

Health and Poverty

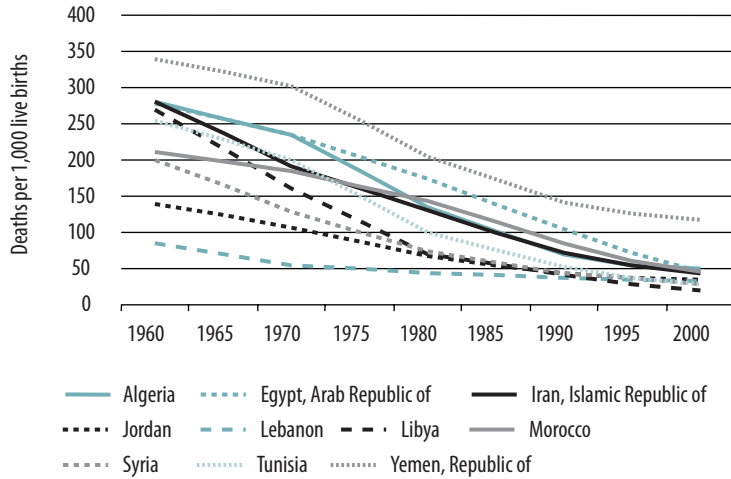
As shown in chapter 2, the Middle East and North Africa Region has made significant progress in improving the average health status of its citizens. During the last two decades, the rate of progress has been above and beyond what can be explained by its initial levels of income and health in 1980 and subsequent income growth. This chapter explores patterns of health spending that may have contributed to this and discusses the extent to which improvements have occurred in the health status of the poor specifically. Key conclusions are (a) despite substantial gains, health disparities continue to exist between the poor and the rich, albeit to different extents in different countries; (b) health spending and outcomes vary among Middle Eastern and North African countries, reflecting different degrees of system efficiency; and (c) coping with the disease patterns emerging from the ongoing demographic transition will require new approaches to health care financing that should aim *inter alia* at protecting budget resources to address the needs of the poor.

Health and Poverty: The Record in the Middle East and North Africa

Figure 4.1 shows how health status has improved in most of the region during the past 40 years, according to the measure of child mortality. There is steady improvement in the case of each of the 10 countries shown here. And the same general picture of improvement applies in the case of other commonly used indicators of health, such as life expectancy or infant mortality. The question that arises is whether the gains in average health status have also redounded to the benefit of the poor. We investigate this first by looking at the disparities in health status that exist across income groups in the region, and then by checking to see if these disparities have been reduced over time.

FIGURE 4.1

Country-Specific Trends in Mortality among Children Less than 5 Years of Age, 1960–2000



Source: World Development Indicators, CD-ROM 2004.

