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# Poverty and health: who lives, who dies, who cares ?

Division of Intensified Cooperation with Countries in Greatest Need

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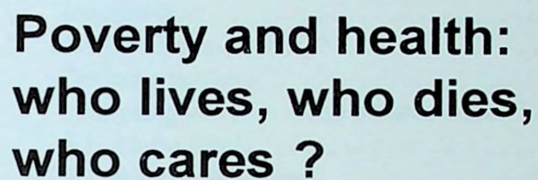

# Poverty and health: who lives, who dies, who cares ?


by

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# SECTION I : SOCIAL AND ECONOMIC ASPECTS OF INCREASING POVERTY - A GLOBAL PERSPECTIVE

## 1. Introduction

There is broad agreement today that good health is a prerequisite for human development and for maintaining peace and security, without which national economies cannot thrive. However, there is no doubt that the main threat to health development today is poverty. In spite of dramatic global economic growth, a quarter of the world's population today is still affected by severe poverty[1] and the gaps between rich and poor are widening. Poverty not only increases the risk of ill-health and vulnerability of people, it also has serious implications for the delivery of effective health care such as reduced demand for services, lack of continuity or compliance in medical treatment, and increased transmission of infectious diseases. Poverty may lead to inequities in access to health care which in turn has implications both for health service capacity and costs which are reflected in, for example, higher rates of complications due to late arrival of patients. At the same time, a lack of adequate free or low cost health services for those unable to pay contributes to further impoverishment of the poor. Growing evidence suggests that health-related risk events may well be the first step towards permanent poverty.

Economic and social developments world-wide have led to a situation where the vision of health for all based on a comprehensive approach to health development through primary health care has given way to a health care model which is based on the market approach. This development has overshadowed the multi-dimensional aspects of poverty. Emphasis has been concentrated on managing the consequences of poverty rather than addressing the complex causal processes which perpetuate poverty and ill-health. The challenge for health professionals, health systems and health decision-makers in poverty eradication is twofold: to actively participate in the creation of an informed, supportive and health enabling environment necessary for the pursuit of health for all; and to develop national health systems which protect and improve the health status of the poorest groups of their populations as an essential element in poverty eradication. This can only be achieved if the health sector is willing to break out of its isolation and pursue collaboration with other sectors and groups in society, and by promoting the integration of health objectives into the respective policies and actions of all sectors.

The aim of this paper is to contribute towards the discussion on poverty and health and on the role of the health sector in poverty eradication. It offers a brief introduction to some of the dimensions of poverty and health by drawing from articles, publications, and studies undertaken at country level. The first section considers some of the definitions of poverty and analyses

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poverty from a micro, intermediate and macro level. The relation between economic growth, poverty and health will be explored within the framework of global developments. Lastly, the influence which poverty and ill-health has on a household and the coping strategies developed by the poor will be examined. The second section will explore possible responses by policy-makers. By first considering a range of interventions outside the health sector, such as land reform, education, economic production, poverty alleviation programmes and partnerships, emphasis is placed on the importance of efforts in all sectors to eradicate poverty. The health sector however, does have a specific role to play and the following part of the paper will therefore focus on its role in poverty eradication within the overall framework of Health for All. The values embedded in the vision of health for all of social justice, health as an integral part of human development and participation of people in decisions which affect their health and lives, will be interpreted into basic principles and specific actions which flow from these principles and which should be considered by the health sector. This includes consideration of issues such as equity in health, acceptability and relevance of health services to the poor and participation of the poor in health development. The section highlights the need of those involved in health to recognize that poverty is about people, and about their choices and opportunities to participate in the process which ultimately creates the conditions for a healthy life.

## 2. Why focus on poverty?

Poverty worldwide is associated with poor health. It is the greatest single cause of ill-health and disease in the world today. Doing something about poverty will therefore have implications for the health of individuals, the health of nations and global health. It will contribute to the effective use of scarce resources for health care and to the sustainability of health services. Poverty eradication, based on intersectoral collaboration and on full involvement of the poor themselves, will create the conditions necessary for the development of appropriate quality care at all levels of the health system. Ultimately a focus on poverty is a challenge both to build consensus around and affirm values and principles which should guide health development in the future and to take specific action to make this a reality.

However, poverty is also a **moral** and **ethical** issue. Giving poverty priority is a recognition of, and a response to, the immense suffering and injustice which still exist in all parts of the world and which we know could be avoided. It is a recognition of the importance of reducing differences in circumstances between people in a way that enables *all* people to develop and realize their full potential and to participate, and contribute towards society.

Poverty eradication is also motivated by **economic** advantages. Poverty represents a waste of human resources and talents which could be invested to the benefit of society, in long term

productivity and economic growth of the country. Poverty eradication which results in improved health and increased productivity is a worthwhile investment - not a drain on the resources of a country.

Furthermore, there is a **social** argument for giving poverty priority. Neglect of poverty has socially de-stabilizing consequences and spill-over effects such as an increase in tensions and conflicts, and in migration both between and within countries. Furthermore, the increase of infectious diseases as a result of poverty ultimately increases risks for all societies. A renewed international commitment to poverty reduction and health development is needed to increase prosperity and human security both on a national and global level[2].

## 3. Defining poverty

It is important to recognize that there is at present no universal concept of poverty and that much of the debate on poverty has developed from a "Western" perspective[3]. The way we describe or understand poverty depends on the historical, cultural and socio economic context in which we live. Any attempt to reduce poverty should therefore reflect and respect these dimensions. Increased efforts are needed to include the contributions from the non-Western thinking in order to fully understand the conceptual variations and the implications this may have for the eradication of poverty on a global level.

Just as the definition of health can range from personal well-being, collective harmony, or wholeness, poverty can be defined from the perspective of the individual such as exclusion, lack of resources and deprivation, or from a perspective which links poverty to stages in the national economic development, or to the existence of a social and economic disequilibrium[1]. Variations in the understanding of poverty is reflected in the range of terms used to describe "poor people" and "poor areas" such as "backward", "under served" or "at the periphery of development". In view of the above, any attempt to define poverty needs to be done cautiously, keeping in mind possible bias which such a definition may represent.

The sense in which poverty is used for the purpose of this paper is based on the definition proposed by Chambers (1995) which refers to " a lack of physical necessities, assets and income. It includes more than being income-poor. Poverty can be distinguished from other forms of deprivation such as physical weakness, isolation, vulnerability and powerlessness with which it

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[1] For an excellent overview of different concepts of poverty see Novak M 1996, Concepts of poverty, in Oyen E et al, 1996. *Poverty : A Global Review. Handbook on International Poverty Research*. Scandinavian University Press

interacts."[4]

## 4. Analysing poverty - who defines what?

Analysing poverty and developing adequate indicators to measure poverty is a complex process since there are so many aspects of poverty, which cannot be measured, such as participation in decision-making or in community life, lack of security and threats to sustainability. As a result, poverty measurements have often been restricted to the analysis of income or consumption. Recognition of the limitations of only measuring the economic dimension of poverty has led to the development by the UNDP, of a Human Poverty Index (HPI) which brings together different features of deprivation in the quality of life, in order to measure the extent of poverty in a community. The three indicators include *longevity* (% of people expected to die before the age of 40), *knowledge* (% of adults who are illiterate) and *decent standard of living* (% of people with access to health services and to safe water, and % of malnourished children under 5)[5]. The HPI provides a measure of the incidence of human poverty in a country but cannot be used to associate the incidence of poverty with a specific group or number of people[2]. Analysis of poverty which seeks to understand the dimensions, causes and manifestations of poverty therefore needs to take into consideration different levels of poverty.

### 4.1 *Micro level*

Poverty should be analysed at the **micro level**, at the level of a person or family in order to identify those family members or entire families in a community who are the most vulnerable and who are most in need.

As part of such a poverty analysis, Chambers[6] suggests that professionals, researchers and development agencies seriously need to question who defines poverty, how local people themselves identify the poor and the poorest members in their society, what criteria of poverty or deprivation they have and what their priorities are. Stronger emphasis and consideration of the reality of poor people as experienced and expressed by themselves will offer insights essential to poverty reduction efforts. Deprivation and disadvantage as experienced by poor people themselves is bound to reflect diversity and although not a single list will include all the variations. some of the experiences of poor people are summarized in the table below.

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[2] The limits of this paper do not allow for an in-depth consideration of the HPI and interested readers are encouraged to read the Human Development Report 1997, UNDP for further reference.

