002;**14**:1-20.

Ref ID: 12

Keywords: Family/Primary Health Care/United State/United States /utilization

Abstract: We examined the effects of health insurance on access and utilization of health care among children of working poor families. These children experience strong access barriers yet have not been studied systematically. 1,492 children in California under 19 years old who had workforce participating parents and a subset of full-time year round working families earning below 200% of poverty were examined from the 1994 National Health Interview Survey. Thirty-two percent of children of working poor families were uninsured in California compared with 26% nationwide. Difficulties in accessing a regular care source and obtaining after-hour care were markedly higher in California. Full-time year round work did not increase insurance coverage and worsened access to a regular source of care. Uninsured children in California were far more likely than insured children to face access barriers and less likely to see a physician in the previous year. Between privately and publicly insured children, the gap in access and utilization narrowed markedly. Health insurance is critical for children in working poor families. Healthy Families, California's response to CHIP, could improve coverage for this population.

13. Guendelman S, Schauffler H, Samuels S. **Differential access and utilization of health services by immigrant and native-born children in working poor families in California.** *J Health Care Poor Underserved* 2002;**13**:12-23.

Ref ID: 13

Keywords: Adolescent/California/Child/Child Health Services/Child Welfare/Child,Preschool/Comparative Study/Disabled Children/economics/Emigration and Immigration/epidemiology/Family/Female/Health Care Surveys/Health Services/Health Services Accessibility/Health Status/Human/Male/Medically Uninsured/National Center for Health Statistics (U.S.)/Poverty/Social Class/statistics & numerical data/Support,Non-U.S.Gov't/United State/United States/utilization

14. Hall SA, Rockhill B. **Race, poverty, affluence, and breast cancer.** *Am.J Public Health* 2002;**92**:1559.

Ref ID: 14

Keywords: Adult/Age Factors/Blacks/Breast Neoplasms/economics/epidemiology/ethnology/Female/Georgia/Human/Incidence/Middle Age/Poverty/Risk Factors/SEER Program/Social Class/statistics & numerical data/United State/United States/Urban Health /Whites

15. Jha P, Mills A, Hanson K, Kumaranayake L, Conteh L, Kurowski C *et al.* **Improving the health of the global poor.** *Science* 2002;**295**:2036-9.

Ref ID: 15

Keywords: Adult/Child/Delivery of Health Care/economics/Female/Government/Health Care Costs/Health Expenditures/Health Services Accessibility/Health Status/Human/Immunization Programs/Medically Underserved Area/Mortality/Poverty/Pregnancy/Preventive Health Services/Public Policy/Support,Non-U.S.Gov't/United State/United States/World Health /World Health Organization

Abstract: We analyzed the technical basis for a major global program to reduce disease among the poor. Effective interventions exist against the few diseases which most account for excess mortality among the poor. Achieving high coverage of effective interventions requires a well-functioning health system, as well as overcoming a set of financial and nonfinancial constraints. The annual incremental cost would be between \$40 billion and \$52 billion by 2015 in 83 low-income and sub-Saharan African countries. Such a program is feasible and would avoid millions of child, maternal, and adult deaths annually in poor countries.

