



# REACHING THE POOR

## *with Health, Nutrition, and Population Services*

### **What Works, What Doesn't and Why**

Health programs do not have to be inequitable.

While most health, nutrition, and population services exacerbate poor-rich inequalities by achieving much lower coverage among disadvantaged groups than among the better-off, many significant and instructive exceptions exist. These demonstrate the feasibility of reaching the poor much more effectively than at present, and point to promising strategies for doing so.

Identifying and learning from such exceptions has been a principal activity of the Reaching the Poor Program. The Program, undertaken by the World Bank in cooperation with the Gates Foundation and the Dutch and Swedish Governments, seeks to find and encourage adoption of strategies for ensuring that disadvantaged groups benefit more fully from health, nutrition, and population services.



# REACHING THE POOR

## What Works, What Doesn't and Why

with Health,  
Nutrition, and  
Population  
Services

### THE PROBLEM

Health, nutrition, and population programs rarely reach disadvantaged population groups effectively. While many working in the health sector have long assumed that their efforts benefit primarily the poor, recent evidence suggests their assumption is misplaced. Both public and private services—including services undertaken specifically to help the disadvantaged—usually end up reaching people in better-off groups more frequently.

This is especially true of higher-level services. But even basic services tend to reach better-off groups than they do the needy for whom they are usually intended. For instance, coverage rates are higher among the best-off 20% of developing country populations than among the poorest 20% for each of the eight basic maternal and child health services shown in figure 1.

In most cases, the same is also true of governmental services, despite the equity rationale typically invoked to justify direct government involvement in service provision. The record of the 21 developing countries covered in figure 2 illustrates this. In over 80% of them (17 of 21), the best-off 20% of the population receives more (15 countries) or as much (2 countries) of the government subsidies to health services as the population's poorest 20%; on average, the benefit going to the best-off 20% is two-thirds higher than that accruing to the poorest 20%.

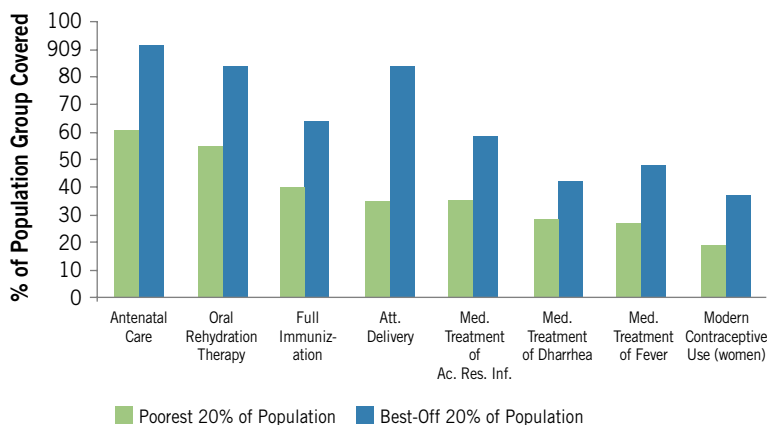
### THE PROGRAM

The Reaching the Poor Program constitutes an effort to go beyond the diagnoses of coverage inequalities like those shown in figures 1 and 2, in order to find ways of reducing those inequalities by raising coverage among the poor. By assessing the record of current and recent health, nutrition, population initiatives, it hopes to alert sponsors of poorly-performing programs to a problem of which they are likely to be unaware, and to draw their attention to approaches that have proven more effective and are thus potentially worthy of adoption. The Program also seeks to begin developing an evidence base for understanding when and why services reach poor people, and to demonstrate the feasibility of monitoring service initiatives from a poverty perspective.

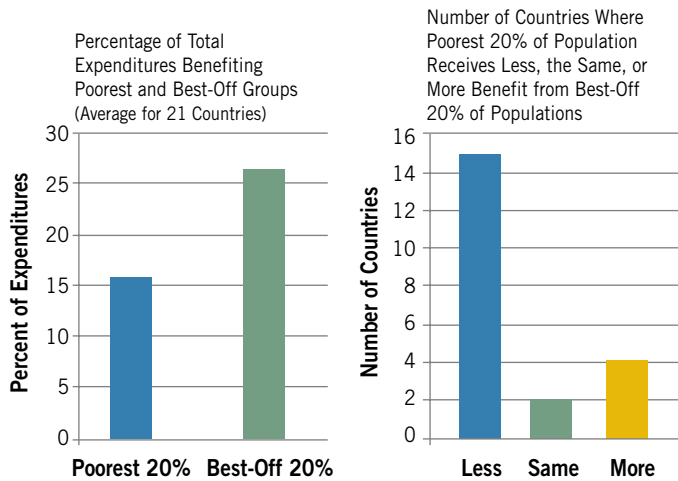
The Program has three components:

- **Documentation** or knowledge generation. To increase the knowledge about the record of health, nutrition, and population programs, the Reaching the Poor Program commissioned eighteen case studies, selected by a professional review committee from among the nearly 150 proposals received in response to an open, internationally-distributed call for proposals. The case studies were quantitative assessments of how benefits from the programs studied were distributed across different economic groups in society, drawing on techniques developed over the past twenty-five years to determine the distribution of benefits from expenditures by developing country governments.
- **Synthesis** of the newly-generated and of previously-existing knowledge. In February 2004, the Program organized an international conference that brought together the authors of the case studies it had commissioned, other investigators doing similar work, and policy makers and researchers from developing countries and international assistance agencies. The conference featured presentations covering over 100 case studies undertaken by the Program-supported and other investigators; and extensive discussions on the implications of the case study findings for health, nutrition, and population programs.
- **Dissemination** of the knowledge generated and synthesized. A large number of activities is currently under way or under development in order to spread awareness about the problem represented by program coverage inequalities and, more

**Figure 1. Use of Basic Maternal and Child Health Services**  
Coverage Rates among Best-Off and Poorest 20% of the Population in  
56 Developing and Transition Countries



**Figure 2. Distribution of Benefits from Government Health Service Expenditures**  
**Percentage of Expenditures Serving the Poorest and Best-Off 20% of the Population in 21 Developing and Transition Countries**



importantly, about ways to reduce those inequalities by increasing coverage among the poor. The activities include this publication, regional conferences in Africa and Asia, a volume of Program-supported case studies, and an overall Program report.

**THE FINDINGS**

Figure 3 summarizes the principal findings from an illustrative sample of 27 case studies by Program-commissioned and other investigators presented at the Program’s global conference. The findings are shown in terms of the two dimensions of program performance described in the text box, “Assessing How Well Programs Reach the Poor”: focus or incidence (shown on the horizontal axis), and coverage (on the vertical axis). Each dot in the figure refers to an individual program; the text boxes in the figure identify five of the more interesting ones.

The study findings indicate that:

- 18 of the 27 programs are pro-poor when assessed in term of focus, in that the poorest 20% of the population receive over 20% of the program’s benefits. (These are the 18 whose dots lie to the right of the vertical line at the 20% mark.) For seven of the 27 programs, the poorest 20% of the population receive more than 40% of total benefits.
- 14 of the 27 programs cover 50% or more of the population’s poorest 20%.

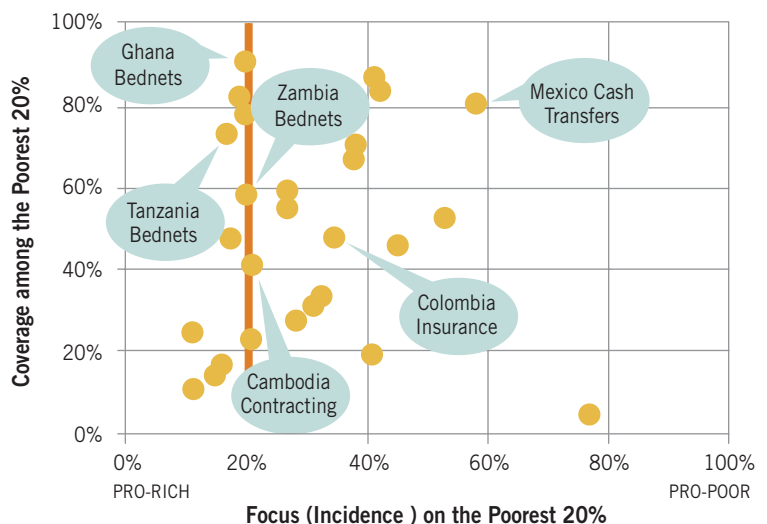
Illustrative of the more promising activities covered are:

- Mexico’s “Progresa” program that pays rather than charges poor families for clinic and school attendance. The Program serves over 20 million people, and the benefits it provides constitute more than 20% of the income of the people served. Almost 60% of

the people reached belong to the poorest 20% of Mexico’s population; 80% of beneficiaries are in the Mexican population’s poorest 40%.

- Colombia’s use of a refined individual targeting technique to provide subsidized health insurance to the disadvantaged. This raised insurance coverage in the poorest quintile of the population from well under 10% in the early 1990s to nearly 50% four years later. 35% of the total program subsidy went to the poorest 20% of the population; 65% to the poorest 40%.
- Cambodia’s experiment in contracting with non-governmental organizations to operate governmental rural primary health services, under contracts calling for attainment of specified coverage levels among the poor. During a four-year experiment, the coverage among the poorest 20% of the population of eight basic services rose from an average of below 15% to over 40% in two experimental districts with a total population of around 200,000. This increase was nearly two and one-half times as large as that experienced in two control districts that continued to receive standard government services.
- Distribution of insecticide-treated bednets through measles immunization campaigns in Ghana and Zambia. In Ghana, the Red Cross and the Government Health Service raised from 3% to over 90%, the rate of treated bednet possession among the poorest 20% of people in a Northern district with a population of around 90,000. A similar program in Zambia produced comparable results: an increase in treated bednet coverage from 18% to 82% in the poorest 20% of the population in five rural districts with a total population of 450,000.

