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Poverty, Health & Development

CONTENTS

Reaching the Poorest & Disadvantaged Populations*

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INTRODUCTION

The past century has seen an overall decrease in infant and child mortality, increased longevity, the global eradication of smallpox, and the control of major infectious diseases, particularly in some parts of the world and in certain social classes. Improved socio-economic conditions and living standards, including better housing and nutrition; public health measures; education; and increased access to medical and health care, are the major causal factors. Developments in medical science and technology and important societal shifts underlie some of the changes. The latter includes participatory democracy, which has increased opportunities for previously powerless sections of society, and recognition of the basic human right to health and health care based on social justice, among others.

However at the start of the new millennium, long-standing and yet unresolved challenges remain. They include the continuing health divide between the rich and poor; between and within countries; the gap between expected outcomes and reality; implementation gaps in health programmes; and disparities in control over decision making concerning health, between the powerful and powerless.

We need to shift attention from just reaching the poor and disadvantaged, which implies merely an extension of the existing paradigm, to understanding issues of poverty, inequality and health, and to less visible yet strong, underlying societal and behavioural processes, which call for fresh approaches and paradigms. As we *'cease our endeavours for a short while, to reconsider and redefine our goals for the future'* (MMM, 2000), which is one of the objectives of this conference, we need to re-vision our understanding of 'self' as a profession and our relationship with the 'other', particularly the poor in society, recognising the deeper oneness and unity between us and them. In reaching out to the poor, and in addressing poverty, we help ourselves. From a traditionally privileged position, increasingly subject to public scrutiny and debate, the health profession can build on its strengths and knowledge base, especially with insights from the social sciences, to increase its social accountability and work in partnership with others, especially the poor, **towards Health for All, Now!** (Health for All, Now! is the slogan of a peoples health campaign underway in many countries, with a **Peoples Health Assembly (PHA)** organised in December 2000)

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CLARIFYING WORDS, RECOGNISING SHIFTING BOUNDARIES

The Poor – Social Minority or Majority?

Critical to the theme of this paper are perceptions of the poor, and their role of agency in transformatory, change processes, towards better health and life in all its fullness, as participant key subjects rather than objects. The word 'marginalised' is often used alongside 'poor and disadvantaged'. This suggests small numbers or minorities at the margins of mainstream society, who are left out and need to be reached. Knowledge, gained through research and experience of working outside hospitals, suggests that numbers are much larger, comprising perhaps the social majority. 'Impoverishment', another word, suggests that social and political processes occur, making people poor.

Measuring the magnitude of persons living in poverty, through poverty lines, is dependent on how poverty is defined. Income poverty or food poverty lines (measuring purchasing capacity for basic caloric requirements as in India) represent a minimal, static and even arbitrary approach, resulting in lowered estimates (Ghosh, 1990). The basic minimum needs approach (including requirements for clothing, shelter, medicine and schooling) and the Physical Quality of Life Index (PQLI) are other instruments. More recently the multi-dimensional Human Poverty Index (HPI) is a composite of longevity (life expectancy), knowledge (literacy), economic provisioning and social inclusion (employment) (UNDP, 2000). Distributional disparities occur between gender, rural and urban areas, region, ethnic and language groups. Incidence and intensity of poverty varies. Those just above the poverty line fall below it during periods of illness, in adverse seasons, during natural calamities, social and political unrest, conflict etc. The gap between rich and poor is widening in countries where economic liberalisation is underway (PHA, 2000). While absolute poverty with a lack of resources, necessary for survival, is associated with poor health, evidence from U.S.A. and U.K. indicate that relative poverty, defined in relation to average resources available in a society, is also a major determinant of health (McCally, 1998). While the poor are sub-classified into being destitute, very poor, very poor and poor, ill health lowers access to good quality health care, and ill-treatment by health providers, are common experiences for the entire group.