16. Keenan HT, Foster CM, Bratton SL. **Social factors associated with prolonged hospitalization among diabetic children.** *Pediatrics* 2002;109:40-4.
Ref ID: 16
Keywords: Adolescent/Adult/Blacks/Child/Child,Preschool/Cohort Studies/Diabetes Mellitus,Insulin-Dependent/Diabetic
 Coma/economics/epidemiology/ethnology/Female/Health Care Surveys/Hospitalization/Human/Incidence/Infant/Length of Stay/Male/Medicaid/methods/Multivariate Analysis/Poverty/Risk/Risk Factors/Socioeconomic Factors/statistics & numerical data/United State/United States /Whites
- Abstract:** **OBJECTIVE:** To determine social factors associated with increased risk of hospital admission from diabetic ketoacidosis (DKA) or diabetic coma as well as risk of prolonged hospital stay. **METHODS:** A cohort of all children (≤ 21 years) with type 1 diabetes mellitus (DM) in the National Inpatient Sample admitted for DKA or diabetic coma during 1996 or 1997 was conducted. Patients' age, race, gender, and insurance coverage were identified. Length of stay and charges were examined; prolonged length of stay was defined as ≥ 7 days. **RESULTS:** A total of 8443 children with a primary hospital diagnosis of DKA and 123 children with type 1 DM and coma were identified; 55% of the children were girls, 32% were nonwhite, 29% received Medicaid insurance, and 33% resided in areas of poverty. Children with prolonged hospital stay were significantly more likely to be of nonwhite race (odds ratio [OR]: 2.0; 95% confidence interval [CI]: 1.6-2.5), to receive Medicaid insurance (OR: 1.4; 95% CI: 1.1-1.7), to live in areas of poverty (OR: 1.3; 95% CI: 1.1-1.7), and to be of younger age. **CONCLUSIONS:** When compared with state census data, nonwhite and poor children were more likely to be admitted with complications of DM and to have significantly prolonged and expensive hospital stays. These children should be targeted for intensive diabetes education and outpatient medical support both to improve their health and potentially to decrease total health care costs.
17. Khoury AJ, Weisman CS. **Thinking about women's health: the case for gender sensitivity.** *Women's Health Issues* 2002.
Ref ID: 17
Keywords: health/women/gender
18. Lalthapersad-Pillay P. **The effects of poverty on women.** *Africa Insight* 2002.
Ref ID: 18
Keywords: poverty/women/gender/social services/education
- Abstract:** Poverty is a multi-dimensional concept that transcends material well-being and is borne disproportionately by males and females. In poor households, women undertake more work than men, are less educated than men and have less access to income-earning activities. Gender relations systematically deny rural women access to land and tenancy rights, institutional support in terms of training programs and extension services, rural credit, farming inputs and other commodities that are vital to socio-economic well-being (Brohman, 1996:279). Tackling poverty depends on the application of sound development strategies. The provision of social services, constitute the essentialness of any long-term strategy for reducing poverty.
19. Legge D. **Globalisation and health. Challenges of globalisation deserve better than simplistic polemics.** *BMJ* 2002;324:44-5.
Ref ID: 19
Keywords: Commerce/Developing Countries/England/Human/Poverty/Social Justice/World Health
20. Leveque A, Humblet PC, Wilmet-Dramaix M, Lagasse R. **Do social class differentials in health and health behaviors exist in young people (15-to-24-year-olds) in Belgium?** *Rev.Epidemiol Sante Publique* 2002;50:371-82.
Ref ID: 20

Keywords: Adult/education/Health Behavior/Health Policy/Income/methods/Poverty/Social Class

Abstract: Background: Socio-economic differentials in health are a reality in adults but their postulated persistence throughout the life-course is a subject of discussion. **Methods:** Given the real socio-economic inequalities in the health of the adult population in Belgium, we used the 1997 national health survey data to measure these inequalities in the population between the ages of 15 and 24 years, inclusive. Concentration indices were calculated for three health-related variables, namely, subjective health, smoking, and drinking, in connection with various socio-economic indicators specific to the individual and/or the household (occupation, education, income, poverty, socio-economic insecurity). **Results:** These concentration indices confirmed the existence of socio-economic differentials in the health of these 15-to-24-year-olds in Belgium. The data showed that a "poor health" status for subjective health and smoking was more frequent in the most disadvantaged socio-economic groups and for daily drinking more frequent in the better-off socio-economic groups. **Conclusions:** We found a relative diversity in the magnitudes of the inequalities measured depending on the parameters used for their quantification. However, there was an overlapping convergence and reproducibility of the patterns in the general directions of the inequality measurements, as follows: the results for a given indicator were remarkably consistent, regardless of the socio-economic variable studied. This consistency argues in favour of the confirmation of socio-economic class differentials in health in 15- to 24-year-olds in Belgium.

21. Nierenberg D. **Correcting gender myopia: gender equity, women's welfare and the environment.** Worldwatch Paper No. 161. 2002.

Ref ID: 21

Keywords: gender/ equity/ gender myopia/ women/ environment/ welfare

22. Porell FW, Miltiades HB. **Regional differences in functional status among the aged.** *Soc.Sci.Med.* 2002;**54**:1181-98.

