Addressing poverty in health:
a framework for analysis and action

Anjana Bhushan, Technical Officer (Health in Development) WHO/WPRO

8th ASEAN & Japan High Level Officials Meeting for Caring Societies
Tokyo, 30 August - 2 September 2010

What is poverty?

Poverty is **multidimensional**:

- Low income
- Poor access to resources and skills
- Vulnerability
- Insecurity
- Voicelessness, disempowerment

  Gender

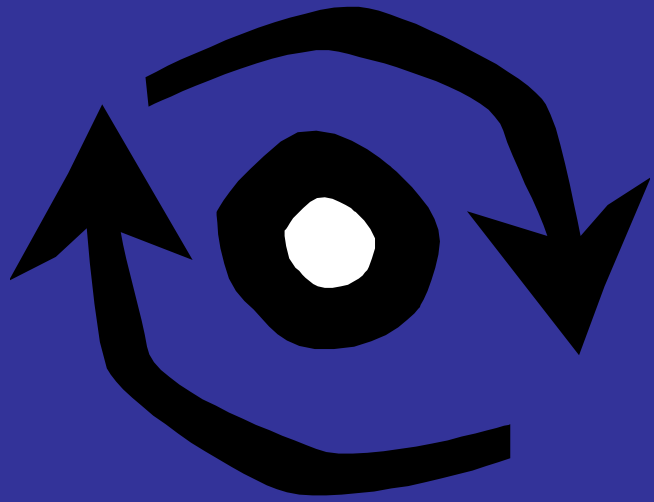
  Race

  Ethnicity

Poverty and health: the links

The vicious circle:

- Ill health leads to poverty
- Poverty leads to ill health

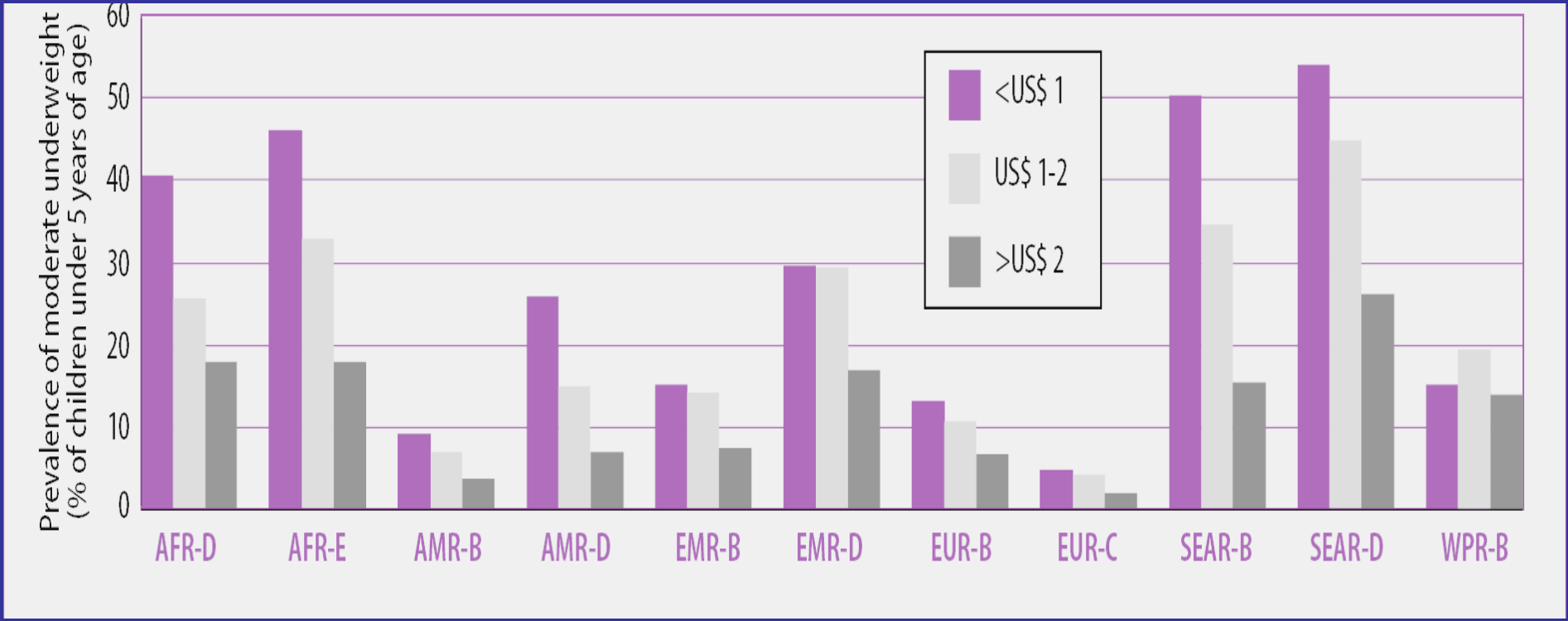


The virtuous circle:

- Good health is linked to higher income and welfare
- Higher income is linked to good health