**TABLE 1**

| Dimensions of deprivation | |
|---|---|
| Poverty | Lack of physical necessities, assets and income |
| Social inferiority | Can be assigned, acquired or linked with age and life-cycle. It can be socially defined as genetically inferior or disadvantaged, including gender, caste, race and ethnic group, or defined by social class/group or occupation. |
| Isolation | Being at the periphery or excluded. It can include geographic isolation, exclusion from communication, contacts and information, lack of access to social services and markets and of social and economic support. |
| Physical weakness | Includes disability, sickness, pain and suffering as well as the effect this has on other household members through reduced capacity to contribute to the household livelihood. |
| Vulnerability | Defencelessness and exposure to external risks such as shocks and stress, and lack of means to cope without damaging loss. |
| Seasonality | Includes seasonal dimensions of poverty such as adverse factors which may coincide with rainy seasons including shortage of food, difficult conditions for agricultural work, scarcity of money, high exposure to infection, and diminished access to health services. |
| Powerlessness | Bargaining power of poor people is reduced by work insecurity and lack of resources and income. Physical weakness and economic vulnerability diminish their influence. |
| Humiliation | Poor people are often treated with a lack of respect which in turn may lead to a lack of self-respect. Dependency and helplessness reinforce the experience of humiliation. |

Source: Adapted from Chambers 1995, Poverty and Livelihoods. Whose reality counts? P 19-20

Knowledge of these dimensions of deprivation is important for the understanding of the effect of poverty on people's behaviour, choices and priorities.

*Absolute and relative poverty*

An analysis of poverty at a micro-level includes a consideration of the concepts of absolute and relative poverty. Much of the debate around poverty and health has emphasized the correlation between **absolute poverty** and ill-health. More recently however, the notion of **relative poverty** is also being used to explain ill-health, in particular in developed countries.

The UNDP Human Development Report of 1997 states that " absolute poverty refers to some absolute standard of minimum requirement, while relative poverty refers to falling behind most

others in the community" [7].

Examples of recent research concerning developed countries points to the importance of relative, rather than absolute living standards. In developed countries, socioeconomic variations in health have been found to relate both to social position and to material circumstances. In terms of causality, studies suggest that the health disadvantage of the least well-off in society is more closely associated with the direct and indirect psycho-social effects of their social position (i.e., people's position in the socioeconomic hierarchy in relation to others) than with the physiological effects of lower absolute material standards (e.g., inadequate housing and heating, poor diets, and air pollution)[8]. A study which looked at income distribution and mortality in the USA found a clear association between variations between States in inequality of income and increased mortality. The study concludes that "these findings provide some support for the notion that the size of the gap between the wealthy and less well-off - as distinct from the absolute standard of living enjoyed by the poor- seem to matter in its own right. This finding in no way diminishes the importance of measures to alleviate the burden of poverty. None the less, in an affluent society such as the United States, reliance on trickle down policies may not be enough - society must pay more attention to the growing gap between the rich and the poor."[9] Caution to draw these final conclusions with regards to the impact of income distribution on average life expectancy among rich countries is recommended by some authors such as Judge[10] who challenges the "predominantly monocausal" explanation of international variations in life expectancy. Wilkinson[11] however, who also found income inequality to be the key determinant of variation in average life expectancy at birth among developed countries explains this by looking beyond income as such. He underlines the importance of income as a determinant and indicator of other material factors and of factors such as sense of control, self-esteem, security, status, exclusion and cohesion[12]. These factors are closely related to those identified by poor people in Table 1 as important dimensions of poverty but since exclusion and lack of self-esteem are difficult to measure, little research has been undertaken on the mechanisms of influence of these factors on health.

The implications of relative poverty on the health of people in developing countries has received little attention, but it would seem relevant to focus on this dimension as well as on absolute poverty in particular if the findings of a study by Beck[13] in West Bengal are widespread among poor people in other parts of the world. Very poor people were asked what it was they valued most, food or self-respect. The overwhelming majority interviewed said that they valued self-respect highest and one person replied : "If I don't have self-respect, will food go into the stomach?"[14] Beck concluded that "despite their regular hunger, more poorest people in the study villages felt it was more important to be treated with respect than gratify immediate needs"[15]. Focus group discussions in Kenya showed that one of the most distressing situations created by poverty was not being able to offer guests a meal and arrival of unexpected visitors created a

situation of humiliation rather than social fellowship[16]. Will this not affect people's health?

Consideration by health professionals and others involved in community health development of the effect of these dimensions to poverty on mental and emotional health, may have far reaching consequences for the type of health care offered.

### 4.2 *Intermediate level*

Poverty can also be examined at an **intermediate level** by assessing the situation of particular groups and people in a society, identifying those who are hardest hit by poverty and exploring possible causes for this. At a national level, it is important to recognize which groups are most affected by poverty and to explore possible common determinants of their disadvantaged position, including ethnic, religious, or political belonging or geographical distribution. At the local level, significant differentiation exists within the poor community, irrespective of which criteria are used to demarcate groups of poor people. Analysing poverty at an intermediate level therefore helps to distinguish the moderate poor from the absolute poor, and to assess the size of the groups.

### 4.3 *Macro level*

It is a well-known fact that low levels of education and poor health decrease people's capacity to work and earn an income, and this in turn perpetuates poverty. Furthermore, the degree of poverty of individuals and households will also be determined by the context in which they live, social stratification, social mobility and the extent to which they may benefit from existing social and economic infrastructure[17]. The lack of social and economic infrastructure, such as roads, transport, water and sanitation, health care facilities, and schools, may be the result of underdevelopment or the malfunctioning of the socioeconomic situation leading to a situation of want, limited participation and lack of resources. As such, poverty can be seen as the result of processes and structures at a **macro level**.

However, it is also important to recognize that poverty is not only influenced by national economic and social policy and development. It is also an international phenomenon influenced by transnational events and developments which result in poverty- producing processes [18] [19] such as the breakdown of economic, demographic, ecological, cultural and social systems. This may lead to a situation of great insecurity or vulnerability for many people which intensifies the situation of poverty. The process of globalization is increasing economic, political and social interdependence and the national and global levels are therefore closely interconnected. The place of national economies within the international economy will influence the extent of poverty in the countries and the extent to which they are able to develop and implement social and health policies to address poverty[20].

**TABLE 2**
**ANALYSING THE LEVELS OF POVERTY**

| | |
|---|---|
| Micro level | Analysis of the multiple dimensions of deprivation as experienced and expressed by poor people themselves |
| Intermediate level | Identification of the most vulnerable and disadvantaged groups |
| Macro level | Analysis of poverty from an economic and political perspective at national and international level. |

## 5. Global health indicators developments

During the last 25 years, an unprecedented expansion of the world economy has taken place. Global health indicators such as life expectancy at birth or infant mortality indicate that developing countries overall have made progress. However, while life expectancy increased in developing countries by 16 years in the period of 1990-1994, from 46 to 62, about one-fifth of the population is expected to die before the age of 40. Infant mortality in the same countries has decreased from 150/ 1000 to 64 /1000 live births, but regional variations exist. Sub-Saharan Africa has a rate of 100/1000, and South-east Asia 112/1000. This is three times that of Eastern Asia and six times that of industrialized countries[21].

Health indicators from the Least Developed Countries[3] reveal global disparities. Maternal mortality, an indicator of the low social status and neglect of women, is 471/100,000 in the developing world, 15 times the rate in industrialized countries. The World Health Report 1996 clearly demonstrates that there has been a sharp re-emergence of infectious diseases from which no country can escape or afford to ignore. The precarious overcrowded conditions in which most of the poor are living is conducive to the spread of the infectious diseases resulting in a dramatic increase in diseases such as tuberculosis, diphtheria, HIV/AIDS, and hepatitis B. Diseases such as cholera which were geographically restricted are spreading to new regions and major diseases such as malaria are making new comebacks in many parts of the world[22]. Added to this is the problem of increasing resistance to available drugs due to poor compliance to treatment. The impact of several infectious diseases on poverty is a two-way relationship between poverty and illness. There is no doubt that for example AIDS, tuberculosis, acute and respiratory infections

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[3] The 1997 Human Development Report defines the least developed countries as " those recognized by the United Nations as low-income countries encountering long-term impediments to economic growth, particularly low levels of human resource development and severe structural weaknesses." p.237

are linked to poverty and poverty itself facilitates the transmission of these diseases. About 17 million people a year in developing countries die from curable infectious and parasitic diseases. In addition to this, many countries are experiencing a dubble burden of disease due to an increase also in non-communicable diseases. Despite improvements in the access of health care, 50% of the population in sub-Saharan Africa do not have access to any form of public health care and although 69% of the world's population now have access to clean water, in numerical terms in the developing world, nearly 800 million people lack access to health care and nearly 1.2 billion lack access to safe water[23].

The increasing pressures that disease places on the poor coupled with disabilitating effects of disease, have devastating consequences for their health and social well-being and in many cases leads to social and economic disintegration and further impoverishment. As a result, the socio-economic development of many countries is substantially threatened.

## 6. Global developments affecting poverty and health

### 6.1 *Globalization of the world economy*

The process of globalization has led to increasing reliance on free market economy and rapid improvements in communications. The "invisible hand" of the market mechanism is oriented towards privatization and liberalization of trade and foreign investment regimes, adaptation of national economic structures and strengthening of export capacity. While the process may bring opportunities and possibilities of economic growth and poverty reduction to some regions such as East Asia, the benefits are not evenly distributed in developing countries as a whole [24].