Ref ID: 22

Keywords: Activities of Daily Living/Aged/Chronic Disease/classification/Demography/Disabled Persons/England/Environmental Health/epidemiology/Female/Frail Elderly/Geography/Health Status/Health Surveys/Human/Life Style/Male/Massachusetts/Medicare/nursing/physiology/Population Density/Poverty/Prevalence/Risk/Risk Factors/Risk-Taking/Socioeconomic Factors/statistics & numerical data/Support,Non-U.S.Gov't/United State/United States /utilization/Women

Abstract: This study investigated regional differences in functional status among aged Medicare beneficiaries in the United States, and the degree to which population risk factors and certain geographic/environmental attributes of communities accounted for the regional differences. Four years of the Medicare Current Beneficiary Survey (1992-1995) were pooled together yielding 37,150 person-year observations of functional status for a sample of aged Medicare beneficiaries residing in the community or nursing homes. Multinomial logit models, estimated on a four-category functional status scale, produced strong empirical evidence of substantial regional differences in the prevalence of functional independence, functional limitations, IADL limitations, and ADL limitations, that could not be attributed to regional population composition, socio-demographic factors, lifestyle characteristics, and chronic medical conditions. Although such population risk factors accounted for much of the regional variations in functional status among older men, the notably higher prevalence of IADL and ADL limitations among older women residing in the Deep South could not be similarly attributed to such risk factors. Rather, the empirical results suggest that a significant portion of the harmful effects associated with residence in the Deep South among older women may be attributed to a higher

prevalence of residence in counties characterized by lower population density and/or higher poverty concentration.

23. Porter A. **Globalisation and health. Globalisation is not good for your health.** *BMJ* 2002;**324**:46.
Ref ID: 23
Keywords: Commerce/Developing Countries/England/Human/Poverty/Social Justice/World Health
24. Pugh LC, Milligan RA, Frick KD, Spatz D, Bronner Y. **Breastfeeding duration, costs, and benefits of a support program for low-income breastfeeding women.** *Birth* 2002;**29**:95-100.
Ref ID: 24
Keywords: Adolescent/Adult/Baltimore/Blacks/Breast Feeding/Community Health Nursing/Cost-Benefit Analysis/economics/Family/Female/Health Care Costs/Human/Income/Infant/Infant Food/Infant,Newborn/Maternal Welfare/methods/Mid-Atlantic Region/Mothers/nursing/Peer Group/Poverty/Program Evaluation/psychology/Social Support/statistics & numerical data/Support,U.S.Gov't,P.H.S./Time Factors/United State/United States /Women

Abstract: BACKGROUND: Breastfeeding can ameliorate some of the complex health issues faced by low-income families. Women who breastfeed and their infants have lower health care costs compared with those who formula feed. Increasing the duration of breastfeeding is recognized as a national priority, particularly for low-income women. This community-based randomized clinical trial involving low-income mothers compared usual care with an intervention comprising hospital and home visits, and telephone support by a community health nurse/peer counselor team for 6 months after delivery. **METHODS:** Forty-one women were recruited after delivery of a full-term singleton infant and randomly assigned to intervention or usual care groups. **RESULTS:** Women receiving the community health intervention breastfed longer than the women receiving usual care. The infants in the intervention group had fewer sick visits and reported use of fewer medications than infants in the usual care group. The intervention cost (\$301/mother) was partially offset by cost savings on formula and health care. **CONCLUSIONS:** Community health nurse and peer counselor support can increase breastfeeding duration in low-income women, and has the potential to reduce total costs including the cost of support.