The poor are at greater risk of ill-health

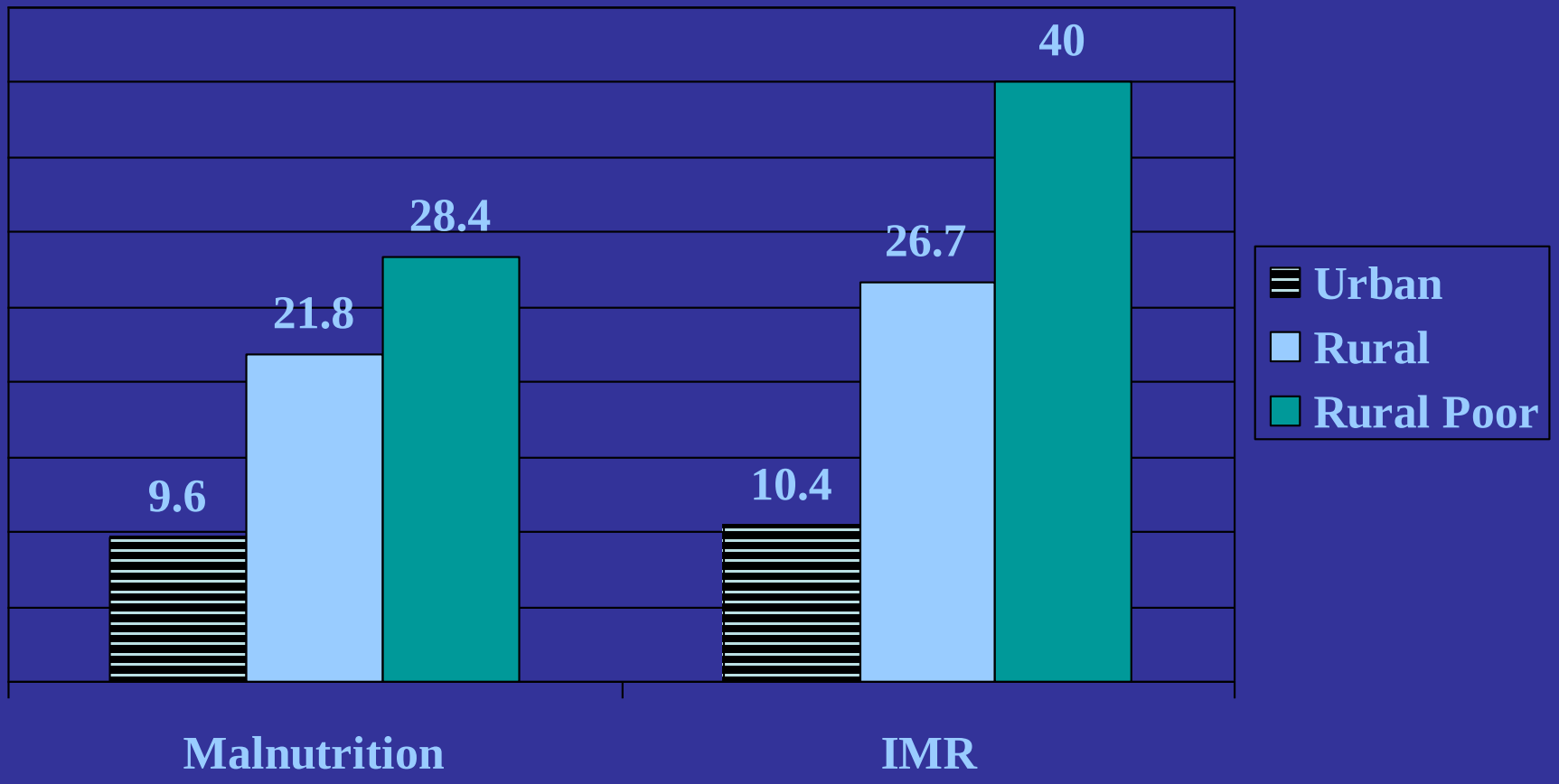
Prevalence of moderate underweight by average daily household, by subregion