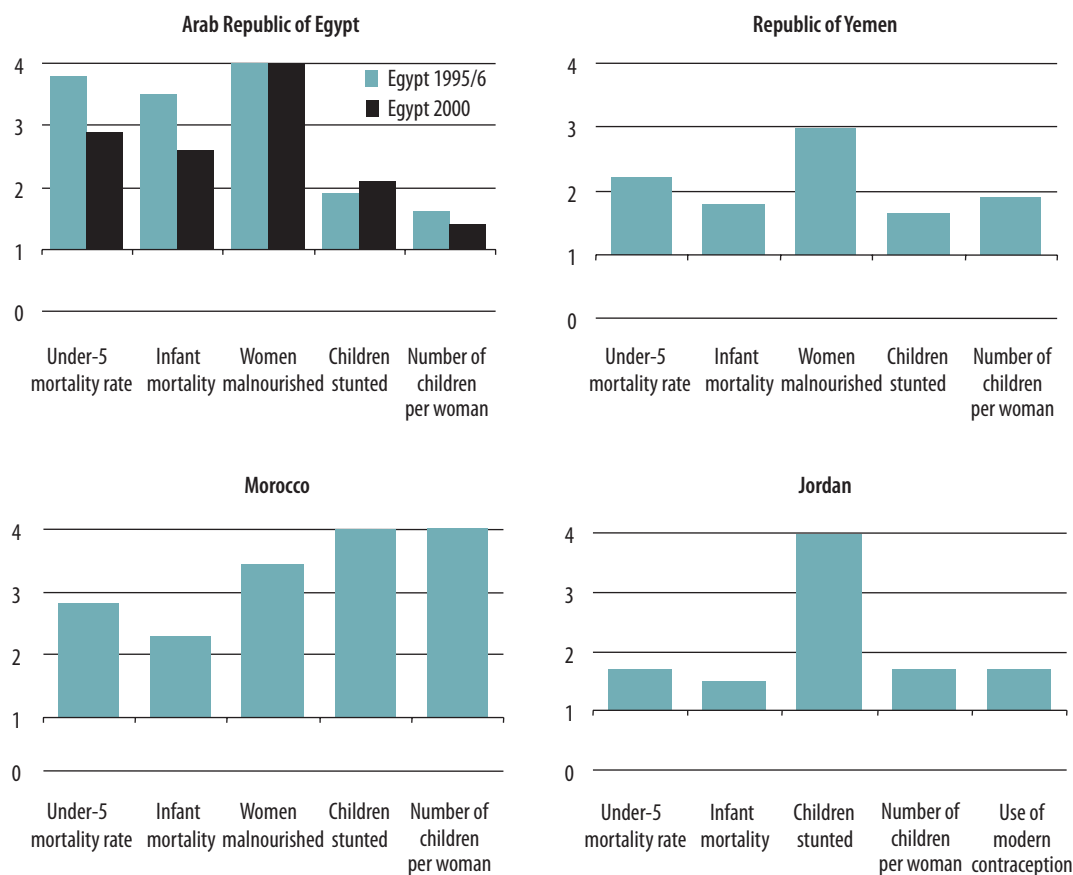
Health and wealth are frequently correlated. A sense of the extent of the correlation in this region can be obtained from recent Demographic and Health Survey (DHS) data for Egypt, Jordan, Morocco, and the Republic of Yemen.¹ These data show that for all four countries and for all five indicators (see figure 4.2), health outcomes among the poorest are worse than among the richest. On average across the four countries, the children of the poorest 20 percent of the population are more than twice as likely to die before they reach their fifth birthday, compared with the children of the richest group. More than four times as many mothers in the poorest group are malnourished, compared with mothers in the richest group. Children in the poorest segment of the population also have rates of malnutrition that are four times as high as those in the richest segment.

The extent of health inequalities varies among these four countries, with Egypt and Morocco having the largest disparities. In these two countries, under-five mortality rates are three times as high for the poorest quintile as for the richest, and infant mortality rates are more than twice as high. Among the poorest quintiles in Egypt and Morocco, infant mortality rates are over 75 per 1,000 live births and under-five mortality rates are close to 100 per 1,000. This is worse than the average for South Asia. The Republic of Yemen also has substantial health inequalities. The poorest 20 percent of that country’s population have among the highest infant and child mortality rates in the world, with rates similar to those

FIGURE 4.2

Health Outcome Inequalities in Selected Countries

(Ratio of data for the poorest quintile to the richest quintile)



Sources: Demographic and Health Surveys for the Arab Republic of Egypt (1995/96, 2000), Jordan (1997), Morocco (1992), and the Republic of Yemen (1997).

found among the poorest people in Sub-Saharan Africa and South Asia. Jordan has much less health inequality than the other three countries. Indeed, it is among the lowest third in terms of health inequality among all countries covered by the DHS studies. Despite this, differences between the richest and the poorest Jordanians are still significant for child malnutrition and certain health process indicators.

Significant disparities at a given point in time, however, can still be consistent with a record of reduction of disparities over time. In general, the substantial decline of child and infant mortality in the region over the past four decades must reflect disproportionately higher health gains among the poor, compared with the rich. But it is useful to get more direct evidence as well. This is possible for the case of Egypt because two

DHSs have been completed there, one in 1995 and the other in 2000. Comparing across these two surveys shows that disparities have declined in Egypt for four of the five measures of health status (see figure 4.2, first panel). For other countries, indirect evidence may be used. For example, during the last two decades or so, the gap in infant mortality rates between rural and urban areas in the Islamic Republic of Iran has declined significantly. This suggests that the general improvement in health status there (as shown, for example, in figure 4.1) has been accompanied by disproportionate improvements in the health status of that republic's poor people. Box 4.1 discusses the factors that lie behind the Islamic Republic of Iran's impressive achievements in primary health care.