25. Reber VB. **Poor, ill, and sometimes abandoned: tubercular children in Buenos Aires, 1880-1920.** *J Fam.Hist* 2002;**27**:128-49.
Ref ID: 25
Keywords: Adolescent/Argentina/Child/Child Welfare/Child,Preschool/Chronic Disease/diagnosis/Government/Health Policy/history/History of Medicine,19th Cent./History of Medicine,20th Cent./Human/Infant/Poverty/Public Health/Tuberculosis/United State/United States /Urban Health

Abstract: children with chronic diseases, such as tuberculosis, have faced difficult lives. Poverty proved a factor in their susceptibility to disease, their abandonment, and their treatment. When public health policies in Buenos Aires shifted from ignoring children to viewing them as victims who needed protection, government agencies, charitable organizations, public schools, and hospitals developed special programs that emphasized both prevention and cure of childhood tuberculosis. Argentine physicians and hygienists supported programs that were similar to those in Europe and the United States. Despite efforts, from 1880 to 1920, diagnosis of tuberculosis remained problematic, health professionals failed to prevent tuberculosis in children, and physicians were unable to cure the disease.

26. Rich-Edwards J. **Teen pregnancy is not a public health crisis in the United States. It is time we made it one.** *Int.J Epidemiol* 2002;**31**:555-6.
Ref ID: 26
Keywords:

Adolescent/England/Female/Human/Motivation/Poverty/Pregnancy/Pregnancy in Adolescence/psychology/Public Health/United State

27. Richards HM, Reid ME, Watt GC. **Socioeconomic variations in responses to chest pain: qualitative study.** *BMJ* 2002;**324**:1308.

Ref ID: 27

Keywords: Anxiety/Chest Pain/economics/England/Family/Female/Human/Interviews/Male/Middle Age/Patient Acceptance of Health Care/Physician-Patient Relations/Poverty/psychology/Risk/Scotland /Self Concept/Social Class/Support,Non-U.S.Gov't/therapy/Women

Abstract: **OBJECTIVE:** To explore and explain socioeconomic variations in perceptions of and behavioral responses to chest pain. **DESIGN:** Qualitative interviews. **SETTING:** Community based study in Glasgow, Scotland. **PARTICIPANTS:** 30 respondents (15 men and 15 women) from a socioeconomically deprived area of Glasgow and 30 respondents (15 men and 15 women) from an affluent area of Glasgow. **OUTCOME MEASURES:** Participants' reports of their perceptions of and actions in response to chest pain. **RESULTS:** Residents of the deprived area reported greater perceived vulnerability to heart disease, stemming from greater exposure to heart disease in family members and greater identification with high risk groups and stereotypes of cardiac patients. This greater perceived vulnerability was not associated with more frequent reporting of presenting to a general practitioner. People from the deprived area reported greater exposure to ill health, which allowed them to normalize their chest pain, led to confusion with other conditions, and gave rise to a belief that they were overusing medical services. These factors were associated with a reported tendency not to present with chest pain. Anxiety about presenting chest pain among respondents in the deprived area was heightened by self-blame and fear that they would be chastised by their general practitioners.

28. Santana P. **Poverty, social exclusion and health in Portugal.** *Social Science and Medicine*.2002.

Ref ID: 28

Keywords: poverty/ health/ Portugal/ social exclusion

Abstract: People in Portugal have never been so healthy. Nevertheless, there are great differences in health status between social groups and regions. In 1994, Portugal was the country with the second worst level of inequality in terms of income distribution and with the highest level of poverty in the European Union (EU). Poverty in Portugal affects mainly the elderly and women (especially in single parent families). Beyond these groups, there are the children, the ethnic minorities and the homeless. Substance abusers, the unemployed, and ex-prisoners are also strongly affected by situations of social exclusion and poverty. Although poverty has been an important issue on the political agenda in Portugal, it shows a worrying tendency to resist traditional Social Security interventions. In the late 1990s, however, welfare coverage rates appear to have risen. To what extent can poverty cause a worsening of health status? Is there any sustainable positive association between welfare and improved health status? How, to whom and when should actions to improve the health status of the disadvantaged be addressed, without subverting the health status of the rest of the population. It is also necessary to reveal the consequences of poor health to individuals, families and communities in terms of income, social empowerment and the ability to fulfill other needs. Finally, reflection on the role and effectiveness of traditional social security models is necessary, in order to improve the impact and adequacy of its interventions. The goal of this paper is to contribute to the knowledge about disadvantage, the current health situation of the most vulnerable groups in Portuguese society-those affected by poverty, deprivation and social exclusion-and to detect the constraints on access to health and health care.

