

# Improving the health of the poor

## 1 Understanding health within a broad development framework

Poverty and ill-health are inseparable. In 127 case studies in *Voices of the Poor* which examine why families have fallen into poverty, ill-health emerges as the single most common trigger for the downward slide. Individual testimonies reflect this finding – ill-health is perceived both as a cause of increased poverty and as an obstacle to escaping it.

Illness can reduce household savings, lower learning ability, reduce productivity and lead to a diminished quality of life, thereby creating or perpetuating poverty. The poor, in turn, are exposed to greater personal and environmental risks, are less well nourished, have less information, and are less able to access health care. They are therefore more at risk of both illness and disability.

The other side of the coin – that improving health can prevent or offer a route out of poverty – has been given less attention. Evidence now shows that better health translates into greater, and more equitably distributed, wealth by building human and social capital and increasing productivity. A healthy workforce not only produces more, but also saves more. Healthy children are better able to learn. Healthy families tend to have fewer children, and better birth spacing.

The inextricable links between health and poverty suggests that health (and other social objectives) should be placed at the centre of the policy-making

process, rather than seen as by-products to improvements in overall economic performance. This requires, among other things, that spending on health and other social sectors should be recognised as an investment. Policies – such as social safety nets – are also needed to protect the poor both from the impoverishing effects of ill-health, and from economic “shocks” which can deepen poverty and in turn worsen health status. These shocks include loss of income due to unemployment, loss of assets (for example, because of a natural disaster) and currency devaluation.

Most fundamentally, it is important to ensure that the benefits of economic growth are delivered equitably – there can be no real progress on poverty reduction, or improvement in health outcomes, unless economic and social inequities are tackled.

One important element of putting health at the centre of development processes is improving cross-sectoral action between health and other sectors, including (but not limited to) education, finance, labour, trade, agriculture and environment. Limited resources may mean that health ministries need to prioritise, that is, to work first and foremost with those sectors that have the greatest impact on health in their country. In many countries, the capacity of ministries of health to analyse cross-sectoral links and to take cross-sectoral initiatives is low, and may need to be strengthened.

## 2 Revitalising public health

In identifying the causes of their ill-health, poor people point to issues traditionally covered by public health – poor nutrition (in particular), dirty water, poor sanitation, inadequate housing and pollution. These issues require urgent attention – in low-income countries, just 46 per cent of people have access to sanitation facilities (5), and one in three children under five in the developing world (nearly 182 million) are stunted as a result of poor nutrition.

Poor people also identify a number of other causes of illness which extend beyond the customary domain of public health. These include unemployment, exhaustion from overwork, domestic violence, isolation (particularly for old people) and the breakdown of social networks.

While the link between economic poverty and poor health is indisputable, it is possible to make significant improvements in the health of the poor without raising per capita income. This requires improvements in (and improved access to) basic public services, such as clean water, sufficient and safe food, decent housing and adequate sanitation, and improved education for girls and women.

In many countries, public health is in disarray. It is typically under-funded and poorly staffed, and wrongly regarded as marginally important compared to health care delivery services. In practice – and partly because of the way that aid is delivered – public health programmes have evolved into a number of uncoordinated vertical programmes, each working individually and without an overall understanding of the country's public health needs.

Health ministries are best placed to take the lead in advocating improvements in public health services. Information on how poverty-focused investments in basic services can improve health will greatly aid this process.

Efforts to revitalise public health must not lose sight of the importance of focusing on poverty. Traditionally, public health has aimed to improve the health of the majority, without regard to whether benefits are reaching the poorest sectors of society. The goal of modern public health should be to improve the health of whole populations, with a focus on the poorest groups. In other words, to address the inequity in health status between rich and poor.

## 3

## Making sure that health systems serve the poor and protect them from impoverishment

More often than not, health services fail those who need them most – the poor. Poor people have nowhere to turn when faced with serious illnesses. The most frequent complaints are that services are far away, access to care is prohibitively expensive, and health staff are rude and unprofessional. Women face particular difficulties – they are often less able to travel and have the least resources for accessing care.

WHO's experience suggests that poor people will be effectively excluded from health care unless services are geographically accessible, of decent quality, fairly financed and responsive.

Most basically of all, services must exist in the places where poor people live. Many countries already recognise that they need to expand health services in poor communities, for example, through outreach services. What is needed is a reallocation of resources to favour peripheral areas over urban ones, and basic health care over tertiary care.

Health services must also be affordable. Poor people already pay a lot, both in fees and for the indirect costs of health care, including unofficial "fees" (corruption), transport, medicines and loss of income. *Voices of the Poor* suggests that there are many cases where free services do not benefit the poor; for example, because of corruption which results in free medicines being sold, and doctors diverting patients to private practice. However, other studies show that even very small charges deter poor people from using health services.