While acknowledging the improvements that have occurred to date, it is necessary to draw attention once again to the health inequality challenges that remain. Health policy in the region must continue to pay at-

BOX 4.1

Primary Health Care and the Rural Poor in the Islamic Republic of Iran

Rural households in the Islamic Republic of Iran traditionally have been the most disadvantaged segment of Iranian society, not only in terms of income and political power but also in accessing basic public services, including health. A major achievement of public policy in the Islamic Republic of Iran over the past 20 years has been the improvement of rural health and the near-elimination of some health disparities between urban and rural populations, the latter often comprising a much poorer group than the former. For example, in 1974 the infant mortality rate was 120 and 62 per thousand live births for rural and urban areas, respectively. By 2000, however, both the level and the differential of infant mortality had declined considerably—to 30 for rural areas and 28 for urban ones. This reduction in the rural–urban infant mortality gap was achieved in large measure through three innovations in the primary health care (PHC) system: (a) establishing “health houses” in remote and sparsely populated villages; (b) staffing the health houses with health workers, known as *behtarzan*, recruited from local communities; and (c) developing a simple but well-integrated health information system.

The health house, usually the only health facility accessible to the rural population, is the most basic unit of the Iranian PHC network. Located in individual villages, it is designed to cover a target population of about 1,500; each health house also serves several satellite villages selected with careful attention to their cultural and social compatibility. The distance between the village in which the health house is located and the satellite villages it serves is typically no more than one hour's walk. Tasks performed at the health house include record-keeping and data collection; public health education and promotion of community participation; antenatal, perinatal, and postnatal care; care of small children as well as school-age children; family planning services; immunization; and disease control services.

tention to reducing the large disparities that remain between rich and poor people through such measures as extending health insurance coverage to the poor, allocating more health resources (such as doctors, nurses, and clinics) to rural or otherwise poor areas, and implementing multi-faceted community-level interventions to reach the poor.

Determinants of Health Achievements in the Middle East and North Africa

The pattern of health status improvement shown by countries in the region is also exhibited by most other developing regions. Indeed, there has been a global wave of improvement during the past four or five decades in such indicators as life expectancy and infant and child mortality. This global

Behvarzan who staff the health houses are chosen from among local people familiar with the households in the village. This facilitates the accurate collection of health information as well as culture-sensitive communication. Potential *behvarzan* receive free training and financial support throughout the two-year period of their training. In return, they are formally obliged to remain and serve at the village health house for a minimum of four years after completing their training.

The health information system enables the *behvarzan* to collect detailed data on rural communities. The main components of this information system are the household file (containing demographic and health information), various logbooks in which daily activities are recorded, and monthly report forms.

The PHC system is entirely funded by the national government, and the pattern of public health spending is oriented toward rural public health services—a fact that may partly explain its good performance with respect to rural infant mortality rates. Among specific measures taken by the PHC system are the promotion of healthy attitudes and behaviors; the universal immunization of children; and encouragement of mothers to breastfeed, use iodated salt, and provide appropriate treatment for children suffering from diarrhea and acute respiratory infections.

The presence of the community-friendly *behvarzan* in the village, with their constant interaction with the community, has helped ensure that health messages have not gone unheeded. Moreover, the ability of the PHC system to support the health messages by providing easy access to the means needed (vaccines, oral rehydration therapy, essential drugs, and so on) where and when they are required has also helped in bridging the gaps often found among knowledge, attitudes, and practice.

Source: Mehryar 2004.

trend is attributable to (a) improvements in medical science and technology and (b) improvements in public health interventions, including cost-effective programs of immunization. However, as shown in chapter 2, health status improvements in the Middle East and North Africa have been faster than in comparable countries. Indeed, for measures of child mortality and life expectancy the gaps that existed in earlier decades between countries in this region and comparator nations were eliminated by 2000. This suggests that there are factors beyond the common global wave of technological improvement that have influenced health achievements in this region. One such factor is likely to have been increases in female education. This is an area in which the Middle East and North Africa has made rapid improvements, although it has not yet closed the gap with comparators. Among other likely factors are levels and patterns of spending on health.

Levels of Spending on Health

Have Middle Eastern and North African countries tended to spend more on health than have comparable countries? Unfortunately, an extensive time series on health sector spending is not available so we cannot arrive at a definitive answer to this question. The available data do show somewhat higher spending in this region in recent years. Data for 2002 (see table 4.1) show that, on average, Middle Eastern and North African countries spend around 5.9 percent of GDP on health, which is just above the 5.8 percent spent by other lower-middle-income countries. However, the public spending component of this is 2.9 percent in the Middle East and North Africa, compared with 2.5 percent in other lower-middle-income countries. And per capita expenditures in the region are around \$89, whereas those in lower-middle-income countries are around \$75. There is a lot of variation within the region with regard to health spending, however, so the averages need to be interpreted with caution. Moreover, the variation in spending is not necessarily associated with differences in health outcomes (see box 4.2).

