Equity in Health (part 1)

Poverty and Health:
A framework for analysis & action

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What is poverty?

Poverty is **multidimensional**:

- Low income
- Poor access to resources and skills
- Vulnerability
- Insecurity
- Voicelessness, disempowerment
- Gender
- Race
- Ethnicity
Poverty and health: the links

The vicious circle:
• Ill health leads to poverty
• Poverty leads to ill health

The virtuous circle:
• Good health is linked to higher income and welfare
• Higher income is linked to good health
Example: Sex work and poverty

- Poverty drives commercial sex work, both establishment-based and other types
- The poor lack skills, education
- The poor lack information
- The poor have lower access to services
- The poor migrate to towns for work
Example: Poverty & tobacco

- Viet Nam: in households with smokers, expenditure on cigarettes is 1½ times that on education; 5 times that on health care; and 1/3 of that on food
- Bangladesh: poorest twice as likely to smoke as the wealthiest
- Tobacco farming often promotes deforestation and does not pay enough
- Cigarette production often employs child labor
The poor are at greater risk of ill-health

Prevalence of moderate underweight by average daily household, by subregion

The poor have greater health care needs

Health Status and Poverty: Viet Nam

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
<th>Rural Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malnutrition</td>
<td>9.6</td>
<td>21.8</td>
<td>28.4</td>
</tr>
<tr>
<td>Infant Mortality Rate (IMR)</td>
<td>10.4</td>
<td>26.7</td>
<td>40</td>
</tr>
</tbody>
</table>

Source: ADB
The poor have greater health care needs

TB prevalence among poor and non-poor, Philippines

Source: Philippines NTP, 2000
Use of services by the poor is low

**USE OF BASIC HEALTH CARE**

Poor-Rich Differences - Average of 44 Countries

- **Antenatal Care** (Avg: 70.8%)
- **Att. Deliveries** (Avg: 52.5%)
- **Diarrhea - ORT Treat.** (Avg: 61.1%)
- **Diarrhea - Med. Treat.** (Avg: 34.5%)
- **ARI - Med. Treat.** (Avg: 46.1%)
- **Immunization - Full** (Avg: 50.6%)

Source: Gwatkin 2003
THE INVERSE CARE LAW

THE AVAILABILITY OF GOOD MEDICAL CARE TENDS TO VARY INVERSELY WITH THE NEED FOR IT IN THE POPULATION SERVED.

Julian Tudor Hart, The Lancet, 1971
The poor can ill afford sickness

Affordability of Health Services: Viet Nam

<table>
<thead>
<tr>
<th>Share of Persons with Health Insurance</th>
<th>Poorest</th>
<th>Second</th>
<th>Third</th>
<th>Fourth</th>
<th>Richest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>6.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second</td>
<td>9.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Third</td>
<td>13.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fourth</td>
<td>18.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richest</td>
<td>28.7</td>
<td></td>
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</tr>
</tbody>
</table>

Source: ADB
Health care costs can impoverish…

Income Distribution in Viet Nam (VLSS 1998)

Source: ADB
Health care costs can impoverish…

Income Distribution in Viet Nam (VLSS 1998)

Poverty Line

Health Expenditure

Source: ADB
Why address poverty in health work?

- **Efficiency**: e.g., Public spending in health is captured by non-poor

Benefit incidence of public spending on health
### Who Benefits from Government Safe Motherhood Expenditures in Viet Nam?

*Distribution of Benefits from Government Expenditures on Antenatal Care and Attended Deliveries, 1996 (Millions of VND)*

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Poorest 20%</th>
<th>Richest 20%</th>
<th>Poor-Rich Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Hospital</td>
<td>116</td>
<td>437</td>
<td>1 : 3.8</td>
</tr>
<tr>
<td>Provincial Hospital</td>
<td>91</td>
<td>562</td>
<td>1 : 6.2</td>
</tr>
<tr>
<td>District Hospital</td>
<td>80</td>
<td>216</td>
<td>1 : 2.7</td>
</tr>
<tr>
<td>Polyclinic</td>
<td>78</td>
<td>40</td>
<td>1.6 : 1</td>
</tr>
<tr>
<td>Commune Health Centre</td>
<td>360</td>
<td>338</td>
<td>1.1 : 1</td>
</tr>
<tr>
<td><strong>Total Benefit</strong></td>
<td><strong>726</strong></td>
<td><strong>1,593</strong></td>
<td><strong>1 : 2.2</strong></td>
</tr>
</tbody>
</table>
Why address poverty...

Equity: Health inequalities are widening

Ratio of U5MR of bottom to top quintile

- Zimbabwe
- Indonesia
- Colombia
- Philippines
- Ghana

- Green: Late 1980s
- Yellow: Mid/late 1990s
Why address poverty…?