The challenge is to create health services that are affordable both for the poor and the state. There is a great need for innovation in financing mechanisms to provide poor people with financial protection against catastrophic illnesses and injury, and to ensure that no obstacles block their timely access to services. Approaches must aim to draw on and build community solidarity, for example, by allowing for payments in kind and payments when resources are available (such as at harvest time). Micro-insurance schemes, such as those run by SEWA (Self-Employed Women's Association) in India, provide important experience to build on. As a basic principle, fees should never cause further impoverishment.

Ensuring that the poor have access to health care requires that health systems are financed by pre-payment schemes. This is the norm in high-income countries, but in low-income countries out-of-pocket spending can account for 40 per cent of total health financing (6). Out-of-pocket spending clearly disadvantages the poor, who are most likely to be ill and injured, and least able to afford health care. The type of pre-payment scheme must be determined by local conditions. A general taxation scheme is most desirable, as this involves the greatest pooling of risk, but this is institutionally very demanding and can be unworkable in countries with large informal economies. Social insurance, voluntary private insurance schemes, and community insurance schemes are alternatives used in poor countries.

As well as being accessible and affordable, health services must be of decent quality. This means not only offering a good standard of care, but also reducing waiting times, making medicines available, and treating patients with respect.

One of the most important findings to emerge from *Voices of the Poor* is that the attitudes of health staff to the poor are frequently appalling, and this is a deterrent to seeking care. This is a problem often neglected by health policy. Strategies to tackle it must include improving staff capabilities, motivation and working conditions; for example, by improving the selection of staff, improving training, and, crucially, ensuring that decent salaries are paid on time. Providing incentives – such as a hardship allowance – will also help to improve the availability of quality staff in poor areas.

Implementation of all these strategies must take into account the specific and special needs of women, in particular, and sub-groups of the poor such as indigenous people. Indigenous people are typically discriminated against by health staff, who may not understand their culture or even their language. Women may be reluctant to seek care from male doctors.

Equally, strategies to improve health services are much more likely to be successful if poor people are involved. Processes to decentralise the management of health services – underway in many countries – provide an excellent opportunity for this. Policies such as co-management and community-based monitoring of health services can greatly improve their effectiveness, as well as their responsiveness to poor people's needs.

## 4 Focusing on poor people's health problems

WHO research suggests that a small number of conditions affect poor people disproportionately. These include communicable diseases (specifically TB, HIV/AIDS and malaria), childhood illnesses (e.g., measles, polio), and reproductive health problems.

While *Voices of the Poor* does not tend to detail the specific illnesses of the poor, it makes clear that bodily afflictions and illnesses are a major concern among poor people. This insecurity around bodily well-being adds to poor people's mental anguish and stress. When talking about ill-health, both men and women also focus on mental and psychological ill-health – such as the mental stress caused by poverty, powerlessness and discrimination.

*Voices of the Poor* points to a serious gap in our understanding of poor people's mental health problems, particularly in developing countries.<sup>5</sup> Even less is known about how to treat such problems: almost all research on the efficacy of mental health treatments – either pharmacological or psycho-social – is based in developed countries, and little work has been done to test the applicability or appropriateness of such treatments to developing countries.

Strategies are needed to ensure that the health services and interventions offered to poor communities are comprehensive, and maintain a balance between addressing physical and mental health problems. Individual interventions and programmes to tackle specific diseases should be integrated as much as possible, both with each other and with health systems, to avoid unsustainable “vertical” programmes.

<sup>5</sup> WHO's Department of Mental Health and Substance Dependence has recognised the importance of the link between mental illness and poverty and one of the four topic areas for discussion at the ministerial round tables in the World Health Assembly in May 2001 was devoted to a discussion on 'Mental Health and Socio-economic Factors', (WHO/NMH/MSD/WHA/01.3). However, in general it recognised that the relationship between poverty and ill-health needs further research and discussion.



## Conclusion

There is growing recognition in both international and national development policy of the centrality of health to economic and social development and poverty reduction. Indeed – many of the conclusions and suggestions made above are reflected in the policies and plans of developing country governments and developed country donors. But in all but a handful of cases this recognition is not being translated into practice. Action is needed. Detailed, cross-sectoral policies on how to improve the health of the poor need to be developed. Poor people's participation in policy development and implementation must remain central. And poor countries and international donors must mobilise the necessary resources to deliver improved health. Governments around the world must respond to the demands of poor people, who are crying out for better health – and dying for change.

## References

- (1) *Voices of the Poor*, a project led by Deepa Narayan, World Bank, published between 1999 and 2002. The resulting 25 publications are available online at [www.worldbank.org/poverty/voices](http://www.worldbank.org/poverty/voices).
- (2) *Study of National Policies on Health and Poverty Reduction*, WHO (forthcoming).
- (3) Wheeler M, *What Constitutes a Pro-Poor Health Policy?*, WHO (unpublished draft).
- (4) *Rapid Guidelines for Integrating Health Nutrition and Population Issues in Interim Poverty-Reduction Strategy Papers of Low-Income Countries*, World Bank, December 2000.
- (5) *World Development Indicators 2001*, World Bank.
- (6) *World Health Report 2000*, WHO.