Incidence of Health Spending

We turn now to some evidence on patterns of spending. The limited amount of information on the incidence of health subsidies by income group in the region shows that the rich capture a larger fraction of the subsidies available through public spending on health. For example, in Algeria the share of household health expenditure for the poorest 10 percent of the urban population is three times higher than the share for the richest 10 percent; for the rural population it is twice as large (World Bank 1999b). In the Republic of Yemen, an analysis of the public health

TABLE 4.1

Health Expenditures in 2002

Country	Health Expenditure (% of GDP)			Health Expenditure (US\$ per capita)
	Public	Private	Total	
Algeria	3.2	1.1	4.3	77
Arab Republic of Egypt	2.4	3.6	6.0	79
Islamic Republic of Iran	2.9	3.1	6.0	104
Jordan	4.3	5.0	9.3	165
Lebanon	3.5	8.0	11.5	568
Morocco	1.5	3.1	4.6	55
Syria	2.3	2.8	5.1	58
Tunisia	2.8	2.8	5.6	126
Republic of Yemen	1.0	2.7	3.7	23
Middle East and North Africa	2.9	3.0	5.9	89
Lower-middle-income countries	2.5	3.3	5.8	75

Source: World Development Indicators, CD-ROM 2004.

BOX 4.2**Health Expenditures and Outcomes in Selected Middle Eastern and North African Countries***Moderate Spending with Good Value for the Money: Tunisia*

Health expenditure per capita in Tunisia is US\$126 a year, out of which 50 percent derives from public sources. Health expenditures make up 5.6 percent of GDP. The level of health expenditure is comparable with international data for countries at similar income levels, although Tunisia is performing better than expected on key health outcomes, including life expectancy at birth, infant and child mortality rates, and maternal mortality rates. The state provides free or subsidized health care to the lowest income groups, and the level of health coverage to the Tunisian population is high compared with many other middle-income countries.

High Private Spending and Limited Access for Poor People: Lebanon

As a share of national income, Lebanon and Jordan spend a larger proportion on health than many Organisation for Economic Co-operation and Development countries (11.5 and 9.3 percent, respectively). With US\$568 in per capita health expenditures a year, Lebanon is by far the highest spender on health in the Middle East and North Africa. Unique for the region, the private sector dominates health financing and service provision in Lebanon. A large share of health expenditure is taken up by costly tertiary care and pharmaceuticals for the well-off population, and most poor people do not have access to care. Lebanon is considered an underperformer with respect to health outcomes (as measured by child mortality and life expectancy).

(Box continues on the following page.)

BOX 4.2 (CONTINUED)***High Public Spending and Good Access for Poor People: Jordan***

Jordan has the highest share of public spending on health to GDP among the countries in the Middle East and North Africa for which data are available, and it possesses a health system that provides good access to the poor. Despite the universal public health coverage in Jordan, there is some regressivity in health financing, with the poorest quintile paying proportionally slightly more out of pocket for outpatient care (9 percent of household income), compared with the out-of-pocket expenditures of the richest quintile (7 percent). The high level of health expenditure, at US\$165 per person a year, raises concerns about financial sustainability. There are structural inefficiencies that will have to be addressed in light of the epidemiologic and demographic transition that will increase both demand for and cost of services.

Low Spending and Limited Access for Poor People: Republic of Yemen

The Republic of Yemen spends only US\$23 on health per capita a year. This is below the World Health Organization's recommended US\$30–40 per person annually to cover basic health care costs, although it is above the minimum annual US\$12 per person estimated for preventive and essential clinical services. Although total health spending increased from 2.5 percent of GDP in 1994 to about 3.7 percent in 2002, it is still among the lowest in the region, and is low compared with other low-income countries that average around 5 percent. The mix between public and private spending is tilted toward the latter, and out-of-pocket health spending as a share of national income in the Republic of Yemen is the second-highest in the Middle East and North Africa (after Lebanon). Nevertheless, results to date have been encouraging. When its endowments (of income and social indicators) and spending are controlled for, the Republic of Yemen has been among the stronger performers in the region in improving child mortality and life expectancy.

subsidies provided through health facilities found the subsidies to be mildly progressive in that the subsidy as a percentage of household per capita expenditure tends to be higher for the poor. However, absolute subsidy levels were almost twice as high for the richest quintile as for the poorest, and households in the richest quintile receive 26 percent of public health expenditure compared with 16 percent for the poorest. The nonpoor population spends about 10 percent of its total health expenditure for treatment outside the country (World Bank 2002f). In the Islamic Republic of Iran, pharmaceuticals are heavily subsidized, with a cost to the government equal to 0.8 percent of GDP in 1998. Although the share in *total* consumption of pharmaceuticals is higher for the poor than for the nonpoor, the *absolute* consumption among the nonpoor is much higher than among the poor. The richest people accordingly receive by far the larger share of the benefits from the pharmaceutical subsidy.