Large segments of the world's population have been excluded, and they are currently suffering deterioration, both in relative and absolute terms. The number of poor is increasing. Between 1987 and 1993, the number of the world's poor rose from 1.23 billion to 1.31 billion[25].

*Who is most affected by poverty?*

The dominant tendency in developing countries and transition countries is that the main pockets of poverty are located in the remote rural areas, and amongst the urban poor. Amongst those hardest hit by poverty are parents with no or little education, households headed by single women, children, young people for whom there are no jobs, the self-employed engaged in small-scale trading, the elderly, people with disabilities, refugees and other displaced people. Women represent 70% of the world's poor[26] and they have less education, longer working hours and lower life expectancy than men[27]. People in developed countries are not spared from poverty and

women and children of these countries are the most affected by poverty. Child poverty has increased throughout the 80s and children are currently the largest age group in poverty[28].

### 6.2 *Increased violence and conflict*

Deepening poverty is one of the main driving forces behind the steady rise in the number of conflicts within national borders and which are creating an unprecedented number of refugees. The poor, in particular women, are disproportionately represented among the victims of conflict and millions of people are forced to live on the brink of survival, either displaced in their own countries or as refugees in neighbouring, often poor countries. Conflict diverts limited resources away from human development efforts and the vicious circle of poverty and violence is nurtured. For years following war or conflict, the health of people is threatened by unexploded mines and total deprivation. Even so called "peaceful" economic sanctions hit the poor hardest, as experienced by Haiti where, during the period of sanctions, drinking water was cut off, malnourishment soared and the cost of staple food rose sharply[29].

### 6.3 *Poverty and environment*

About one half of the world's poorest people live on marginal or fragile lands and there is an intimate connection between environmental degradation, and poverty-related behaviour such as the search for food or fuel, and migration.[30] Degradation of the environment not only increases the health risks for the poor and vulnerable but hinders sustainable development. In addition, the health of people living on marginal land is often seriously neglected since health services seldom reach these areas. The process of urbanization (in part a result of migration towards the cities, due to low agricultural productivity and lack of income gaining opportunities in rural areas) is also a major global environmental change which directly affects human health today[31]. The urban areas in which the poor live and work generally have sub-standard housing, weak infrastructure and lack sanitary installations. Moreover, industrial pollution and high traffic density contribute to the increased vulnerability of the poor in these areas[32].

### 6.4 *Demographic changes*

Demographic pressures may also affect the already precarious environmental situation of the poorest populations. However, one way of coping with the stress and insecurity of poverty is to have many children who can participate in the household responsibilities, such as fetching wood and water as well as in earning income for the family. Rapid population growth weakens the potential for savings. It reduces the resources for improving health and education and it puts pressure on natural resources. It also weakens women's health, equality and autonomy- because women end up with reduced options for education and income-earning work"[33].

## 7. Changes within the health sector as a result of global developments

### 7.1 *The debt crisis and structural adjustment*

Increasing concern by people and institutions worldwide is being expressed regarding the effects of the debt crisis on the health and well-being of individuals and societies as a whole. Introduction of structural adjustment programmes (SAPs) was proposed by the World Bank and IMF as a way to overcome the severe economic and financial crisis affecting most of the developing world in the early 1980s. Many indebted developing countries implemented SAPs which aimed at decreasing State spending and stabilizing the economy and reductions were made in public spending, often within health and education. The impact on the health sector of reduced public spending was dramatic in many countries. Where funds were reduced for physical infrastructure, equipment, drugs, staff salaries and training, the functioning of the health services in several countries came to be seriously threatened [34].

Another clear result of reduced public spending on health was an increase in Selective Primary Health Care (SPHC), narrow cost-effective technological health interventions[35]. Although health interventions such as oral rehydration therapy and immunization were designed to target specific identified problems of poverty, evidence suggests that they have not been able to reach their targets or to improve the health status of poor people and in particular that of children[36]. The broad Primary Health Care goal of improving the health status of of all populations, especially that of the most vulnerable groups, was overshadowed in the implementation of SPHC.

Caution to draw cause and effect conclusions about the relationship between health and economic crisis is advised by Sahn[37] who found in a study of 21 Sub-Saharan African countries, that there seem to be no causal relationship between macro-economic adjustment and a decreasing government sector. Genberg[38] also cites a study of 5 Latin American countries which concludes that there is not sufficient evidence to associate the increase in morbidity at a national level with the economic crisis. However, it is important to note that although "on average" there may seem to be no relationship, there may be one for specific groups such as the poor. This is clearly demonstrated in the examples from Nigeria and Zimbabwe presented in the following section. The extent to which the poor have become poorer depends on their place in the economy (the sector in which they are working, the prices of the products of those sectors, changes in government subsidies and transfers, changes in prices of popular consumer goods etc).

In the process of globalization, the introduction of market mechanisms into the provision of health care was proposed as the way forward for countries facing economic difficulties [39]. Health care reforms involving policy changes in financing strategies and in public sector organization were widely implemented. The most important reforms involved **cost sharing through the**

**introduction of user fees** and **decentralization** of health care.

### 7.2 *Impact of user fees on utilization of health services by the poor*

In an attempt to counteract the decrease in public spending within the health sector, and with the aim of generating funds for health services, cost-sharing such as user- fees or co-payment has been introduced in a large number of countries.

Many case studies have analysed the impact on the demand for health care following the introduction of user fees. Among the conclusions drawn from these studies, user fees or a price increase in health care have a tendency to reinforce existing inequalities in access to health services unless exemption policies are put in place to protect the poor. Those at highest risk, the old and poor, are generally pushed out of the system[40] .

An example from Nigeria illustrates well the effects of user fees on maternal mortality. In Nigeria, a recent survey suggests that introduction of user fees has deterred at-risk women from seeking antenatal health care with the result that the number of emergencies being admitted without prior care has increased. Many of the women are poor and already at high risk since "poverty greatly amplifies every other high risk factor for maternal mortality and maternal morbidity"[41]. The unbooked emergencies are high risk patients and they make up 70% of all hospital maternal deaths, and a higher number of intra-uterine and perinatal deaths. The women arrive late, when their lives are already in danger due to difficult labour, complications, and coincidental disease. The late arrival increases operational risk, and for those who survive, the recovery is slow, hospital stay is prolonged and treatment costs, both for the provider and the beneficiary are substantially increased[42].

The consequence of reduced government spending has also had high social and humanitarian costs in Zimbabwe where maternal mortality increased from 101 in 1989 to 265 per /100.000 in 1992 [43]. In 1991 Zimbabwe introduced rigorous fee collection at public health services in order to reduce the fiscal deficit. The cost-recovery programme had a clear negative impact on the health of the many poor people who were no longer able to afford the costs. Visits to health centres decreased, in particular to antenatal clinics. As in the case of Nigeria, the number of births in the Harare Central Hospital to mothers with no antenatal care increased substantially, from 1.6% to 8.8%. The perinatal mortality rates for these women is five times as high as for those who attend antenatal care[44]. In view of the adverse effect of user fees on poor people, Zimbabwe withdrew the cost-recovery programme from rural clinics in 1995.

It is important to note that reduction of demand for health care as a result of the introduction of user fees may also be closely linked to the quality of services. Studies such as the study by

Litvick and Bodart[45] in Cameroon have shown that if user fees are reinvested in improving the quality of care (such as availability of drugs), the reduction of demand may be lower than expected and in some cases demand may even increase.

Variations in results of impact of the introduction of user fees or other cost sharing methods on access to health services, especially of poor people, highlights the importance of allowing for many factors and conditions in the studies of impact of user fees before drawing conclusions. One important element is the comparison of the situation of poor people and in particular the poorest people, before any cost sharing, with that after the introduction of cost sharing. A second element is the examination of the use of the user fees collected - whether they have been reinvested to improve quality of care in the health services or if they have been transferred to the Ministry of Finances to reduce the fiscal deficit.

The above examples from Nigeria and Zimbabwe highlight a very important aspect of poverty. While reduction in health spending is introduced to save costs, poverty may reverse the savings. The existing situation needs to be carefully evaluated by policy-makers before introducing changes in the financing mechanisms of health care which may adversely affect the poor.

### 7.3 *Decentralization*

Since the early 1980s, decentralization has been associated with the principles of Primary Health Care, and it has been seen as a way to improve equity in health, increase accountability, raise responsiveness to local needs and improve access of the poor to public health services. Decentralization remains however a political issue which is influenced by different interpretations by social and political groups and bodies with contrasting interests[46]. Although the potential of increased community participation in decision-making and planning is present, its success depends on a range of factors, including leadership, the influencing power of the local elite, decision-making process and central commitment to equity in health. Decentralization can increase inequities in health if the central level does not establish the means of ensuring equitable distribution of resources. Decentralization has also been combined with cost-sharing mechanisms which, as the case of China illustrates, has not always led to an improvement in the health status of the poor.