Source: World Health Report 2002

The poor have greater health care needs

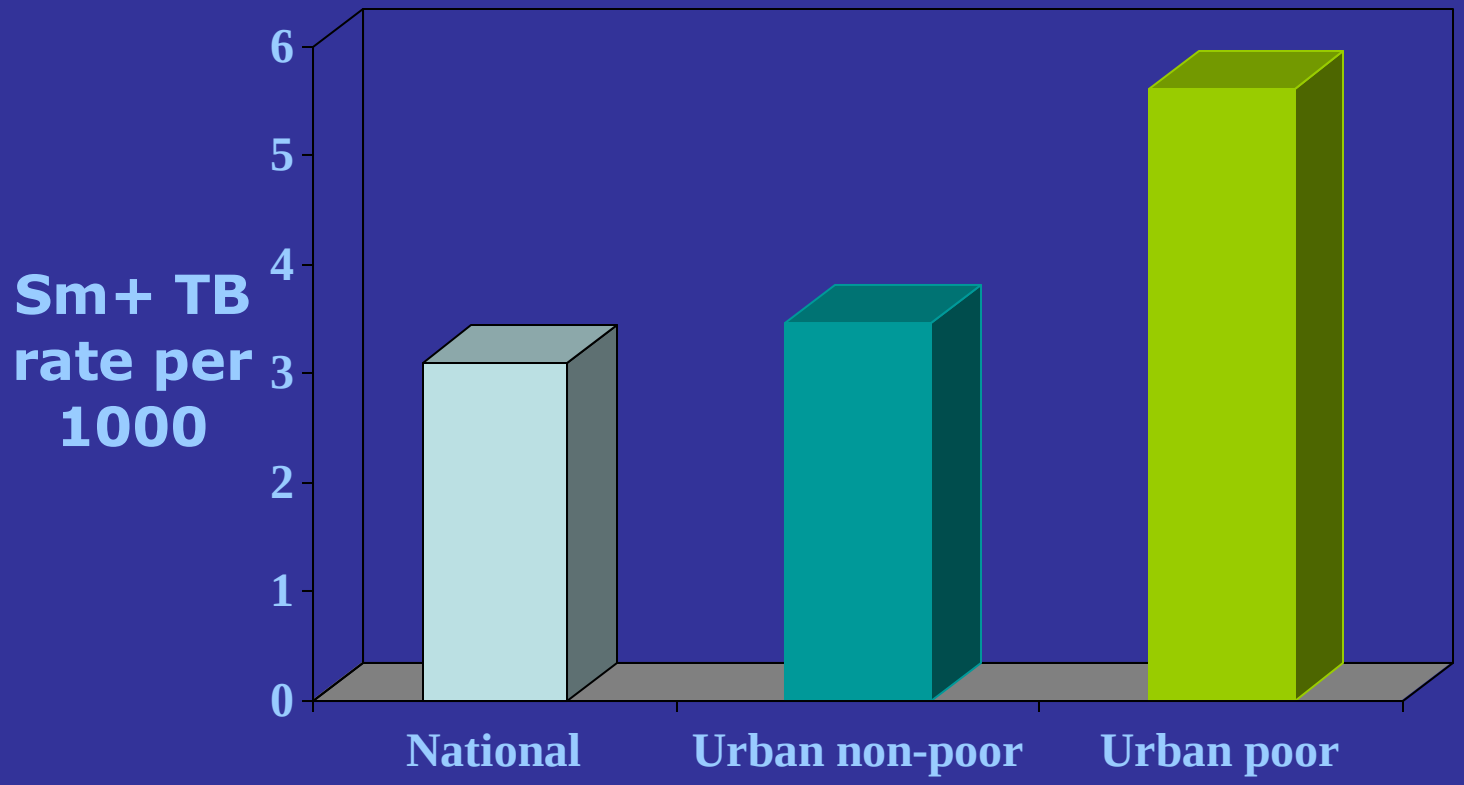
Health Status and Poverty: Viet Nam



Source: ADB

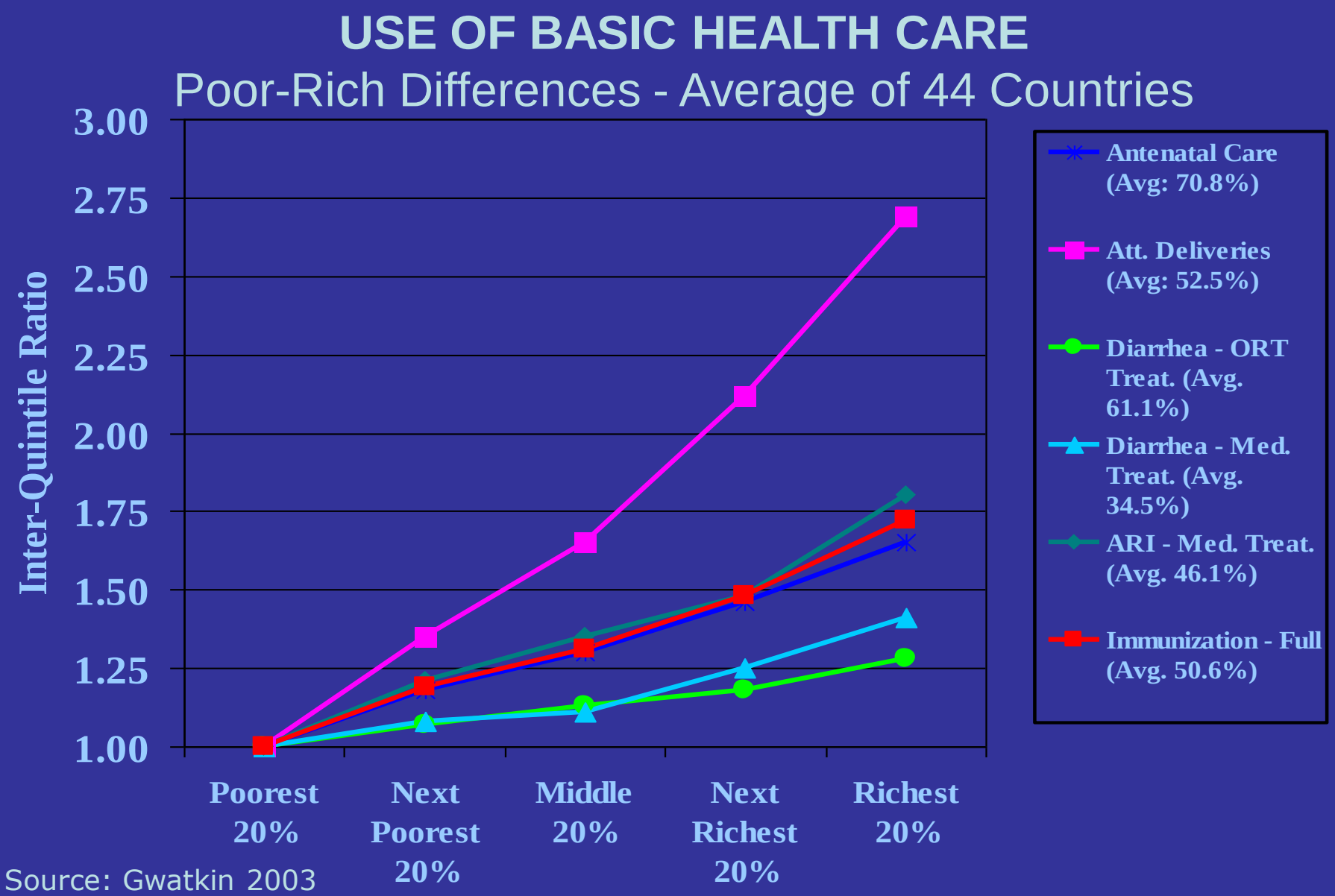
The poor have greater health care needs

TB prevalence among poor and non-poor, Philippines



Source: Philippines NTP, 2000

Use of services by the poor is low