29. Sen A. **Why should there be equity in health?** *Rev. Panam. Salud Publica* 2002;11:302-9.
Ref ID: 29
Keywords: Female/Goals/Health Care Costs/Health Policy/Health Resources/Health Services Accessibility/Human/Latin America/Life Expectancy/Male/Poverty/Quality-Adjusted Life Years/Social Justice/Socioeconomic Factors/supply & distribution/United State/United States/WorldHealth Organization
30. Sidley P. **Health, poverty, and sanitation to feature highly in world summit.** *BMJ* 2002.
Ref ID: 30
Keywords: health/ poverty/ sanitation
31. Singh V, Jaiswal A, Porter JD, Ogden JA, Sarin R. **TB control, poverty, and vulnerability in Delhi, India.** *Tropical Medicine and International Health* 2002.
Ref ID: 31
Keywords: TB/ Delhi/India/poverty
32. Singh GK, Miller BA, Hankey BF, Feuer EJ, Pickle LW. **Changing area socioeconomic patterns in U.S. cancer mortality, 1950-1998: Part I--All cancers among men.** *J Natl. Cancer Inst.* 2002;94:904-15.
Ref ID: 32
Keywords: Adolescent/Adult/analysis/epidemiology/Human/Incidence/Income/Male/methods/Mortality/Neoplasms/physiopathology/Population Density/Poverty/Regression Analysis/Sex Characteristics/Socioeconomic Factors/Unemployment/United State/United States /trends
- Abstract: BACKGROUND:** Lung cancer and colorectal cancer are leading causes of U.S. cancer mortality. Because mortality rates for many cancers vary by socioeconomic characteristics, we used area socioeconomic indices to examine patterns in U.S. lung and colorectal cancer mortality between 1950 and 1998. **METHODS:** A factor-based area socioeconomic index was linked to 1950-1998 county mortality data to generate annual lung and colorectal cancer mortality rates for each area socioeconomic group. Joinpoint regression analysis was used to model and identify statistically significant changes in the mortality trends. **RESULTS:** Area socioeconomic patterns in U.S. lung cancer mortality changed dramatically between 1950 and 1998. Men aged 25-64 years and those aged 65 years or older in higher socioeconomic areas generally had higher lung cancer mortality than did those in lower socioeconomic areas during 1950-1964 and 1950-1980, respectively. Area socioeconomic differences in lung cancer mortality began to reverse and widen by the early 1970s for younger men and by the mid-1980s for older men. In 1998, lung cancer mortality was 56% (95% confidence interval [CI] = 49% to 64%) higher for younger men and 38% higher (95% CI = 34% to 43%) for older men in the lowest area socioeconomic group than for the same age groups in the highest area socioeconomic group. Lung cancer mortality among older women in all socioeconomic groups increased sevenfold to eightfold between 1950 and 1998, with higher mortality in higher area socioeconomic groups. The positive socioeconomic gradient in colorectal cancer mortality diminished substantially over time. Although colorectal cancer mortality among women in all area socioeconomic groups showed a consistent downward trend, colorectal cancer mortality among men in low area socioeconomic groups, but not in high area socioeconomic groups, showed an upward trend. **CONCLUSIONS:** Socioeconomic gradients in male lung cancer mortality reversed between 1950 and 1998, and those in colorectal cancer mortality narrowed over that time. Area measures may be useful for monitoring socioeconomic disparities in cancer mortality and for identifying areas for potential cancer control interventions.
33. Solomons NW. **Malnutrition and excess mortality in Shangri-La.** *Nutr. Rev.* 2002;60:59-62.

Ref ID: 33

Keywords:

Aging/Cities/Guatemala/Human/Infant/metabolism/Morbidity/Mortality/Nutrition Disorders/Poverty/standards/Tibet/United State/United States

Abstract: Populations living at high altitude in the Tibetan highlands suffer extraordinarily high rates of maternal mortality, infant and juvenile mortality, and infectious morbidity. Poverty and living condition, more than altitude, contribute to the adverse statistics. The traditional nomadic herders are the most affected among the residents. The question remains whether contemporary standards of adequate health and nutrition are compatible with the integral folkways of traditional tribal groups.