By the end of the 1970s, China had put in place a cooperative organization of rural health financing (called cooperative medical systems -CMS) which covered roughly 95% of the villages. The system involved community participation and cost sharing (small contributions from farmers and subsidies from collective welfare funds) and gave farmers access to basic health care[47].

Market economy reforms were introduced in the early 1980s involving a shift away from communal to a household production system. This resulted in increased production autonomy for farmers, better access to markets, and greater opportunities for local and regional trade. However, the shift to a household production system meant a decrease in revenue for the cooperative medical system, and at the at the same time, the Government reduced financial support for recurrent health costs, following the introduction of user fees and liberated prices in the medical sector. This led to a dramatic rise in prices, and in many places the RCMS (Rural Cooperative Medical Systems) were unable to generate sufficient income to cover their costs. This, combined with administrative and political obstacles, led to the collapse of the RCMS. In turn, this resulted in a decrease in preventive and curative care, and an increase in some infectious diseases. By 1993, RCMS covered only 10 percent of the population in 4.8% of the country's villages.

In view of these problems, steps have been taken to improve access to health care in the rural areas and to re-establish different models of RCMS by adapting them to the economic reforms and to the local economic situation.

The example of China illustrates clearly that when introducing change, every situation must be considered in its own context, from the historic, cultural, political and socio-economic perspective. It also draws attention to the changing role of the State, within financing and the provision of health care, and to the need for greater government regulation and monitoring of the protection of the most vulnerable in the process of economic growth.

## 8. Influence of poverty and ill-health on the household and coping strategies of poor people

The relation between poverty and household economy is of special importance to any discussion of poverty and health and it is at this level that the synergistic link between poverty and health is most tangible. Poverty undermines health, renders people more vulnerable, and reduces work capacity and productivity, thus limiting opportunities of income-earning. Low income in turn perpetuates poverty and poor health.

The household economy[4] is determined by a range of assets which most commonly refer to

[4]A useful framework which analyses the basic features of a household economy has been developed by Carrin and Politi. The family is considered the basic unit of analysis and is defined as a group of people living together or closely connected, sharing their food and/or working formally or informally in a family enterprise. Carrin G. And Politi C. 1997, *Poverty and Health, an overview of basic linkages and public policy measures.* Technical briefing note, WHO Task Force on Health Economics, 1997

"capital, physical or financial, from which people can derive a future stream of income"[48]. However, it is also important to include other assets, including intangible assets of a social, personal and environmental nature. The effect of ill health on these assets may be a major determinant for further impoverishment of poor people.

8.1 The main assets of poor people are their **bodies** [49]. In many parts of the world household labour continues to be the most important input for food or subsistence production. The poorer people are, the more they depend on being able to work and earn an income. Their ability to work is determined at large by their physical capacity which puts a very high price on physical disability. At the same time, the poorer people are, the more vulnerable they become, to sickness and accidents due to malnourishment and poor resistance to disease which in turn leads to slow recovery. Poor people also have less access to timely and effective treatment or prophylaxis and in many countries, the lack of employment may also mean exclusion from access to health services.

8.2 **Economic assets** include land, livestock, housing and financial capital (savings and credit). Poor health is an economic burden to the poor and in many countries contributes to substantial erosion of these economic assets.

A study in Bangladesh revealed that the hard core poor households (those who were in the lowest two deciles) spent up to 7-10% of their income on private health expenses[50]. Poor people are also extremely vulnerable to serious, unexpected health problems which may lead to a loss of income and income-earning capacity. They may be forced to borrow money or sell the few assets they may possess, including livestock or land, to cover the costs. This leaves them more vulnerable and often indebted with little possibility of repaying the debt and in great danger of moving further down the poverty spiral. The same study in Bangladesh found that " health-hazard related risk events explain on average 16% of the causes of deterioration along the poverty spiral experienced by households during the 1990 - 1994 period. For non-poor households, which slipped into hard core poverty, the share of health-related causes is as high as 21%. While such slippage may originate in the random nature of events, for many of these households it may well turn out to be a route to permanent poverty"[51].

8.3 The **health of the breadwinner** is critical to the health of the household. Preventing or curing his or her illness may also be vital to the state of nutrition of children. Findings from a study in an urban slum in Khulna, Bangladesh revealed that there was a strong association between loss of income due to illness and severe malnourishment in pre school children[52]. The study found that there were two and a half times more likelihood that children were malnourished in a household where an adult earner had been sick during the last month, than in households where the breadwinner was not sick. Preventing adult sickness may therefore be the cheapest way

to prevent malnutrition in children. However, the problem of malnourishment is not limited to children - closer studies of households with severely malnourished children and incapacitated earners, reveals that in addition to the children, most of the other household members are malnourished.

Chronic illness which strikes a household will have severe effects on the family income and in many cases, chronically incapacitated households are the most indebted with consumption loans which may reach 500% of the monthly income[53]. Attempts to increase the household income will be made by entering women and children into the labour force. However, restricted economic options available to poor uneducated women intensify the pressure on the male income earners and on the situation of the household, since women will rarely be able to reach incomes equivalent to those of men. In their struggle to survive and earn income, women and children may be exposed to high health risks such as injury among working children or infections and violence among women forced into prostitution.

A permanently disabling disease can lead to slow but sure impoverishment and destitution in young developing households. This was revealed in a study in Guinea looking at the impact of onchocerciasis (river blindness) on individuals, households and villages. The disease, which affects to a large extent young men, puts severe constraints on the ability of the household to sustain its viability, rendering the household more and more dependent on help from the extended family and others in the village[54] (Box.1).

The example of river-blindness clearly demonstrates the link between ill-health and poverty and it also highlights the importance of considering the impact of disease on a household level rather than an individual level. The process of progression of the disease and subsequent problems for the

The progression of disease may include the following:

- increased dependency ratios (ratio of number of consuming household members to number of active producing household members)
- decrease in nutritional and health status of all household members and increased vulnerability to other diseases
- decreasing labour input
- decreasing capacity to participate in traditional labour exchange system
- decreasing area under cultivation
- decreasing ability of household food production to feed household members
- increasing duration of food shortage
- decreasing ability to undertake food shortage coping strategies
- increasing expenditure on scarce household resources on health problems, in particular blindness
- decreasing household viability
- increasing stress and household disunity
- increasing reliance on village welfare system and extended family

Box 1: The path from ill-health to poverty - the example of river-blindness

household is in no way unique to river blindness and similar assessments could usefully be made for other diseases in order to identify the social and economic dimensions of ill-health.

Death of family members, especially men, may determine the future survival of women in many countries. Inheritance laws do not always protect the surviving widow and in many countries, widows do not inherit from their husbands, as is the case of many widows in India. If a widow has no surviving sons, her property can be seized by the family of the deceased husband leaving her extremely vulnerable [55] .

8.4 An important asset for most poor families and especially for the women is **time**. Women suffer from the lack of time, due to their triple burden of caring for the family, taking care of domestic responsibilities, and earning money. Ill-health can seriously deprive them of time. Coping mechanisms include involving children in the day-to-day domestic duties or income-generation. But this may take them away from school or expose them to physical strain which threatens their own health.

In studies of malnutrition in children, especially where there is a chronically sick earner, maternal time and intense financial poverty were major constraints on child care and feeding. The time which is needed to visit health services, to cover long distances to get there, and long waiting times all prevent women from earning income and these time constraints contribute to the non-attendance of children at nutrition centres of health services. Studies from Uganda, Nigeria and Cote d'Ivoire show that people seeking medical care may spend between 2 to 8 hours to get to the hospital or clinic[56]. The situation is particularly precarious for women who are heads of households.

8.5 **Social and political assets** include relationships of trust and mutual concern such as those which exist within the extended family, which can be drawn on in times of stress or crisis. Such relationships reflect the social cohesion which exists in many poor communities and they are at the base of a broad range of self-help activities organized by the poor collectively to cope with the consequences of poverty.

However, these relationships of mutual concern and support can be threatened in times of increased social tension, conflicts, or as a result of problems such as alcoholism that results from a deep decline into poverty or loss of income. The breakdown of the extended family as a result of war and of AIDS, where the responsible adult population is severely reduced, leaves orphans or other family members in a particularly vulnerable situation. Chronic ill-health can also put a strain on social relationships and lead to increased tensions in the family or community. Ill-health poses a special problem for people living in slum areas in cities where traditional protective social networks such as the extended family, do not exist to the same extent as in rural villages.

In these situations, a greater burden falls on the individual households, in particular on the women.

As illustrated above, the loss of one asset can in many cases lead to loss of others. Loss of time due to ill-health often results in a loss of income which in turn can put pressure on social relationships and lead to increased violence. Studies show that women in Hungary, Mexico, the Philippines and Zambia have found a clear link between an increase in violence and a decline in men's income [57]. Emotional distress inevitably accompanies the financial distress.