Source: Gwatkin 2003

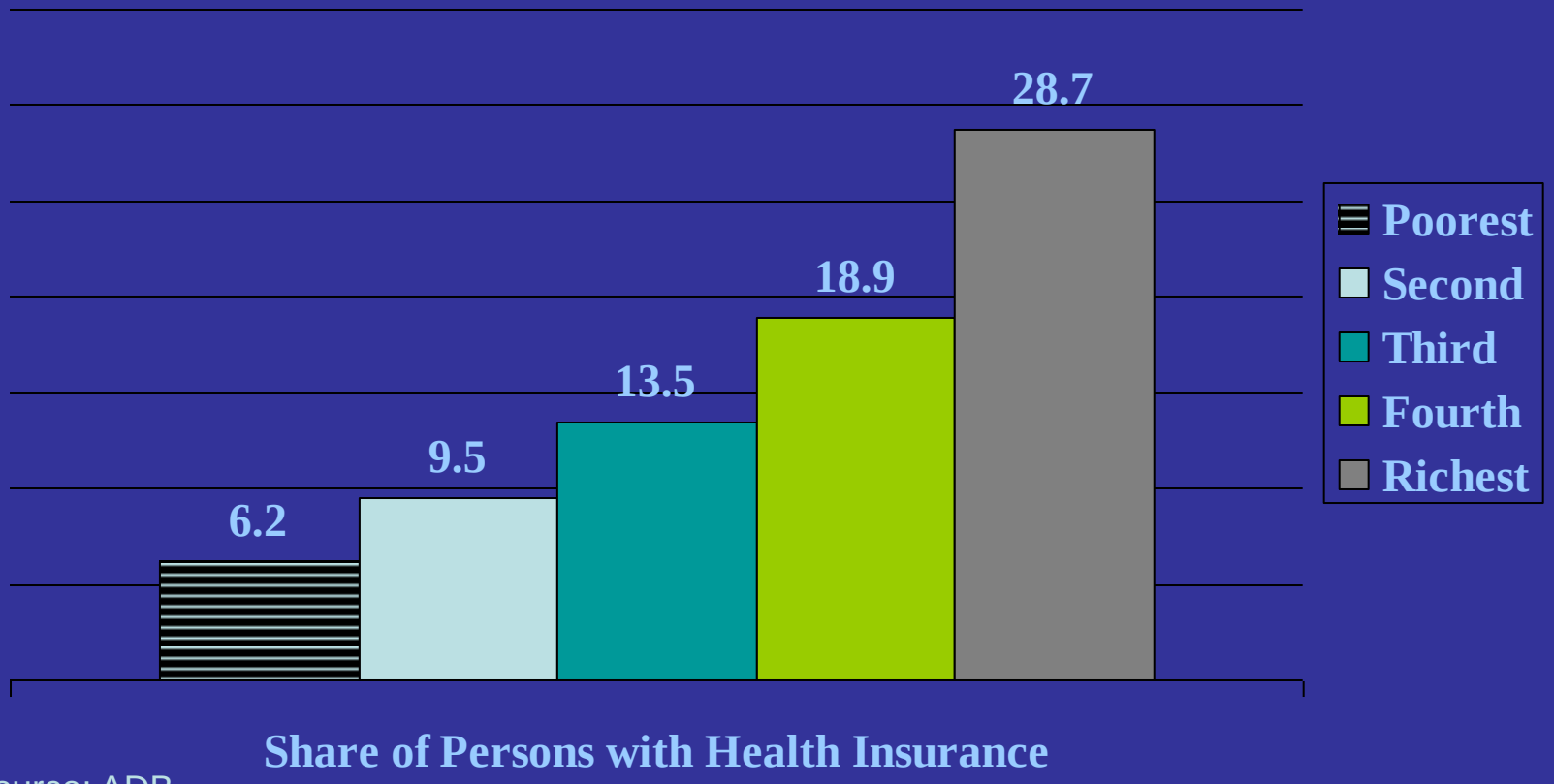
THE INVERSE CARE LAW

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



Source: ADB

Why address poverty in health?

- **Efficiency**: Public spending in health is captured by non-poor

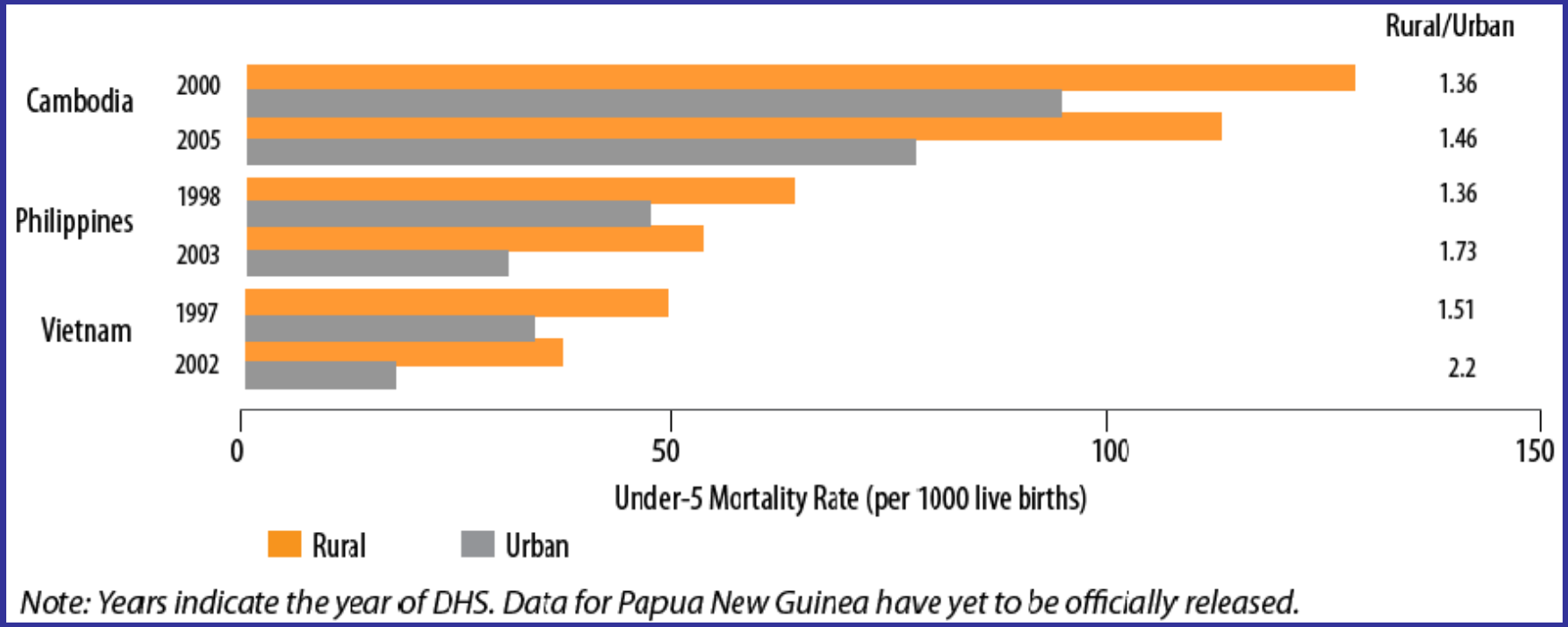
Distribution of Benefits from Government Expenditures on Antenatal Care and Attended Deliveries, 1996 (Millions of VND)

Facility Type	Poorest 20%	Richest 20%	Poor-Rich Ratio
Central Hospital	116	437	1 : 3.8
Provincial Hospital	91	562	1 : 6.2
District Hospital	80	216	1 : 2.7
Polyclinic	78	40	1.6 : 1
Commune Health Centre	360	338	1.1 : 1
Total Benefit	726	1,593	1 : 2.2

Why address poverty…?