• **Human rights:**
  An obligation of society
  – Availability
  – Accessibility
    • Non-discrimination
    • Physical accessibility
    • Economic accessibility
    • Information accessibility
  – Acceptability
  – Quality
Example: Sex work and human rights

Issues:
- Criminalization (blaming the victim)
- Stigma
- Health risks

Impact:
- Increased health risks
- Lack of services
- “Freelance” or “indirect” sex work
- Stigmatization, harassment and re-victimization
Sex work and human rights

Sex workers have increased risk of infection due to:

- stigmatization, marginalization
- limited economic options
- limited access to health, social and legal services
- limited access to information and prevention means
- gender-related differences and inequalities
- sexual exploitation and trafficking
- harmful, or a lack of protective, legislation and policies
- exposure to risks associated with lifestyle (e.g. violence, substance use, mobility)

http://web.amnesty.org/library/index/ENGACT770842004
What barriers do the poor face?

1. Geographical access: distance, remoteness, isolation
What barriers do the poor face?

2. Economic costs:
   - Direct costs
   - Indirect costs (food, transport)
     - China: 89% of per capita income
     - Malawi: 584% of non-food monthly income (poor families) vs. 176% (non-poor families)
   - Opportunity costs: wages, time
   - Lack of safety nets
What barriers do the poor face?

3. Low knowledge and awareness, stigma, fear of social isolation

4. Lack of health system responsiveness: public, private
Knowledge of HIV/AIDS Prevention (Men) -- rates among poor and rich

C: Latin America, Caribbean
E: South Asia
F: Sub-Saharan Africa
What can we do?

- Put **health** on the poverty agenda
- Put **poverty** on the health agenda
Putting health on poverty agenda

• Increase resource flows to health and improve resource allocation

• Advocacy: promote understanding of health as central to development

• Cross-sectoral work: address non-health sector determinants of health inequities
Putting health on poverty agenda

Global examples:
- MDGs
- Commission on Macroeconomics and Health
- Commission on Social Determinants of Health

Country examples:
- Health in PRSPs
- National socioeconomic development plans
- MDGs
Putting poverty on TB agenda

1. Strategies for geographical barriers

- Target/Prioritize regions or areas
1. Strategies for geographical barriers

- Introduce community-based approaches
- Conduct outreach for remote, isolated or marginalized groups
2. Strategies for resource allocation

Target/prioritize:

• Health conditions that disproportionately affect the poor
2. Strategies for resource allocation

Target/prioritize:
• Types of service
2. Strategies for resource allocation

Target/prioritize:
- Levels of service
2. Strategies for resource allocation

Target/prioritize:
- Population groups
3. Strategies for financial barriers

- Consider incentives/enablers for targeted patient groups (cash, kind)
- Provide other support: social protection, income replacement, micro-credit
3. Strategies for financial barriers

- Finance services according to means and ability to pay
- Replace direct out-of-pocket payments with prepayment
- Apply risk pooling and fund sharing principles where appropriate
- Introduce targeted subsidies
4. Strategies for system responsiveness

Public sector

- Ensure appropriate quality
- Consider provider incentives
- Address possible provider bias
4. Strategies for system responsiveness

- Involve private sector: e.g., contracting of services to NGOs
4. Strategies for system responsiveness

In monitoring and evaluation:

- Disaggregate information by income, sex, ethnicity, rural-urban residence, employment status, etc.
- Conduct operational research to:
  - Analyze incidence of benefits: do the poor benefit at least proportionately? why or why not?
  - Identify and evaluate options
5. Strategies for cultural barriers

• Develop appropriate IEC, especially for marginalized groups

• Address stigma
5. Strategies for cultural barriers

Address other cross-cutting issues

Indigenous health

Gender

Human rights, participation
Human rights: principles for action

Example: HIV and sex workers

- Non-discrimination: e.g., decriminalization
- Participation: e.g., SWHROs
- Empowerment: e.g., build personal skills
- AAAQ:
  - Availability: e.g., ensure eligibility
  - Accessibility: e.g., social protection
  - Acceptability: e.g., re-orient health services
  - Quality: e.g., respect, confidentiality

Human rights: examples of action

100% CUP strategies to empower sex workers in negotiating with customers:

1) Motivation for sex workers to insist on condom use, through education and reduction of economic disincentives for clients by involving all establishments.

2) Skills on negotiating condom use with reluctant clients, including making condom use more satisfying or proposing alternatives to risky sex that do not require a condom.

3) Support by creating an “enabling environment” through:
   • having 100% CUP for all establishments
   • making establishment owners responsible to support sex workers in negotiating with very reluctant clients
   • assuring access to high quality condoms

Source: Responding to questions about the 100% condom use programme, 2004
THANK YOU