34. Szilagyi PG, Schaffer S, Shone L, Barth R, Humiston SG, Sandler M *et al.* **Reducing geographic, racial, and ethnic disparities in childhood immunization rates by using reminder/recall interventions in urban primary care practices.** *Pediatrics* 2002;**110**:e58.

Ref ID: 34

Keywords: United State/United States/Cities/Poverty/Medicaid/Family

Abstract: **CONTEXT:** An overarching national health goal of Healthy People 2010 is to eliminate disparities in leading health care indicators including immunizations. Disparities in US childhood immunization rates persist, with inner city, black, and Hispanic children having lower rates. Although practice or clinic-based interventions, such as patient reminder/recall systems, have been found to improve immunization rates in specific settings, there is little evidence that those site-based interventions can reduce disparities in immunization rates at the community level. **OBJECTIVE:** To assess the effect of a community-wide reminder, recall, and outreach (RRO) system for childhood immunization rates between inner city versus suburban populations and among white, black, and Hispanic children within an entire county. **Setting.** Monroe County, New York (birth cohort: 10 000, total population: 750 000), which includes the city of Rochester. Three geographic regions within the county were compared: the inner city of Rochester, which contains the greatest concentration of poverty (among 2-year-old children, 64% have Medicaid); the rest of the city of Rochester (38% have Medicaid); and the suburbs of the county (8% have Medicaid). **Interventions.** An RRO system was implemented in 8 city practices in 1995 (covering 64% of inner-city children) and was expanded to 10 city practices by 1999 (covering 74% of inner-city children, 61% of rest-of-city children, and 9% of suburban children). The RRO intervention involved lay community-based outreach workers who were assigned to city practices to track immunization rates of all 0- to 2-year-olds, and to provide a staged intervention with increasing intensity depending on the degree to which children were behind in immunizations (tracking for all children, mail, or telephone reminders for most children, assistance with transportation or scheduling for some children, and home visits for 5% of children who were most behind in immunizations and who faced complex barriers). **Study Participants.** Three separate cohorts of 0- to 2-year-old children were assessed-those residing in the county in 1993, 1996, and 1999. **Study Design.** Immunization rates were measured for each geographic region in Monroe County at 3 time periods: before the implementation of a systematic RRO system (1993), during early phases of implementation of the RRO system (1996), and after implementation of the RRO system in 10 city practices (1999). Immunization rates were compared for children living in the 3 geographic regions, and for white, black, and Hispanic children. Immunization rates were measured by the same methodology in each of the 3 time periods. A denominator of children was obtained by merging patient lists from the practice files of most pediatric and family medicine practices in the county (covering 85% to 89% of county children). A random sample of children (>500 from the suburbs and >1200 from the city for each sampling period) was then selected for medical chart review at practices to determine demographic characteristics (including race and ethnicity) and immunization rates. City children were over sampled to allow detection of effects by geographic region and race. Rates for the 3 geographic regions and for the entire county were determined using Stata to adjust for the clustered sampling.

Main Outcome Measures. Immunization rates at 12 and 24 months for recommended vaccines (4 diphtheria-tetanus-pertussis:3 polio:1 measles-mumps-rubella: = " border=0 height=10 src="ge.gif" width=71 *Haemophilus influenzae* type b on or after 12 months of age). **Results. Disparities by Geographic Region:** Baseline immunization rates (1993) for 24-month-olds were as follows: inner city (55%), rest of city (64%), and suburbs (73%), with an 18% difference in rates between the inner city and suburbs. By 1996, immunization rates rose faster in the inner city (+21% points) than in the suburbs (+14% points) so that the difference in rates between the inner city and suburbs had narrowed to 11%. In 1999, rates were similar across geographic regions: inner city (84%), rest of city (81%), and suburbs (88%), with a 4% difference between the inner city and suburbs. **Disparities by Race and Ethnicity:** Immunization rates were available in 1996 and 1999 by race and ethnicity. Twenty-four-month immunization rates in 1996 showed disparities: white (89%), black (76%), and Hispanic (74%), with a 13% difference between rates for white and black children and a 15% difference between white and Hispanic children. In 1999, rates were similar across the groups: white (88%), black (81%), and Hispanic (87%), with a 7% difference between rates for white and black children, and a 1% difference between white and Hispanic children. **Conclusions.** A community-wide intervention of patient RRO raised childhood immunization rates in the inner city of Rochester and was associated with marked reductions in disparities in immunization rates between inner city and suburban children and among racial and ethnic minority populations. By targeting a relatively manageable number of primary care practices that serve city children and using an effective strategy to increase immunization rates in each practice, it is possible to eliminate disparities in immunizations for vulnerable children.