The infinite variety of coping mechanisms put in place by the poor themselves to overcome the consequences of poverty reflect "enormous creativity, strength and dynamism on a daily basis to solve problems [...] Poor people have assets, in their own minds and bodies, in their social institutions, in their values and cultures, in their detailed and sophisticated knowledge of their own environment"[58]. **Protecting these assets and strengthening them will be one of the key factors of success in the eradication of poverty.**

How can this be achieved ? The following sections will consider some of the strategies used to overcome poverty in particular those which may be developed by the health sector.

## SECTION II : THE PLACE OF HEALTH IN REDUCING POVERTY

### 9. Poverty eradication as part of the overall development goal

In societies with clear policies on equality and democracy and where the overall goal of equity is the improvement of all its population's health status, the chances of health development for the poorest people will be higher. Experiences from countries with a historical commitment to health as a social goal, and to equality as a political goal confirm this. Costa Rica, Sri Lanka and the State of Kerala in India have achieved considerable improvements in the health status of the population by a series of political, social and economic interventions in society as a whole, actively involving communities in the process[59]. In Costa Rica, where health is considered an "investment in the nation, a necessity for social vitality and economic progress.[....].progressive health policies have increased the income of the poorest 10% of the population by more than 65%"[60].

A redistribution of resources in favour of the poor has been an important element of the overall development policy to improve health status[61]. Also in developed countries, social policies seeking to redistribute income and reduce income inequalities will have a significant effect on health inequalities. In countries such as Japan, where the income differentials between the highest and the lowest income quintiles are decreasing, improvements in the health status of the population as a whole can be noted [62]. In countries such as the UK and USA, where these income differentials are increasing, less improvements in health status and wider inequalities in health have been found[63].

Although not all countries have a national political commitment to equity and poverty eradication, many sectoral strategies have been put in place to reduce poverty.

### 10. Poverty reduction through improved health

Some of the most effective strategies to strengthen poor people's assets (in particular health), to reduce poverty and to enhance the participation of poor people in social and economic activities, have been undertaken outside the health sector. Examples of this have been amply described elsewhere [64] and what follows is a brief summary of some of these strategies.

### 10.1 *Land reform*

A major cause of poverty today is unequitable distribution and ownership of land, which not only contributes to rural poverty but also to the expansion of urban slum areas. Land reforms which aim at a more equitable distribution of land and a more efficient use of the land, will contribute substantially to poverty reduction. This is confirmed by the experiences from Japan, South Korea and Taiwan where, as a result of land redistribution, farm output increased which in turn led to increased income and saving and to a higher demand for domestic products[65]. In the State of West Bengal in India, considerable social benefits have resulted from the introduction of legislation to strengthen tenure laws, protect landless labourers and enhance the position of share croppers[66].

### 10.2 *Policies for increasing the economic asset-base of the poor: credit schemes*

Credit schemes enable the poor to sustain their level of consumption in difficult times, by allowing them to pay for physical investments as well as services such as health care and education[67]. In addition, they may offer poor people opportunities to participate in the labour market or the production of goods, thus allowing them to create new assets from which to draw. Successful examples of credit schemes can be found in all regions and they include for example investments in income generating activities for women in Bangladesh, farming co-operatives in Zimbabwe[68] or housing initiatives in The Gambia and Antigua[69]. One of the most well-known credit scheme is the Grameen Bank in Bangladesh which since 1983 has been giving credit to the landless and to poor women. The scheme has currently half a million members, the majority of whom are women. The repayment rate is extremely high at 98% and the scheme has become a model of participatory development[70]. An independent evaluation of the programme found that villages which have adopted the scheme, benefited from a lower poverty rate, higher employment rates, and higher assets levels than villages which have not developed a local branch of the scheme[71].

There are however caveats to credit schemes - although credit may be granted to women, they may not always have control or decision-making power regarding its use, and in some cases they do not even benefit from the loans, as was the fate of some of the women who belonged to the Grameen Bank credit scheme in Bangladesh where loans provided to women were invested by male relatives[72]. Secondly, an increase in income is not enough to guarantee the poor a sustainable existence - the loans may be used to pay back a debt or for health services - and the poor may become even more vulnerable as well as indebted. The need therefore to improve access to social services is essential if the poor are to benefit from their increased productivity. While credit schemes can offer opportunities for the poor, they do often not reach the poorest people who may also be hesitant to join the scheme for fear of becoming indebted.

## 10.3 *Promotion of education - investing in women*

The role of education and in particular primary education has long been recognized as one of the most important determinants of human welfare, opportunities and economic growth. This has been amply proven by the investments in education which have been undertaken by South-East Asian countries experiencing rapid economic growth. According to the World Bank, the differences in growth experienced by these countries compared to other developing countries is largely due to their investment in education.[73]

There is today, broad agreement of the importance of education of women for health status. Despite this, of the 840 million adults who are illiterate, 538 million are women.[74] Lack of education opportunities for women and girls which is still prevalent in many developing countries, reflects a deep rooted structure of gender discrimination which denies women and girls opportunities of participation in society. Not only does this limit women's possibilities of earning income, but it also leaves them in an extremely vulnerable position if they are left alone to head the household.

Many countries such as China, Costa Rica, Sri Lanka and the State of Kerala in India, have recognized the importance of female education and have given priority to this in overall development strategies to improve women's status and opportunities. In response to the vicious cycle of deprivation which women face, many groups, notably NGOs and community organizations all around the world are engaged in activities which increase opportunities for women. Programmes are often combined with several capacity-building activities such as nutritional programmes, literacy training, awareness raising and problem solving activities.[75]

One of the current obstacles to primary education of girls is that it will take them away from essential domestic tasks such as wood and water collection and child care. Anti poverty strategies which encourage girls to attend school will therefore need to provide incentives which take this into consideration such as flexible school hours and communal water and fuel provision[76].

## 10.4 *Poverty alleviation programmes and targeting the poor*

As a result of decreasing public resources, Structural Adjustment Programmes and privatization, many developing countries are "targeting" scarce resources to the most needy. The type of activities and programmes vary between countries, and may include rationed food subsidies. supplementary feeding programmes, employment and public works programmes, food stamps, subsidized food shops and assuring basic food at low cost[77] . While some countries have experienced a positive impact on the welfare of low income groups as a result of the



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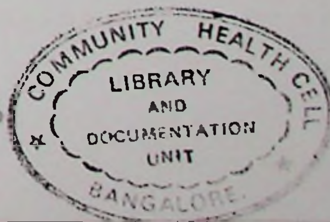

programmes[78], it is important to be aware of the dependency that such programmes may create. Furthermore, although poverty alleviation programmes of this kind are aimed at the poorest populations, evidence shows that they are often not able to reach their objectives.

The "target" approach involves interventions which have been initiated by others than the poor. Poor people are seen as " targets rather than decision-makers cum actors capable of improving their own condition, given the right incentives and skills"[79]. Other anti-poverty programmes while declaring themselves in favour of empowerment of the poor, have not moved beyond the rhetoric of community participation and insufficient action has been taken to actively include the poorest people in all the processes of development of the programmes[80]. In some cases, political use of programmes for partisan purposes, top-down implementation and centralism have further weakened peoples' participation at local level and to the extent that existing local self-help groups have been undermined[81].

The question of targeting also raises an important consideration with respect to long-term sustainability and improvement of conditions for the poor. While in many cases, the programmes are important and do contribute to alleviation of poverty in a difficult period, they address only the manifestations of poverty and seldom have an impact on the conditions of the poor and the underlying causes of poverty. They cannot resolve long term poverty and this seems to suggest that the long term impact of such programmes may be limited.

### 10.5 *The participatory approach - partnerships with NGOs and civil society organizations and community groups*

An alternative approach adopted by many NGOs, community groups and civil society organizations, is the participatory approach which involves the poor themselves in all aspects of the formulation of social policy, including situational analysis of the existing social, political and economic causes of poverty, definition of the main problems encountered, and formulation of possible solutions to the problems.

This approach is being adopted by many governments and NGOs since there is increasing evidence that when the poor themselves are involved as actors and not merely objects in the development process, the chances of influencing and achieving human development and equity are significantly strengthened[82]. Innovative activities are often built on the concept of empowerment of people. Methodologies such as Rapid Rural Appraisal, Participatory Action Research and Popular Education based on the ideas of liberating education by Paulo Freire, are used to reach the goal of enabling the communities to analyse and seek solutions to their problems.