- **Equity:** Health inequalities are widening

Under-5 mortality: rural-urban rates and ratios, selected countries



Source: Achieving the Millennium Development Goals in an Era of Global Uncertainty: Asia-Pacific Regional Report 2009/10. UNESCAP, UNDP and ADB, 2010

Why address poverty…?

- **Human rights:**

  An obligation of society
  - **Availability**
  - **Accessibility**
    - **Non-discrimination**
    - **Physical accessibility**
    - **Economic accessibility**
    - **Information accessibility**
  - **Acceptability**
  - **Quality**

What barriers do the poor face?

1. Geographical access: distance, isolation remoteness

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)

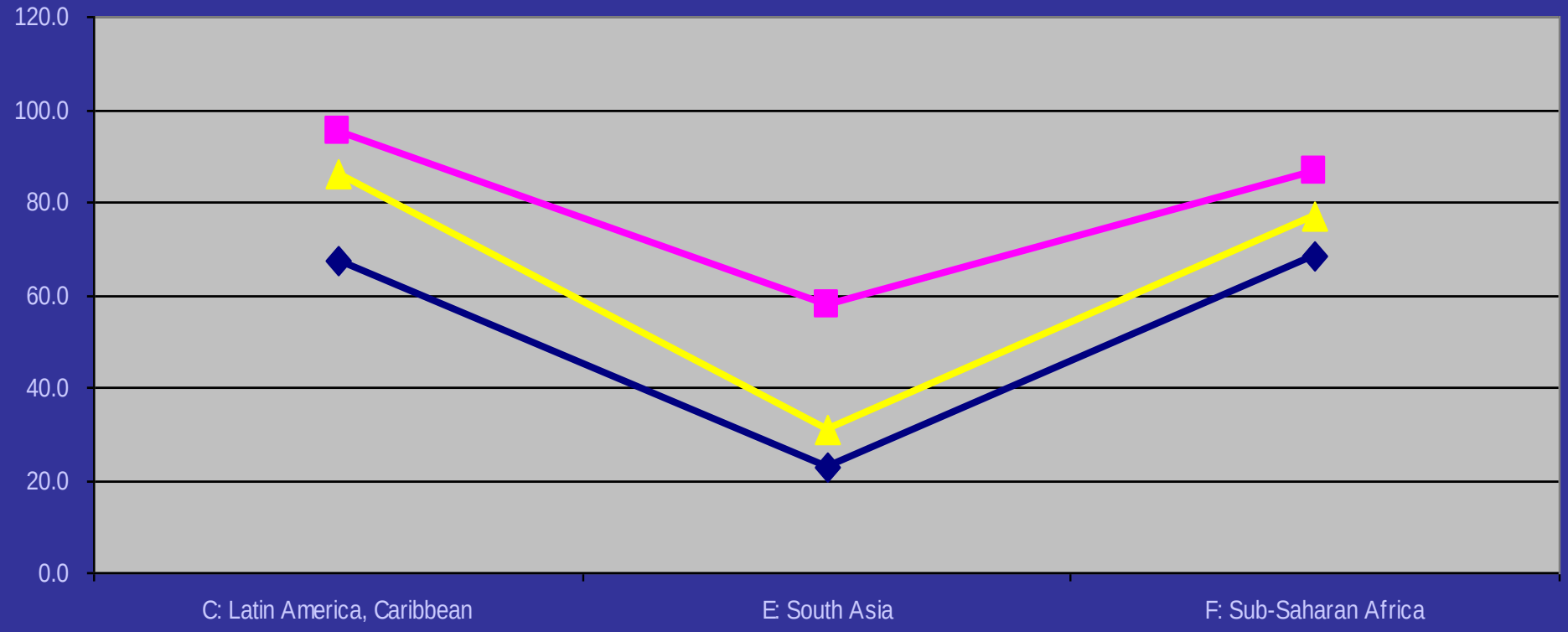
- Opportunity costs: wages, time
- Lack of safety nets

What barriers do the poor face?