35. Szwarcwald CL, de Andrade CL, Bastos FI. **Income inequality, residential poverty clustering and infant mortality: a study in Rio de Janeiro, Brazil.** *Social Science and Medicine.* 2002.

Ref ID: 35

Keywords: Brazil/ poverty/ mortality/ infant/income/ inequality

Abstract: In this paper, we propose an approach to investigate the hypothesis that the residential concentration of poverty affects health status more deeply than when poverty is randomly scattered in a given geographical area. To characterize the geographic pattern of poverty in the city of Rio de Janeiro, Brazil, an index that measures the heterogeneity of poverty concentration among sub-areas was proposed. We used census data and defined poverty by means of the household head monthly income. The 153 neighborhoods that compose the city were used as the geographic units, and the census tracts as the sub-areas. The proposed index measures differences of poverty concentration across census tracts within a neighborhood. The effects of geographic poverty clustering on infant mortality related variables (early neonatal mortality rate; post-neonatal mortality rate; proportion of adolescent mothers; and fertility rate among adolescents) were estimated by partial correlation coefficients, controlling for the neighborhood poverty rate. Our study revealed that intra-city variations of the post-neonatal mortality rate are associated with geographic patterns of poverty, and that pregnancy in adolescence is strongly and contextually correlated with intra-neighborhood poverty clustering, even after adjustment for the poverty rate. The evidence of relevant health differences associated with the spatial concentration of poverty supports the hypothesis that properties of the environment of residence contextually influence health. Our findings suggest that prevention of some infant mortality related problems has to be focused directly on features of communities, considering their physical, cultural and psychosocial characteristics, being of particular concern the health of communities segregated from the society at large by extreme poverty.

36. Trubek LG. **Working on the puzzle: health care coverage for low-wage workers.** *Health Matrix Clevel.* 2002;12:157-79.

Ref ID: 36

Keywords: Adult/Child/Consumer Advocacy/Cooperative

Behavior/economics/Employment/Fees and Charges/Health Care Coalitions/Health Policy/Health Services Accessibility/Human/Insurance Carriers/Insurance Coverage/legislation & jurisprudence/Medicaid/Politics/Poverty/Social Welfare/Societies/trends/United State/United States/Wisconsin

37. Tucker CM. **Expanding pediatric psychology beyond hospital walls to meet the health care needs of ethnic minority children.** *J Pediatr.Psychol.* 2002;**27**:315-23.

Ref ID: 37

Keywords: Adolescent/Child/Child Health Services/Child Psychology/Community Mental Health Services/ethnology/Health Promotion/Human/Interinstitutional Relations/Minority Groups/Models,Organizational/organization & administration/Poverty/psychology/Research/United State/United States

Abstract: OBJECTIVE: To discuss the need for an ecological model and new approaches for meeting the psychological and physical health care needs of minority children. **METHOD:** I support approaches that are informal, empowerment oriented, and culturally sensitive and that address illness prevention and health promotion. **DISCUSSION:** Assessment, intervention, and research challenges involved in implementing these approaches are identified, and some strategies for overcoming these challenges are discussed. **CONCLUSIONS:** Pediatric psychology can be expanded to embrace the advocated model and intervention approaches to better meet the health care needs of minority children.

38. Wall S. **Bridging the gaps: can we afford not to invest in global health?** *Scand.J Public Health* 2002;**30** PMI:162-5.

Ref ID: 38

Keywords: Communicable Disease Control/Health Policy/Health Priorities/Human/Internationality/Poverty/Public Health/Research Support/World Health

39. Wilkinson R.,Bezruchka S. **Income inequality and population health. Better measures of social differentiation and hierarchy are needed.** *BMJ* 2002;**324**:978.