Poverty is also defined in contemporary times "as the denial of opportunities and choices most basic to human development – to lead a long, healthy and creative life, and to enjoy a decent standard of living, freedom, dignity, self-esteem and the respect of others" (UNDP, 1997).

Given the broadened definitions, which are required when using a value base of social justice, there is evidence that a substantial proportion of the global population, live in poverty, with different degrees of deprivation, alienation and social exclusion.

In India, the proportion below a minimal poverty line declined slowly from 50% in 1951 to 35% in 1994, but due to population growth (which is also dependent on social development), the actual number increased from 164 million to 312 million. Recent surveys of rural households show 68% as landless wage earners and 45% of households without anyone literate (cited in Lamba, 1999). In 1998-99 in India, among children under age three, 46.7% were

underweight (weight for age), 44.9% stunted (height for age) and 15.7% wasted (weight for height) (NFHS 2, 2000). Among women aged 15-49 years, 51.8% were anaemic (*ibid.*).

This evidence along with several other studies, indicates that a much larger proportion of people suffer from deprivation, be it food, education or biological poverty, than indicated by income poverty lines, which are now below 30%. Thus it is suggested that the poor in India and globally comprise a social majority (Pinto, 1998).

Does this make a difference to our strategies?

What is being reached – Health and/or Medical care?

Increased provision of medical care reduces unnecessary pain and suffering, but in itself only marginally improves health status. WHO defines health as a state of physical, mental and social well being, and not merely the absence of disease or infirmity. Attempts to improve health status, towards reaching this ideal, have long recognised the importance of access to basic determinants of health, such as nutrition, safe water, sanitation, clean air, housing, employment, safety at home, in the work place and on the roads. Social inequality deprives the poor of these basics. Is the medical and health profession interested in just medical care or also better health?

The WHO-UNICEF declaration in Alma Ata in 1978, on **Health for All** (HFA) by 2000 through the Primary Health Care (PHC) approach, used social justice as its basis and explicitly adopted intersectoral coordination as a strategy to address the need for access to basic determinants of health. The role and scope of the health profession and health sector was thus even then broadened beyond medical care. This was mandated and accepted by all WHO member countries, and followed up by resolutions, national health policies, plans and programmes. This was seen as an advance in improving the health of the poor. Very soon however this broad based approach was narrowed down, selectivised with vertical single disease programmes, and medicalised with a focus on diagnostics and drugs, not on people, communities and society.

In 2000, while WHO busied itself with Safe Blood as the theme of its WHO Day, on 7th April, impoverished peoples and civic society networks and movements in India pledged, through a national campaign, to continue to work with greater urgency towards Health for All, Now! This is part of a wider international peoples health campaign, leading to a Peoples Health Assembly in Dhaka in December 2000, which asserts that Peoples Health should be in Peoples Hands and reaffirms the role of the state in primary health care and public health (PHA, 2000). At the turn of the millennium we need to be analytical and remind ourselves of the reasons that prevented Health for All, through Primary Health Care, from becoming a reality.

STRATEGIC APPROACHES TO IMPROVED HEALTH FOR THE POOR

Promoting Indigenous Systems of Medicine and Healing Traditions

Poor people across the world have developed diverse traditions of healing and systems of medicine. Women are often the carriers of local health traditions and also carers of people during illness. Modern medicine with scientific arrogance has often

labelled traditional knowledge as non-knowledge, and healers as quacks and witches, causing disempowerment and loss of heritage. There is an urgent need for dialogue based on respect, to enable learning, restoration and promotion of these systems and traditions. This needs to be accompanied by safeguarding community and people's rights from the avariciousness of commercial interests and patent rights.

