



World Bank – Health Systems Development — February 2006

Economic Viewpoint



"Reaching the Poor", by **Abdo S. Yazbeck**, Lead Economist, Health at the World Bank Institute. [Read the article.](#)

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Does universal coverage at low income levels mean fewer resources allocated to programs and care for the poor?

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[Reaching the Poor with Health, Nutrition & Population Services](#), D. Gwatkin, A. Wagstaff, A. Yazbeck eds., The World Bank, 2005.

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Reaching the Poor



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Public Investments in health should mean investing in the poor but more often than not publicly financed health services are likely to benefit the better off. In light of the especially high burden of disease and malnutrition among the poor, it is not surprising that many policy makers have assumed that investing in health is investing in poor people. Unfortunately, increasing empirical evidence finds that for most health and nutrition programs in developing countries, investing in health is investing in the better off, who tend to be the principal users of health services. (Gwatkin et al. 2000, Castro-Leal et al. 1999, World Bank, 2003). While this orientation of public spending is not unique to health, it has contributed significantly to large poor-rich gaps in health outcomes like child and maternal mortality.

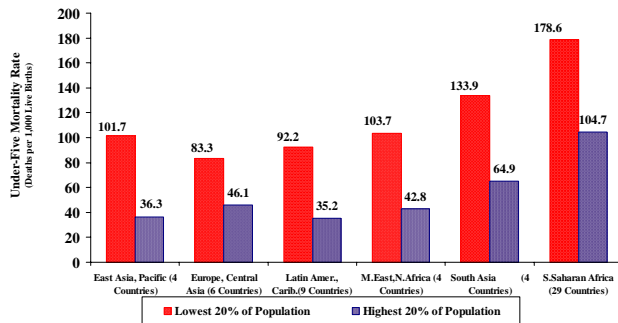
and measurement of inequalities in health outcomes and in health service use, especially with regard to inequalities by economic status, and (b) the identification of strategies for reducing those inequalities.

Documentation of Inequalities

Work on documentation has been fueled by the discovery that information about household assets—for example, ownership of such common articles as bicycles and radios, and sources of water and fuel—can be used in place of income or consumption to assess families' economic status (Filmer and Pritchett 2001). Because assets are far easier to measure through household surveys than income or consumption, this innovation made it feasible to examine economic inequalities in health status and service use. The previous focus on inequalities in health inequalities attributable to gender, educational status, religion, and place of residence could therefore be broadened.

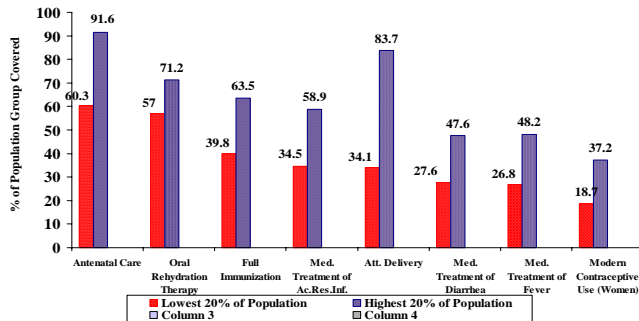
The application of the asset measurement method not only allowed the analysis of distribution of health outcomes and health system outputs in such surveys as the DHS-based studies of Gwatkin and others (2000); it also opened the door for other agencies to include asset questions in their surveys and thus undertake their own distributional analysis. Among the agencies sponsoring major household survey programs that have recently done so are the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). Over the past few years, asset questions have been added to UNICEF's Multiple Indicator Cluster Surveys (MICS) and to WHO's World Health Survey (WHS).

Economic Inequalities in Under-five Mortality
56 Developing and Middle-Income Countries



Economic Inequalities in the Use of Basic Maternal and Child Health Services

Average of 56 Developing and Middle-Income Countries



Although not yet fully appreciated in all health policy circles, the accumulating empirical evidence on inequalities has become well enough known to begin making itself felt. The result has been increased work on two issues: (a) the documentation

Identification of Strategies for Reducing Inequalities

Concern among policy makers about improving health equity has grown faster than their knowledge of how to go about it. This dichotomy has intensified the need for and interest in policy and strategy options that can help policy makers realize their aspirations. A number of research and knowledge management activities have tried to address this gap in knowledge about what works in reaching the poor with health, nutrition and population services.

An early activity was the Global Health Equity Initiative organized by the Rockefeller Foundation and the Swedish International Development Cooperation Agency. The Initiative produced the well-known book *Challenging Inequalities in Health: From Ethics to Action* (Evans and others 2001). A more recent health research effort, also partially supported by the Rockefeller Foundation, is being conducted by the INDEPTH Network of demographic surveillance sites in developing countries. The volume of studies produced by the initial phase covers inequalities in both health outcomes and health service use (INDEPTH Network 2005).

World Development Report 2004 (World Bank 2003) summarizes the growing evidence on how public spending on education, health, nutrition, water, sanitation, and electricity fails the poor in many low- and middle-income countries. The report offers alternative ways of improving the efficiency and equity of health and social sector expenditures by examining and strengthening the relationships between poor people, policy

makers, and service providers and by strengthening accountability mechanisms.