## 11. Health sector involvement in the eradication of poverty : an option or an imperative?

Whether or not the health sector can or should play a role in the eradication of poverty is no longer a relevant question. Health services are already deeply involved in trying to cope with the consequences of the increase in poverty in all regions of the world, treating new outbursts of disease which were thought to be controlled; responding to the increase in ill-health; attempting to provide adequate levels of health care with increasingly scarce resources; facing people in need but unable to respond to their needs because of shortage of drugs, supplies or staff; witnessing deaths and permanent disability which could have been prevented... However, managing the consequences of poverty is not enough. The health sector is paying a high price for the lack of political will to invest in health determinants. The question today is rather *how* health professionals, health services and health policy-makers can best contribute to the process of eradication of poverty.

## 12. Summarizing the interaction between poverty and the health care establishment

The main dimensions of the interaction between poverty and the health sector can be summarized as follows:

*From the perspective of the poor*:

- Lack of adequate free or low cost health services may contribute to further impoverishment of the poor. Cost-sharing or fees-for-service may deter the poor from attending health services and lack of resources to pay for transport may deter poor people from attending preventive health services such as immunization or ante-natal care. Scarce resources may be used on drugs at the cost of essential food products which in turn may cause other health problems such as child malnutrition.

- Poor quality of services such as inadequate attention by the physician, lack of available drugs, long waiting times, absence of doctors, ineffective treatment and the charge of "extra"fees" may also discourage the poor from attending health care services[83].

- Health services which are provided at a high social cost (long distances to health facilities, many hours away from renumerated work) to the poor may contribute to the depletion of their assets through loss of capital and precious time.

- Health services do not adequately take into consideration or build on local structures

and community coping mechanisms which may already exist to reduce the effects of poverty and to improve health.

*From the perspective of health services*

- Poverty undercuts the ability of the health sector to carry out its responsibilities adequately and it also increases costs. For example, treatment of infectious diseases is hampered by constant exposure of people to insanitary living conditions; preventable illnesses may be presented at a late stage when complications have set in; and medical treatment may be discontinued due to a lack of resources to pay for drugs.

- Decrease in use of health services may lead to reduced income for health services which in turn may affect the efficiency and effectiveness of the health services. Decrease in use may also affect the staff morale and quality of care.

- Lack of health professionals in rural areas may be linked to a lack of opportunities for medical doctors to earn a living. In many countries, medical doctors are therefore resistant to working in these areas and this may influence the treatment of patients and their attitudes to the local culture. The emphasis of the medical training of most doctors is technical and does not take into account the link between health and development or poverty and health.

- The lack of understanding about poverty and of the multi-dimensional aspects of poverty may also influence the choice of health services which may not always be to the benefit of the poor (e.g. certain essential clinical packages which do not take into consideration the multi-causal nature of ill- health).

- Disease has an impact on the individual as well as the household. Neglect of this may lead to inadequate and unsatisfactory treatment methods which focus on individuals rather than all members of a household.

- The health of other adults and in particular of the breadwinners, is critical for the health and nutrition of children.

- Women are disproportionately affected by poverty exposing them to greater health risks which lead to higher morbidity and mortality. Lack of adequate health services adapted to the needs of women substantially increases these health risks.

- The health sector has a broad network of professionals to draw from - in no other sector

is there such an organized network of people directly involved with the poor. The potential of this network in poverty eradication is currently insufficiently exploited.

## 13. Poverty eradication and Health For All

The above considerations call for a response from the health sector if Health For All is to remain a valid goal today. The vision of Health for All which was launched at the Alma Ata Conference in 1978 is a vision of " the universal attainment by the year 2000 of a level of health that would permit all people to lead socially and economically productive lives. The call for Health For All was - and remains, fundamentally- a call for social justice"[84]. Primary Health Care (PHC) was seen as the most practical approach to achieving the overall objectives of Health For All. Inherent in the PHC approach was an implementation strategy for community involvement in determining health care and health status. Poverty eradication and any policies within the health sector aiming to address the problem of poverty will therefore need to be based on the principles of equity and increased participation of people in decisions and events which will affect their health. Equity is understood here as a concern for "fairness" which includes the notion of social justice and the fair distribution of the benefits that accrue to a society and the goal of equity is to eliminate the differences in health status of different groups in society.

The increase of poverty in many countries suggests that we have a long way to go in attaining Health For All and that much of the commitment to Health For All seems to have gone lost over the last decades. The comprehensive approach reflected in PHC has given way to "piecemeal" approaches within health systems. Conflicting concepts of health have developed. Health is promoted by some as a commodity and something which can be bought or sold while others see health as "prerequisite both for overall human development and for maintaining peace and security without which economies cannot develop and thrive"[85]. Some suggest that the health sector is at a crossroads and the future of innumerable people trapped in poverty will depend on which way it chooses to go: "Countries need to know that either they continue the current trend of diminishing access to comprehensive health services through a market approach to financing, provision and allocation of medical services, or they embrace a radical reorientation towards the development of health systems whose goal is the improvement of the health and well-being of entire populations, giving priority to those with greatest needs."[86]

## 14. Basic principles and strategies for health sector involvement [5]

While it is clear that poverty eradication will not depend on the efforts of the health sector alone, health professionals, health systems and health policy-makers do have an important role to play by pursuing effective health interventions which will reduce health inequalities and by mobilizing support for the creation of an informed, supportive, and health-enabling environment necessary for the pursuit of health for all. For this, the values of the vision of Health For All need to be interpreted into basic principles which can guide the choice in health care development.

### 14.1 *Equity in health care*

The underlying principle of equity in health care requires that it be distributed according to need and regardless of ability to pay. In practical terms this means providing universal access by the poor to comprehensive, good quality health services without regard to financial barriers. The government will need to assume a key role in ensuring that the principle of equity is interpreted into specific and concrete actions through the design and monitoring of the overall health policy.

#### 14.1.1 *Equity in access and health care financing*

One of the most important contributions the health sector could make to poverty eradication is to pursue mechanisms of financing health care which protect the most vulnerable. Many examples of such mechanisms aimed at creating equity can be found which include development of social security systems which cover curative services for the underprivileged, community financing schemes aimed at empowering the community, payment on the basis of income, exemption of payment for health services for those unable to pay, financing of public health activities through tax, and subsidy to private providers and NGOs offering services to poor communities.

When considering ways of protecting poor people from payment, it is important to note that although exemption from payment is important, their implementation in practice is not always straightforward. Even where exemption policies have been designed to protect the poorest people, practical, institutional, and social difficulties may render them inadequate [87]. Some schemes have opted not to exempt anyone and require even the poorest people to pay a "token" contribution. To ask poor people to pay something might guarantee their right to a service. In this way they may also avoid a certain stigma. This has been the practice of the Gonoshasthya Kendra health care system in Savar, a non-governmental organization in Bangladesh in the development of a community health insurance scheme.

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[5] Adaptation of basic principles proposed by Nick Spencer in Poverty and Child Health p 212-214

A study which looked at equity and financing of health care in developing countries, found that despite the existence of explicit objectives of government policies and despite the efforts which governments have made to provide equal access to health for everyone in need, many countries have failed to generate an equal distribution of health care utilization[88]. One of the main reasons for this may be the bias which has emerged towards urban-based hospital care over basic preventive measures and the inadequate portion of the budget allocated to rural areas. Equity in health care financing may therefore need serious reconsideration of the allocation of resources. This requires a clear commitment by the government to allocate adequate funds to the poorest areas and to ensure that the health needs of the regions are well represented in the health budget[89]. The public health sector remains, in principle, the main source of health care accessible to poor people. It therefore has a responsibility to advocate for government commitment and to make sure that the funds actually do reach the areas and people most in need. It is important to note however that, although crucial to the health of poor people, allocation of health services may not be enough to reach the poorest populations. Alternative provisions such as outreach programmes may therefore need to be developed.

Greater equity in the distribution of health services may be achieved through the involvement of communities themselves in development of the infra-structure and in decision-making regarding resource allocation and health care. Community monitoring of the performance of health services will also enhance accountability of health services to the population[90].

#### 14.1.2 *Promoting gender equity*

In view of the burden of poverty that falls on women and the increased risk women suffer due to this, it is vital to ensure that health services are made available to women. This calls for sensitivity and respect for the cultural context in which women live since it may influence access of women to health services. An understanding of the role of women in their communities and families will enable health workers to make more appropriate choices regarding the health services offered to them. The specific needs of women (such as reproductive health needs) should be given priority and responded to in a way which is not limited to technical interventions but in the true spirit of PHC, contributes towards the well-being and empowerment of women and equips women with the necessary tools and knowledge to reduce health risks (e.g. increased domestic violence, illegal abortions and high-risk pregnancies). Reproductive health services can play a major role in creating a “legitimate” space for women to discuss, organize, and overcome barriers to their health and well-being.

### 14.1.3 *Protecting the health of household wage earners and producers*

The health problems of women should also be considered from the household perspective. While many health and nutrition programmes are concerned with mothers and pre-school children, the health of other adults and in particular the breadwinners, is critical for the health and nutrition of children. New health policies are therefore required to identify the mechanisms and means to meet the health needs of all household members. In particular the health of household wage-earners and producers must be protected and improved. Moreover, health services at district level must become more geared to providing outreach contacts to remote vulnerable households, including the dwelling migrants whose temporary periods of work may provide the means of survival to their families living elsewhere.