As part of its 5000 year old living civilisation, India has evolved several indigenous systems of medicine, such as *Ayurveda* (the science of life) *Siddha, Unani, and Yoga*, all with texts, which form part of the world's oldest written medical literature. A wealth of local, oral traditions exist, being passed on from generation to generation by folk healers. Similar knowledge bases and caring traditions exist world-wide. There is minimal budgetary, legal and institutional support for the growth and promotion of these systems. They are scarcely involved in health planning and programmes. Some have been pushed into subaltern states by the dominant modern biomedical paradigm. Recognition, legitimisation and strengthening of these traditions will enhance the contribution of people themselves to improved health and quality of life. Supported by the philosophical traditions they represent, indigenous systems are less compartmentalised, and deal differently with issues such as the meaning of life, quality of relationships, attitudes, and acceptance of death. In the quest for health we need to include multiple world views, multiple realities, multiple voices. For this we need to listen, to learn, and to allow a questioning of the hegemony of modern medicine.

Fostering Community Involvement

Community involvement, a cardinal principle of primary health care and of community health, has been fragmented by a combination of professional and commercial interests (the doctor-drug producer axis) operating through market forces. It has been declared idealistic, non-workable and immeasurable by experts, who are impatient and focussed on specifics.

The potential power of the community as healer, as being able to hold brokenness and restore wholeness, are human and higher dimensions beyond market and biomedical paradigms.

At another level, community involvement in micro-planning, decision making and in running health programmes have made possible more rapid, sustainable, health gains, at low cost. This is the experience of NGOs globally. Community participation in public sector programmes, through elected representatives and civil society groups, enhance implementation, including quality.

On a larger scale, social movements of the poor raise basic issues, which impact on health. These include movements regarding livelihoods, water, and environment. Socially conscious professionals and others have worked on campaigns for rational therapeutics, women's health, and workers' health, from which there is an emerging health movement.

However resistance by the medical profession to subject itself, and its technology, to social control, through local committees, consumer and patient groups, ethical committees and elected local bodies, hampers outreach, development and access to the poor, and is one of the barriers between people and the health services.

Bridging Implementation Gaps

All aspects of health policy in some countries, including problem identification, policy content, programme planning and implementation, are influenced by dominant

interests, in ways such that the needs and interests of the powerless and poor come last (Narayan, 1998). This is evident in the poor implementation of tuberculosis programmes with continuing high mortality and poor treatment outcomes, despite effective, low cost treatment.

High rates of child undernutrition and anaemia; large proportion of people still lacking access to safe water and sanitation; high maternal, infant and child mortality; are all witness to implementation gaps in public policy.

Political economy factors are evident in the energetic promotion, on the other hand, of population programmes, euphemistically given new names, such as, family welfare, reproductive and child health, but still driven by demographic determinism. These factors are also evident in the disproportionate leverage in national policy planning that donor agencies expropriate, despite very small proportions of actual aid, or more recently even with loans.

Several scholars and agencies recognise the need to improve institutional mechanisms to strengthen implementation and reduce gaps. This includes the need for good governance, leadership at different levels, management, and most importantly strengthened capacities and humane attitudes and relationships, at the interface between patients, people and providers. Involvement of different stakeholders, especially women and NGOs, with systems of accountability and transparency, enhance implementation. There is a recognition however that the poor, preoccupied with survival tasks, are the least organised and articulate, with less bargaining and negotiating abilities. On the other hand, professionals, technocrats, bureaucrats and industry, form strong alliances. With access to upto date information, good communication and coordination mechanisms, the playing fields are very uneven. Thus implementation factors are complex, but need to be given priority and close attention, at all levels, particularly locally, if better health for the poor is to become a reality now (Narayan, 1998).

Addressing Political Processes and Power

At the turn of the millennium there is a need for explicit recognition that political structures and processes, and issues of power, help determine content, direction and implementation of health policies and programmes. Equally important is the recognition that the medical profession itself is a strong political player, very protective of group interests, well organised, working in alliance with governments, industry, and international agencies, and often unmindful of the real interests of the poor, despite public statements and individual acts of commitment. Professionals as a group violate the health rights of the citizens, particularly the poor, by non-implementation, non-action, apathy, non-availability, provision of poor quality care, corruption and rude behaviour (Narayan, 1998). Though occurring to different extents in different parts of the world, this factor needs recognition and redressal.