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

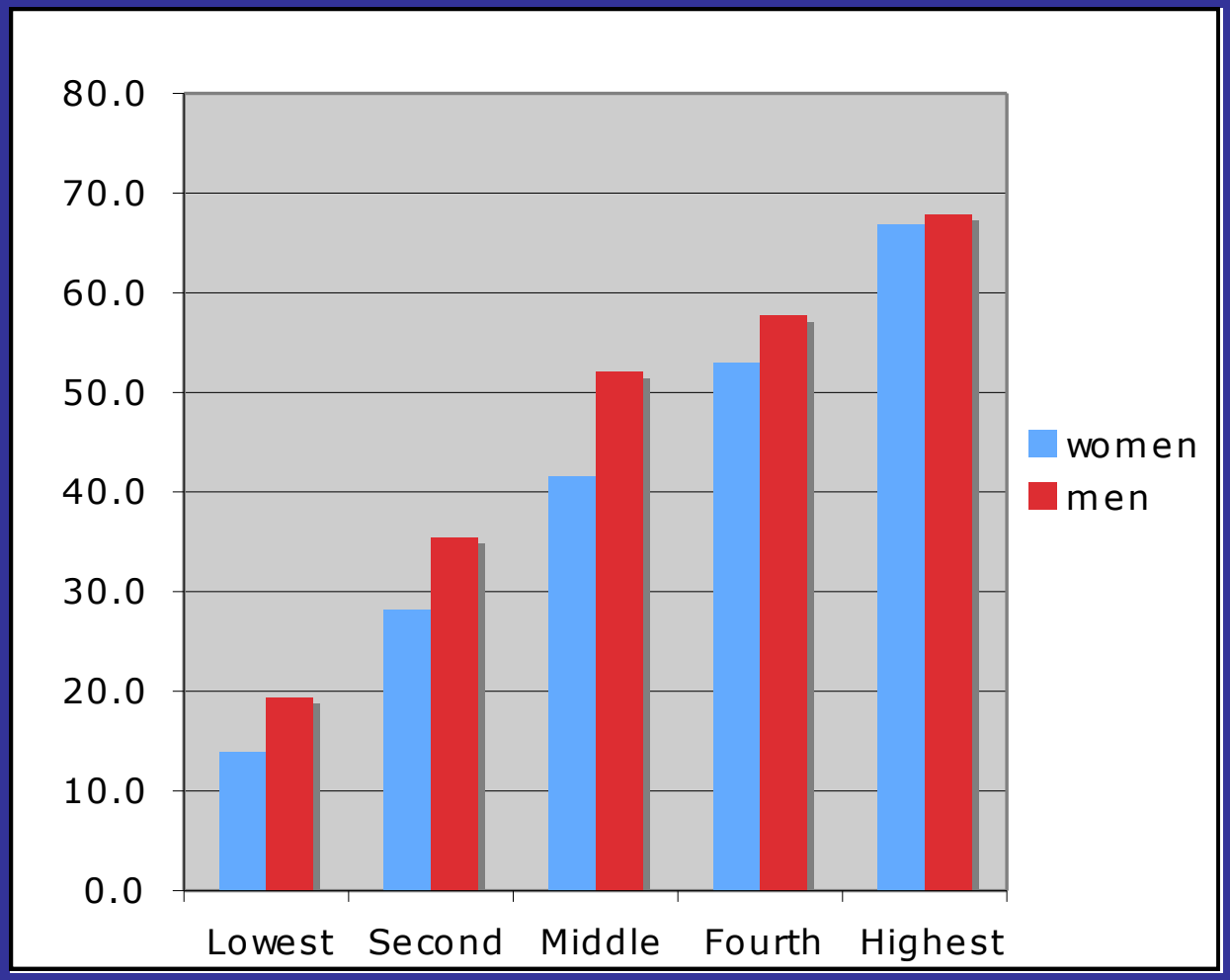
4. Lack of health system responsiveness: public, private

Knowledge of HIV/AIDS Prevention (Men)--rates among poor and rich



Gender differences in access to resources:

Proportion of women and men (15-49 years) who read a newspaper at least once a week, by income quintile, Philippines, 2003



Source: Gwatkin D, *et al*. *Socioeconomic Differences in Health, Nutrition, and Population in Philippines.* Washington, DC: World Bank, 2007

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:

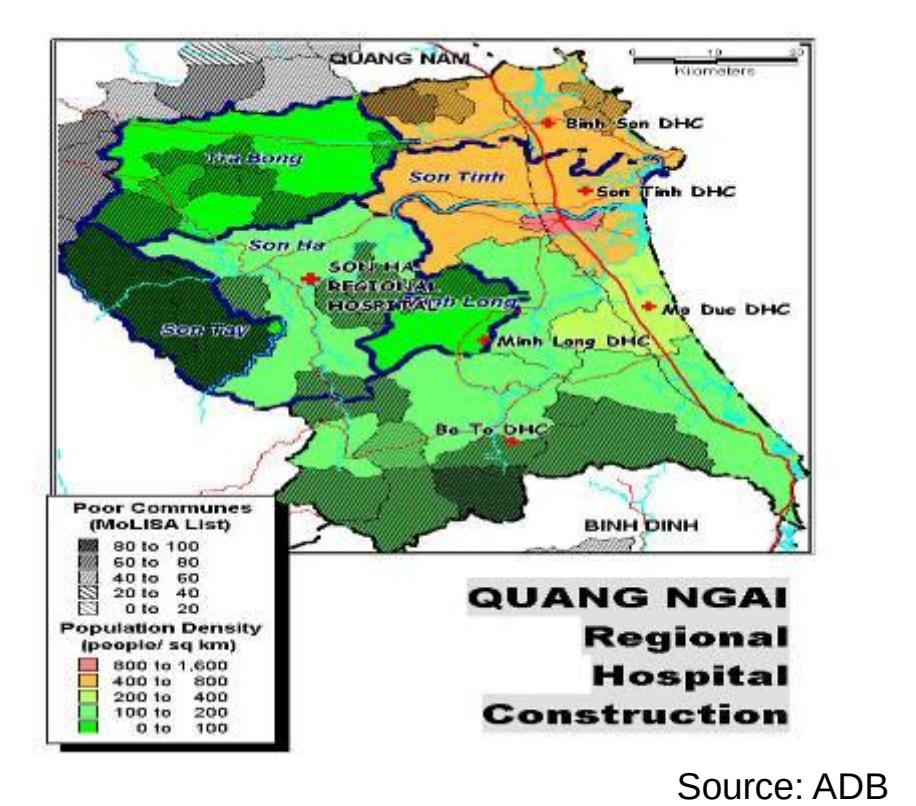
- **MDGs**
- **Commission on Macroeconomics and Health**
- **Commission on Social Determinants of Health**