Ref ID: 39

Keywords: England/Health Status/Human/Income/Poverty/Social Dominance/Socioeconomic Factors

40. Willis DJ. **Introduction to the special issue: economic, health, and mental health disparities among ethnic minority children and families.** *J Pediatr.Psychol.* 2002;**27**:309-14.

Ref ID: 40

Keywords: Adolescent/Child/Child Advocacy/Child Health Services/Cooperative Behavior/Early Intervention (Education)/ethnology/Family/Health Planning/Human/Mental Health Services/Minority Groups/organization & administration/Poverty/Socioeconomic Factors/United State/United States

41. Woodcock J. **Globalisation and health. Struggle for public health and against economic globalisation go hand in hand.** *BMJ* 2002;**324**:45-6.

Ref ID: 41

Keywords: Commerce/Developing Countries/England/Human/Poverty/Public Health/Social Justice/World Health

Subject Index

(With serial no. of the articles)

A

Adolescence	26
Adult	1, 3, 5, 14, 15, 16, 20, 24, 32, 36
Africa	18
Aging	33
Anxiety	27
Argentina	25
Asia	8

B

Baltimore	2, 24
Brazil	35
Breast Feeding	24

C

California	12, 13
Canada	10
Cancer	32
Chest Pain	27
Child	5, 13, 15, 16, 25, 36, 37, 40
Child Psychology	37
Chronic Disease	5, 22, 25
City Stress Inventory	7
Community Health	1, 10, 24
Consumer Advocacy	36
Cultural Deprivation	5

D

Delivery of Health Care	15
Deprivation	4, 5
Diabetes	1, 16
Disabled Children	13
Disease	5, 22, 25, 38

E

Education	7, 9, 16, 18, 20
Employment	36
England	3, 5, 9, 19, 22, 23, 26, 27, 39, 41
Environmental Health	22
Epidemiology	5
Equity	6, 21, 29
Ethnicity	34
European Union	28

H

Health	1, 2, 3, 4, 5, 6, 7, 9, 10, 12, 13, 14, 15, 16, 17, 19, 20, 22, 23, 24, 25, 26, 27, 29, 30, 31, 36, 37, 38, 39, 40, 41
Health Care	1, 2, 3, 4, 6, 9, 12, 13, 15, 16, 24, 27, 29, 36
Health Expenditures	15
Health insurance	12

Health Policy	20, 25, 29, 36, 38
Health Resources	29
Health Status Indicators	5, 7
Hispanic	1, 34
Hypertension	1

I

Immunization	15, 34
Income	4, 10, 20, 24, 32, 35, 39
India	31
Inequality	9, 20, 28, 35, 39
Infant	5, 16, 24, 25, 33
Insurance	36

L

Latin America	29
Life Expectancy	29
London	3

M

Malnutrition	33
Maternal Welfare	24
Mental health	2
Mental Health	2, 3, 37, 40
Mexico	8
Minority Groups	37, 40
Morbidity	4, 33
Mortality	4, 15, 32, 33, 35

N

Negroid Race	1
Nutrition	33
Nutrition Disorder	33

P

Policy	12, 15, 20, 25, 29, 36, 38
Poor	2, 13, 25
Population	11, 22, 32
Portugal	28
Poverty	4, 7, 8, 10, 11, 12, 14, 16, 18, 20, 22, 28, 30, 31, 32, 34, 35
Preventive Health Services	1, 15
Primary care	9
Psychology	37

R

Race	1, 14, 34
Regression Analysis	3, 32
Rich	26

S

Scotland	5, 27
SES	4
Social inequalities	6
Social Justice	19, 23,
29, 41	
Social Welfare	36
Stress	7
Stress Index	7

T

Tuberculosis	25
--------------	----

U

Unemployment	32
United States	1, 2, 4, 7, 12, 13, 14, 15, 16, 22, 24, 25, 26, 29, 32, 33, 34, 36, 37, 40, 41
Urban Health	1, 7, 14, 25

V

Violence	7
----------	---

W

Women	10, 17, 22, 24, 27
World Bank	8
World Health	15, 19, 20, 23, 24, 29, 38, 39, 41
World Health Organization	15, 29, 30

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