Preventing Distortions due to Privatisation

Another important issue, in the current neoliberal context, that hurts the interests of the poor, is the promotion of privatisation in all sectors, particularly in medical and health care, by powerful institutions such as the World Bank and allied bodies. Despite cautions by WHO, these institutions used loan conditions to further this agenda. Thus commercial high tech, secondary and tertiary care was introduced, opening up

markets for multinational consumer products, along with stagnation and reduction in real public sector health spending. This worsened pre-existing inequities in health.

Global policy prescriptions for contraction of public sector expenditure, derived in part from over-extended unsustainable health budgets in industrialised countries, following rising costs of medical care. Generalisations to countries with different contexts, where health budgets were far below WHO recommended norms, makes any contraction of health expenditure counter productive, leaving money for salaries but not for service or infrastructure maintenance. A public private mix is advocated with a larger role for the private sector, in the absence of evidence of significant or sustained private sector participation in health promotion, health prevention, rehabilitation or public health. There is also little evidence of greater cost effectiveness, efficiency or quality of care in the private medical sector, particularly in low-income countries, where regulatory mechanisms are least developed. These policy changes have diminished access to care, particularly for the poor, causing shifts to poorer quality care in the informal sector and in households by families, thereby adding to the workload and anxiety, particularly of women. The ethics of introducing major policy changes, without evidence or monitoring, need to be addressed.

There is widespread concern about the potential impact of the World Trade Organisation (WTO) agreements on access to health care (PHA 2000, Health Counts 2000). For instance, the TRIPS agreement (Trade Related Aspects of Intellectual Property Rights), through patents and higher drug prices, prevents access by the poor to the benefits of new science and technology developments in the pharmaceutical industry.

Responding to Indebtedness and Ill-health

In low income countries, in the absence of functioning public sector health services, a significant proportion of persons with chronic illness or acute emergencies get indebted while purchasing private medical care (Narayan, 1998). In India, medical expenditure comprises the second most important cause of rural indebtedness. Studies in China show that chronic ill health is a cause for persons and families being pushed below the poverty line. Public sector provision of medical care therefore has a poverty alleviating effect on households.

At a global level, NGOs, the Jubilee 2000 coalition, UNICEF and others have documented the adverse effects of international debt on the health of the poor. In 40 heavily indebted poor countries, life expectancy is 12 years lower than other developing countries and 27 years lower than industrialised countries (BMA, 2000). Debt repayments surpass health expenditures by 3-4 times in these countries. The per capita expenditure in health in these countries is less than £6, while it is more than £950 in the U.K. (ibid.).

With a total debt of $2000 billion (UNICEF, 1999) there is a net transfer of resources from poor to industrialised countries and a continuing of the process of impoverishment, which has a deep structural roots.

Besides indebtedness, conditions linked to Structural Adjustment Programmes result in increased unemployment, a shift to the informal sector where there is no social security, introduction of user charges, reduced access to care, downsizing of the public

sector in health, changed nutritional status and increased nutrition, insecurity with withdrawal of food subsides and currency devaluation. These changes have been documented in Africa, Eastern Europe, Latin America and Asia, with widening gaps between and within countries. Urgent action is required to address this issue.

CONCLUSION

Important issues concerning health of the poor and poverty and health linkages, have come to the global policy agenda, during the last few decades of the millennium. They reflect widespread concerns that we, the human race, have not done as much as we had hoped or expected. Valuable lessons have been learned, and insights gained, during the struggle or period of trying to reach Health for All by 2000. This knowledge gained has been both experiential and research based. The challenge before us is how we integrate this knowledge, including the negatives, into positive, affirmative action for equity in health. Equally important is how we go about the process, moving beyond biomedical and market paradigms, allowing ourselves to be led beyond barriers, especially by the agency of the impoverished. ■

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"Now we are having a very difficult life,