**Figure 3. Focus, Incidence and Coverage of Health Interventions**



## ASSESSING HOW WELL PROGRAMS REACH THE POOR

Two dimensions of performance are typically measured in assessing how well a program reaches the poor:

- **Focus**, sometimes called incidence or benefit-incidence. This is the proportion of a program's benefits that go to different groups within a population—especially to the disadvantaged group that is of greatest concern from a poverty perspective. The higher the proportion of a program's benefits going to that group, the more effective a program is in terms of reaching the poor. (Suppose, for example, that 35% of a country's population lives below the poverty line. If more than 35% of people served by a program are among this poor 35%, then the program would be considered progressive or "pro-poor." Conversely, if less than 35% of the program's services go to that group, the program would be regressive, benefiting the better off more than the disadvantaged.)
- **Coverage**, or the percentage of poor people within the country who are reached by the program. Unlike focus or incidence measures, which explicitly or implicitly compare coverage among groups within a society, coverage measures refer a program's record with regard to the poor alone.

Because focus or incidence measures compare coverage across groups, they serve to assess the impact of a program upon inter-group **inequality**: how much the program contributes to increasing or decreasing coverage disparities between the poor and the better-off, for instance. Coverage measures, on the other hand, are used to assess a program's **poverty impact**—how much benefit the program brings to the poor, irrespective of whether that benefit is larger or smaller than that which the program provides to the better-off.

- Marketing of insecticide-treated bednets in Tanzania. In two Southern districts, with a total population of about 60,000, the Ifakara Health Research and Development Centre developed and implemented a social marketing program that raised the ownership of bednets in the poorest 20% of households from 20% to 73%. As in Ghana and Zambia, the increase in bednet use/ownership was higher among the poor than among the better-off.

These and the other programs that appear to have reached the poor effectively have varied greatly in scope and approach. While some (Ghana, Tanzania, Zambia) were relatively small experiments with initiatives against specific diseases, others (Mexico, Colombia) represented country-wide reforms that touched on many fundamental aspects of national health systems. Some (Cambodia, Ghana, Tanzania, Zambia) featured a change in service delivery organization and/or in strategy, while others (Colombia, Mexico) focused on modifying the way services are financed. While some (Ghana, Zambia) focused only on communicable diseases of children, several others (Cambodia, Colombia, Mexico) were much broader, also dealing with adults and with chronic diseases

The range of techniques featured in the apparently successful projects and programs was wide. Among the techniques were: improved means of identifying poor individuals (Colombia, Mexico), cash payments for use of services (Mexico); services provided by NGOs working under contracts with carefully-specified pro-poor performance indicators (Cambodia); mass campaigns (Ghana, Zambia); and social marketing (Tanzania).

## THE CONCLUSIONS

Experiences like those just presented indicate that there is no need to accept as inevitable the clearly inadequate record of most current health, nutrition, and population programs in reaching the poor. It is possible to do much better.

The widely varying nature of the encouraging experiences raises doubts about the existence of any one best strategy for improvement. Further investigation may yet identify such a strategy; but at least equally if not more likely is the availability of multiple, very different promising approaches, with the suitability of each depending heavily upon the characteristics of the setting and of the disease or condition at hand.

This argues for a focus on determining which of the many promising approaches available is best suited to a particular situation. The experiences identified through the Reaching the Poor Program are intended to help in such a determination, by presenting instructive information concerning the numerous possibilities worthy of consideration. There is much to be gained from studying all the possibilities, selecting the most promising for a specific setting, adapting those selected on the basis of knowledge about that setting, trying them out, tracking their impact, refining those that work well, abandoning those that do not and trying others in their place.

The Reaching the Poor Program is coordinated by Davidson Gwatkin, Adam Wagstaff, and Abdo Yazbeck. Further information about it may be obtained through:

- The "Reaching the Poor Program" section of the World Bank's poverty and health website: <http://www.worldbank.org/povertyandhealth.html>, or
- An e-mail query to the World Bank's health advisory service: [healthpop@worldbank.org](mailto:healthpop@worldbank.org)

The World Bank thanks the Bill and Melinda Gates Foundation and the Governments of the Netherlands and Sweden for the support that has made the Program possible.

Parts of this presentation draw upon material appearing in Davidson R. Gwatkin, Abbas Bhuiya, and Cesar G. Victora, "Making Health Systems More Equitable," *The Lancet*, vol. 364, no. 9441, pp. 1273–80.