### 14.2 *Protecting the assets of poor people by adapting health services to their needs*

When considering costs in health care and access to health services, it is important to take into account the social costs incurred by poor people and barriers to access. Health services which require that poor people pay a high price in terms of long walking distances and long waiting hours may contribute to the depletion of their assets through loss of precious time which could be invested in income generating activities or in agricultural production, or loss of capital due to transport, drug and treatment costs. The health sector can therefore contribute to poverty reduction by making efforts to reduce these social costs. This demands a great deal of flexibility on the part of health services and concerted efforts to explore alternative methods in health care delivery such as community outreach programmes, introduction of opening hours which are adapted to people's needs and the provision of transport facilities to the services. Flexibility is also needed on the part of health professionals, to become involved in issues which are not exclusively medical.

For example, a group of medical doctors working in Matagalpa, a coffee growing region of Nicaragua, were made aware of the high social costs incurred by plantation workers in seeking health care at the main health centre. This spurred the medical doctors to meet with the owners of the coffee plantations to discuss the possibility of setting up a small health centre within the plantation which could be run by health workers visiting the plantations on a regular basis. Negotiations led to agreement by the plantation owners to contribute towards the costs of the health centre and to allow the workers to visit the centre and participate in health promotional activities including training of community health workers during working hours[91].The importance of such initiatives is that the assets of the poor are protected whilst at the same time health services are contributing towards improving their health status. This ultimately benefits the plantation owners through increased production capacity.

14.3 *Acceptability and relevance*

Policies and strategies need to take into consideration not only the geographical distribution and the quality of care but also the need for information on the health care services so that they are understood and accepted by the population and perceived as relevant.[92] Health professionals and communities may not always share a common concept of health or health problems, nor will they always be in agreement about how to tackle the health problems. This may lead to the development of health services which are unacceptable or irrelevant to the communities and therefore not used[93]. The case of Kisembo (Box 2)[94] reflects the need for health professionals to pursue opportunities to better understand traditional medical practices and the broader implications of this on the well being and social cohesion of the community.

> With regards to health problems, an experience from a health center in Zaire illustrates the tension which may exist between "western" medicine and traditional beliefs. Despite the fact that Kisembo's mother had taken him regularly to the pre-school clinic, participated in the health education sessions and had made sure he was fully immunized, he died of kwashiorkor. When asked about his condition, the mother informed the nurses that he had been miserable for several weeks leading up to his death. When asked why she did not bring Kisembo to the hospital she answered that " He was not sick, he had lost his peace. Misery cannot be cured by foreign medicine. I took him to the traditional healer but he could not help either".

Box 2 The importance of understanding traditional beliefs

The political structure, decision-making processes, the cultural beliefs, traditions and subsequently the status of women all form part of the local context which needs to be taken into consideration. Rural populations may be more isolated than urban communities from national political developments and they may be much more dependent on the local political structures and hierarchy for decision-making, support and advice than on government authorities or health services[95]. Awareness by health professionals of these structures will help to identify how a community should be approached, how community health leaders should be identified, and the manner in which decisions should be made, both within a family and in the community as a whole.

In many cases, local health services have neglected the importance of the local process and have set up parallel structures such as village health committees which may find themselves in conflict with the traditional structures and decision making processes. The health committees set up by health services may not be relevant or acceptable to the local communities who as a result will not support them. Building on the local structures and strengthening them, will contribute towards making health services more relevant to the local context.

### 14.4 *Participation of the poor in health development*

Broad involvement of people themselves in health development is the only way to reach Health For All. Although this message has been repeatedly stressed and agreed on in many documents and declarations since the Alma At Conference, insufficient attention in practice, has been given to transforming words into reality. For health services, this may mean opening up the process of participation and decision-making to community representatives to discuss issues directly or indirectly affecting the life of communities and to facilitate their effective participation in all aspects of health care[96]. It may mean visiting communities, listening to their concerns and including them in the design, management and control of health services. It may mean being prepared to learn from the poor who are the experts on poverty, to change and to adapt.

This participatory approach recognizes the strengths and resources of the poor communities including existing community-based structures, and seeks to facilitate and enhance these strengths, both on an individual and collective level. The underlying principle of the approach is to promote growth and equity and to strengthen the democratic process at a local level through a bottom up process which enables the poor to become full participants in development and decision-making[97]. Although " participation alone cannot overcome all the barriers to health arising from economic and social deprivation, [..] given a positive climate created by an equitable social policy, communities can become empowered to improve the health of their households"[98].

Community-based health programmes which apply these principles of participation can be found all over the world. In some cases communities have taken on the task themselves of organizing activities, self support groups and actions in favour of the poorest; in others cases, partnerships have developed between the local health services in particular the health services and the communities.

However, community enabling and community organization is not without problems - the process does not give instantaneous results, nor does it deliver goods immediately which is what some people expect[99]. The process is one of individual and collective growth, of awareness raising and one which ensures that the poor assert their rights - to health, to dignity, to participation in decision-making and to their fair share of resources. For health professionals, this may pose a major challenge. Increased participation of people means increased access to information, decision-making and power. In the process, health professionals may see their own power diminish and to accept this will require a change of attitude for many medical doctors. The change will not be easy.

Participation is not passive and awareness raising can lead to concerted action of the poor which may challenge authorities and decision-makers who are not prepared for this. In some places this

has led to increased social tensions, confrontations and deliberate actions of authorities to suppress the initiatives taken by the poor. Efforts need to be strengthened on the part of local and national health authorities to be responsive to the needs of the poor and to include them in a process of decision-making based on true partnership and collaboration. Not only will this process diminish tensions but it will have a greater chance of success.

A multi country study undertaken by WHO and which looked at the role of civil society in District Health Systems, clearly demonstrated that each programme or intervention must be adapted to the local situation and needs of the people, and each situation treated within its own right[100]. There are no generic strategies which can be implemented and used as models and a great deal if sensitivity and respect is needed to each situation.

### 14.5 *Training of health professionals*

The above study also pointed to an important shortcoming within the health sector. While health professionals often have a great deal of experience and systematic ideas about health, they often lack knowledge and understanding of the development process and of the link between poverty and health. A study from India which looked at participatory research in universities highlighted the existing tension between the training which medical doctors receive and demands which await them in practice. "Currently, many universities disable students who pass through them, conditioning them with attitudes and behaviour based on a feeling of superiority and teaching methods which have to be unlearned as they prove ineffective in field situations"[101]. An alternative university training which enables students to be sensitive, humble, to listen, to be self critical and to enable others requires basic changes in both the university system and the health system. Awareness raising of health professionals to the importance of civil society organizations in health development and to participatory action research to develop skills, instruments and methodologies to promote strategic local health planning and management will also require serious consideration by policy-makers of the current medical curriculum. Encouraging experiences of introducing participatory methods into universities and government institutions do point to promising developments which may also influence research on aspects of health and poverty in the future. One such example is The Network of Community-Oriented Educational Institutions for Health Sciences, an international network which aims to strengthen and mutually support the members in curriculum development for community health.

### 14.6 *Information and data monitoring*

In order to develop suitable responses to the problems caused by poverty, adequate data is needed which monitors both health trends and the distribution of poverty in a population. However, the current practice of producing average data masks the real indicators in disadvantaged population



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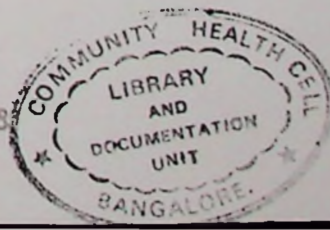

groups, concealing existing disparities in health status and health care. In many countries lack of data may also be a problem. In order to identify disparities it is vital that routine data related to health is collected according to socio-economic status, sex, clan and region. The parameters used to measure and adequately reflect differences in socio-economic status and the process of information collection will need to be developed at country level. The involvement of the poor themselves in research, information collection and monitoring the situation of poverty and health should be sought, using methods such as the Participatory Rural Appraisal which includes data analysis, interpretation and use[102].

Universities and research institutions could play a significant role in bringing information to the attention of policy makers, encouraging poverty eradication which is more effective, flexible, and appropriate. Changes in the health status of the poorest groups as a core indicator of poverty eradication should be promoted and adopted at national and international level.

### 14.7 *Intersectoral collaboration and partnerships in health*

The multi-dimensional character of poverty will require a response which includes many sectors and many actors, private, public and within civil society . Both the Ministry of Health and health systems have a major leadership role to play in this by mobilizing commitment to health as an integral part of development and in influencing policy and actions in other sectors. By monitoring the health and poverty effects of sectoral interventions and programmes, and by participating in intersectoral discussions such as round tables and NGO forums, the MOH and those involved in health are also in a position to analyse the trade-offs related to other sectors.