The emphasis on health services in World Development Report 2004 and other recent activities has recently been complemented by the focus on the social and economic determinants of health inequalities adopted by a commission established in March 2005 by the World Health Organization. The commission, chaired by eminent epidemiologist Sir Michael Marmot, hopes to develop a "third major thrust" that can complement health system development and poverty relief by finding ways of reducing social disparities (WHO 2005).

The Reaching the Poor Program

The Reaching the Poor Program (RPP) was initiated in 2001 by the World Bank's Health and Poverty Thematic Group, which brought together members of various Bank units who shared a concern for the health of the poor. Financed through grants from the World Bank, the Gates Foundation, and the governments of Sweden and the Netherlands, the Program had three phases:

Phase 1: Knowledge generation. Case studies were commissioned through an international competitive bidding process.

Phase 2: Knowledge synthesis. A global conference held in February 2004 brought together researchers financed by the RPP program and investigators who had done similar work financed by other sources.

Phase 3: Knowledge dissemination. The final phase of the RPP program consists of several components. Among the most prominent are:

- A book, *Reaching the Poor, What Works and What Doesn't*, was launched on December 7, 2005.
- A special issue of the *World Bank Institute Journal Development Outreach* designed for a policy audience and featuring briefer and less technical versions of some of the more interesting conference presentations, designed for a policy audience.
- A series of dissemination seminars for policy makers.

The most important finding of the Reaching the Poor Program is that health, nutrition, and population programs do not have to be inequitable. The RPP studies and conference has found that there are more than enough documented cases of programs favoring the poor to show that it is possible to overcome inequality. A second finding is that there are many ways of running pro-poor health programs, using different approaches employed through a variety of implementation arrangements. A few examples of programs that were found to successfully reach and serve the poor include:

- Financing health insurance for the poor in Colombia;
- Contracting with NGOs for services delivery with targets to serve the poor in Cambodia;
- Social Marketing insecticide-treated bed-nets in Tanzania;
- Service delivery and outreach for poor women by a women's union (SEWA) in India;
- Geographic targeting of facilities within a universal program in Brazil;
- Participatory planning for reproductive health services in Nepal;
- Community based micro insurance in Rwanda.

Given that the roots and manifestations of poverty and inequality vary from country to country and even within large countries, it is reasonable to expect that several different approaches can be developed and implemented to address inequalities in health service use. While a single approach is not the answer, the programs that have succeeded in reaching the poor provide some patterns and general recommendations. A characteristic of some of the successful programs was making reaching the poor an explicit goal and leading motivation of the effort. In order to achieve this objective, many programs recognized the importance of analyzing the bottle necks faced by the poor and in existing health systems. Two additional characteristics were monitoring for distribution and experimentation with creative approach to planning and delivering services.

The accumulated evidence of inequalities in health services use should convince us the good intentions are simply not good enough when financing health service. The Reaching the Poor Program is showing that with hard work and focus on the needs of the poor it is possible to decrease inequalities and that there are many different ways of doing it.

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Universality: A Failed Ideal?

In the international health policy arena, a lively debate exists between proponents of universal versus targeted approaches to health care.

Those who advocate universality claim the poor are best served when they have equal access to a national health service financed through progressive general taxation. Proponents of this approach maintain – with strong conviction – that in the case of health care, need should be the principal criteria for equitable financing and access, not ability or willingness to pay. They point out that providing the whole population with access to a uniform health service is the only way to avoid a two tiered health care system in which the rich and poor have access to different levels of care. Furthermore, they say that such a system avoids the social stigma associated with having to means test the poor.

In the OECD, 12 countries have achieved universal access through such a national health services approach to health care financing and service delivery, while many of the other countries offer the same benefits through a national social health insurance type of arrangement. Among the OECD countries, only Mexico, Turkey, and the US still fail to provide universal coverage for full range of health care services for their population.

Many developing countries have tried to follow a similar path. Most have failed. Why? First, at low-income levels financial resources available through the public sector are extremely limited. It is hard to collect taxes from poor rural and informal sector workers. People with limited income are often reluctant to contribute to an insurance program where the benefits they will receive may not materialize until some distant point of time. Lack of quality and trust in government run programs compound this problem.

Second, countries that have tried to cover health care for their whole population end up spreading scarce public resources so thinly across a large population that no one gets much of anything. Since many health needs require interventions beyond those that are affordable when offered to the whole population, most people – including the poor – end up seeking at least some care outside the supposed universally available public system. The fact that 80 percent of health care spending in many low-income countries is out-of-pocket indicates just how inadequate this approach really is.

An alternative approach is to spend more public money on the poor who need subsidies the most and less on those who do not. Every dollar spent on care for people who could afford to contribute is a dollar not spent on the poor. With money freed up in this way, the poor can be offered more adequate services that extend beyond minimal basic care, decreasing their need to buy these themselves from private providers.

Improved targeting can be achieved in several ways: (a) focusing scarce public resources on poor individuals or households; (b) allocating resources preferentially to poor regions within a country or on population groups that are particularly vulnerable to poverty; (c) emphasizing health, nutrition, and reproductive services used by the poor; and (d) giving greater attention to health care providers that serve the poor. Countries can still include the non-poor in their public policies by supporting the establishment of contributory health insurance or some other forms of prepayment programs so that the health needs of those that can afford to pay are also dealt with in a responsible way but without diverting scarce public resources from the poor.

The poor may be best served when such pragmatism prevails over lofty ideals about universality.