Pattern of Spending

Private spending on health accounts for about half of all health spending in the region, and insurance makes up only a small fraction of this. In other words, most private spending represents out-of-pocket outlays. The significant reliance on out-of-pocket spending means that many households have little or no financial protection in the event of a catastrophic illness or injury. Such vulnerability is higher among lower-income households. In general, such households allocate higher proportions of their budgets to health care services. For example, in the Republic of Yemen the rural and poorer population spends a higher share of household expenditures on health care services than do urban inhabitants. Health expenditures represent 1.3–2.0 percent of household expenditures for the poorest quintile in rural areas, compared with 0.6–1.6 percent for the poorest quintile in urban regions. The design of sustainable health insurance schemes to mitigate such risks among the poor and the near-poor should be considered a matter of high priority in the region.

Health Challenges Arising from Demographic and Epidemiologic Transition

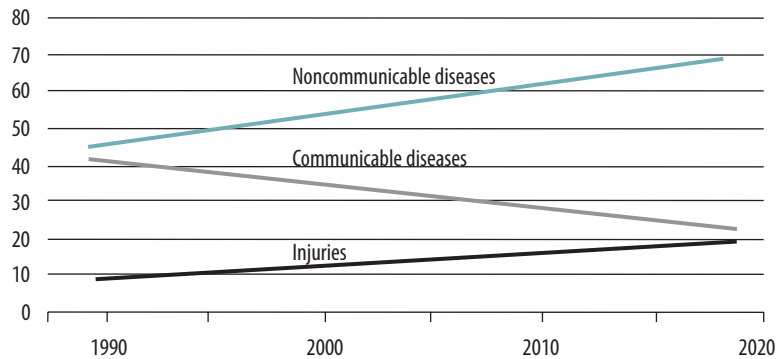
Health challenges of the future are likely to be different from those in the past, in part because of the ongoing demographic and epidemiologic transition. In the 1980s and early 1990s the Middle East and North Africa had the highest population growth rate of any region in the world. Population growth slowed in most countries in the 1990s and is now about 2 percent for the region as a whole (which is still higher than all regions except Sub-Saharan Africa). It is estimated that by 2015 the number of adults in the region will have increased by 140 percent, representing the highest adult population growth in the world after Sub-Saharan Africa.

Over the next two decades, health patterns in the Middle East and North Africa will be profoundly influenced by continued declines in fertility and mortality as countries go through the demographic transition. A further 50 percent decline in fertility with modest gains in life expectancy is projected for the region by the World Bank. The overall effect of the declines in fertility and mortality is a dramatic shift in the age structure and causes of morbidity and mortality (WBI 2004; World Bank 2002c). Several countries in the region will soon have 5 percent or more of their populations over age 65. Some of the lower-middle-income countries in the region, including Lebanon, the Islamic Republic of Iran, and Tunisia, are well advanced in the demographic transition, with low birth rates (around two children per woman) and low mortality. Algeria, Egypt,

FIGURE 4.3

Trends in Deaths, by Cause, in the MENA Region

(Percent)



Source: WBI 2004.

Jordan, Morocco, and Syria are in mid-transition, with declining fertility and low mortality rates.

The challenges of an aging population include a substantial rise in non-communicable diseases and increasing demand for costly long-term care (see figure 4.3). In addition to the impact of the demographic transition, rapid urbanization and changing lifestyles have contributed to an increase in noncommunicable diseases and injuries in the region. Dealing with these challenges may have implications for the poor. The emerging disease patterns require individual-oriented and technology-intensive treatment regimes that are expensive. Thus an increasing share of health budget resources is likely to be pulled toward the treatment of such cases. This may put the poor at a disadvantage if the needed resources are taken from services that address their needs. Indeed, there is some evidence that such a shift in resources already is occurring. In recent years, governments in the region have been investing in expensive medical technology to cope with the rising demand from urban middle-class populations. Finding a balance between competing demands to address the demographic and epidemiologic transition and improve access to quality health services for poor people represents a major challenge for the countries in the Middle East and North Africa.

Note

1. DHSs have been completed for 56 developing countries in recent years including four in the Middle East and North Africa—Egypt (1995 and 2000), Jordan (1997), Morocco (1992), and the Republic of Yemen (1997). These surveys provide information on selected health indicators disaggregated by income quintiles.