Suitable mechanisms should also be sought which encourage other sectors to consider the health impacts of their interventions. In Sweden, where political commitment to equity is high, public agencies are required to pursue goals which reduce socio-economic inequalities and to analyse the health impact of all national policies[103]. The MoH could play an important leadership role in this by promoting the integration of health objectives into the respective policies of all sectors so as to ensure the elimination of exposure to health risks by the poorest as well as to strengthen the impact of those sectors whose activities can improve health.

Change calls for political action at the highest level and partnership building between government, NGOs, professional health associations and civil society can stimulate this change through promotion and advocacy. In Brazil, where there are dramatic disparities between rich and poor, an anti poverty campaign was launched in 1993 which has succeeded in mobilizing large parts of the society including trade unions, churches, community organizations, the private sector, banks, professionals, students and women's groups. The aim of the Campaign against Hunger, Misery and for Life was to "raise awareness within Brazilian Society of the rights and

responsibilities of individuals and social groups, and of the need to tackle poverty."[104] The campaign has worked at local level, creating job opportunities and assistance in the form of food donations to the poor; it has been instrumental in the mobilization of the poor to put pressure on local and federal authorities to address poverty issues; and it has been successful in securing government support and in shaping government policy in favour of social equity[105]. It is a unique example of how State, NGOs and civil society have come together to work against poverty. One of the outcomes of the campaign, a prerequisite for the creation of an social environment in which poverty eradication can take place, is that it has " awakened a spirit of solidarity and public responsibility, which is important against a background of growing fear, violence, insecurity and lack of hope"[106].

### 14.8 *Strengthening of Ministries of Health*

A recurrent problem in many parts of the world is that the MoH is not adequately equipped to tackle the multiple requirements of intersectoral action and poverty reduction. Many national MoH are entirely preoccupied with budgets and the specifics of health sector reform and have little time to develop their new leadership role to ensure that health is high on the national development and political agenda. Furthermore, the MoH in many countries has a relatively low status in the government and subsequently health policy is given little attention. This situation requires that the MoH is strengthened in its negotiating role and that it actively pursues opportunities to develop capacities in the area of economics, policy analysis and planning, and legislation.

### 14.9 *Advocacy*

The health sector has a broad network to draw from - in no other sector is there such an organized network which ranges from health committees at the local level to associations of health professionals at national and international level. The human resources and in particular the health professionals which could be mobilized against poverty are far reaching and many health movements worldwide are recognizing this potential and taking initiatives to come together to analyse, advocate and act for the advancement of policy solutions which promote health. Conferences on health and poverty are being organized, such as the one held recently in London in March 1996[6] which brought together representatives from institutions and bodies representing

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[6] A series of international meetings have been sponsored by ICO/WHO on the theme of poverty and health. They include a Congress in Baltimore 1997 on the theme "Investment Strategies for Healthy Urban Communities", a meeting in London 1995 which drew together health professionals, one in Ireland 1996 which targeted national and international NGOs and one in London 1997, a follow-up to the Baltimore meeting. Reports are available from ICO.

health professionals, to look for ways in which to reduce the harmful effects of poverty. Greater coordination was called for between international agencies, NGOs and professional groups and recognition was given to the fact that health professionals have a specific role to play by " showing their indignation at the continued wastage of humanity and acting as advocates for effective policies to reduce poverty and its consequences for health"[107].

### 14.10 *But not without the non-poor...*

Most studies on poverty have focused on the poor[108] and more should be done to involve the non-poor if any change is going to be sustainable. The task today should be to tackle the underlying causes of poverty and not only try to address the manifestations of poverty. This means that efforts must be made to reverse the current trends and to involve the non-poor in serious self-examination.[109] Urgent questions need to be considered and answered by the non- poor themselves: to what extent are they willing to examine their own role in sustaining and creating poverty? What images do the non-poor have of the poor which influence their behaviour and decision-making?[110] Are people who have gained economically prepared to forego further gains in order to reverse the trends? [111] Poverty and the poor cannot be treated as a "phenomenon that can be understood in isolation of society at large",[112] and the fact that poor people are living in symbiosis with the rest of society should therefore be the starting point of future research and consideration.

## 15. From principles to action

It is becoming increasingly clear that the existence of a strategy, policy or principle is no guarantee that action will be taken to implement it. The experiences of implementation of anti-poverty strategies and health policies aiming to reach the poorest suggest that problems have developed which were not envisaged at the start of the process. Many factors which seem to have little to do with the *content* of the strategy have played a role in determining the extent to which an intervention has yielded the desired results. Elements which most seem to influence the success of a strategy such as community involvement, power relations, cultural traditions and structures, political manipulation or lack of management, have just as much, if not more, to do with the implementation of the strategy or policy than with its content. In considering the role of the health sector in poverty eradication, attention should therefore not be limited to focusing on the objectives and content of the policy or intervention; more attention needs to be given to the *context* in which the strategy has been developed, to understanding the *process* of implementation, and to the *actors* involved in shaping or implementing the policies.

With this in mind, a simplified framework for action is proposed in table 3.

**TABLE 3**
**A FRAMEWORK FOR ACTION**

| PRINCIPLE FOR ACTION | IMPLICATIONS |
|---|---|
| Strengthening the capacity of health systems both informal and formal | Protecting and improving the health status of the poorest groups as an essential element in poverty eradication.<br>Defining roles and functions of the health system as an integral component of national poverty eradication strategies and programmes. |
| Advocacy<br><br><br><br><br>Strengthening MoH | Mobilizing the health professional network at national and international level, to participate in poverty reduction and the creation of an enabling environment.<br>Critically analysing policies and practices and informing policy-makers.<br><br>Developing capacities in the area of negotiation, economics, policy analysis and planning, and legislation.<br>Political support. |
| Intersectoral collaboration | Mobilizing commitment to health of all sectors.<br>Promoting the integration of health objectives into the respective policies and actions of all sectors.<br>Promoting the adoption of changes in the health status of the poorest groups as a core indicator of poverty eradication .<br>Creating and mobilizing partnerships with groups in civil society. |
| Promoting participation of the poor in health development<br><br>Protecting the assets of the poor | Opening up the process of decision making to communities by letting go of power by authorities and those in powerful positions.<br>Supporting and facilitating community participation.<br>Recognizing and enhancing community strengths and assets.<br>Practising sensitivity and respect. |
| Ensuring equity in health | Protecting the most vulnerable who cannot afford to pay .<br>Ensuring provision of adequate funds to poor areas.<br>Ensuring that quality health care reaches the poorest. |
| Promoting gender equity | Making health services available to all women.<br>Creating space for the participation of women in decision-making. |
| Developing a household approach to health care | Responding to health needs of all members, in particular the breadwinners.<br>Active outreach to poorest households. |
| Increasing flexibility in adapting health interventions to the needs of the poor | Reducing high social costs for the poor through innovative activities e.g. community outreach programmes. |
| Ensuring acceptability and relevance | Increasing information on health services.<br>Increasing knowledge of communities and the coping mechanisms of the poor.<br>Sensitivity and respect for cultural and traditional health practices.<br>Recognizing and strengthening local structures. |
| Data collection and information | Collection of disaggregated data.<br>Involvement of the poor in data collection and research. |
| Training of health professionals | Awareness raising of the link between health and poverty.<br>Promoting a change of attitude from medical to social. |

## 16. Concluding remarks

The health sector has an important role to play in the eradication of poverty and through its network of health professionals worldwide, it has the informal and formal structure needed to take on the challenge at local, national and international levels. The process of poverty eradication will demand innovative thinking and combined efforts among people who believe that it is possible.

No single political, social or economic intervention or sector can resolve the complex problem of improving the quality of life and reducing poverty, suffering and deprivation. New integrated approaches need to be explored in which "the emphasis is placed both on improving the capabilities of the poor, through the provision of health care, education, and productive assets, and on creating an enabling environment in which those capabilities can be realized."[113] The process will only be successful if there is active participation of the poor people themselves and if the focus of poverty is broadened to address the role of the non-poor part of the population who need carefully to consider also their role in creating and sustaining poverty[114].

One of the aims of advocacy, coordination and collaboration in poverty eradication at all levels should be to develop consistent, coherent and unambiguous global consensus on the values and principles for poverty eradication. Poverty is both global and country specific. The global causes of poverty must be tackled from a global level by the broad international community including the bilateral and international agencies such as the UN agencies and the Bretton Wood Institutions, International Non Governmental Organizations, Civil Society, the Private sector and peoples' movements. Country specific implications of poverty should be addressed at the country level also by the broad range of actors.

According to UNDP calculations, the additional cost of providing basic social services to all in developing countries for the next ten years amounts to $40 billion a year. In a world economy of $25 trillion this represents 0.2% of the global income and less than half of the combined net worth of the seven richest men in the world[115]. Poverty eradication is not about lack of resources.

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