Country examples:

- **Health in PRSPs**
- **National socioeconomic development plans**
- **MDGs**

Putting poverty on health agenda

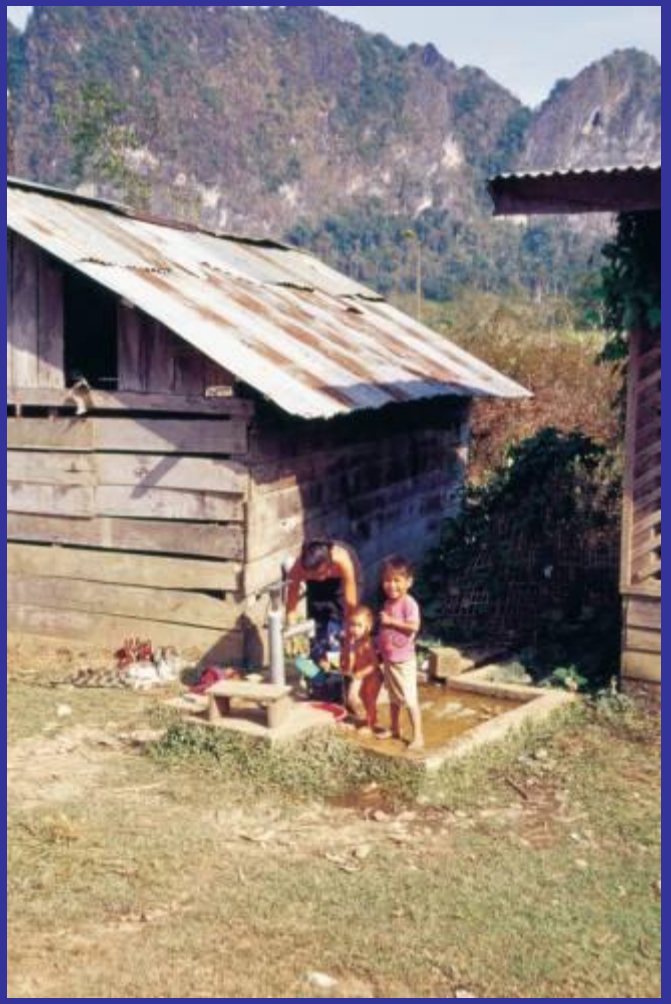
1. **Strategies for geographical barriers:** Target/prioritize regions or areas



Source: ADB

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

Example 1: Strengthening poverty focus of China TB programme

Background:

- Social assessment 2003-05 found barriers to access for TB suspects and patients: lack of knowledge about TB and services; stigma by providers and general population; costs, perceived and actual; delays in seeking care and diagnosis; weak adherence; gender, socioeconomic, age, ethnic differences
- These findings were confirmed in 2006 mid-term review

Objectives:

1. Strengthen poverty focus of national TB programme
2. Build capacity of national and provincial TB staff on equity, poverty and gender issues in TB

Activities

1. Improve reporting and recording:
    - Pilot adding socioeconomic variables (income, ethnicity, residence, occupation) to standard reporting formats to enable analysis of disaggregated patient data by
2. Systematic review of pro-poor initiatives:
    - Which pro-poor strategies are relevant? Are they effective in reaching the poor? What lessons can be learned?
3. Finalize, evaluate current operational research, pilot new interventions:
    - Pilot study of perceptions and experiences of healthcare providers regarding a transport subsidy for poor TB patients
    - Pilot study of case-based payment for TB outpatient treatment
4. Build capacity of national and provincial TB staff: workshop on addressing poverty and gender issues in China TB programme (Sept. 2009)

Example 2: Women, gender & tobacco control pilot project, Viet Nam

Background

- High (56%) male smoking prevalence (female: 1.8%); male-dominated culture
- Second hand smoke a serious health threat to women: ½ of children and 2/3 of women exposed to SHS at home in the week before interview

Objectives:

1. Raise awareness on harmful effects of smoking, SHS
2. Encourage women to raise a strong voice against smoking, and thus:
   - Promote smoke-free homes
   - Help smokers to change smoking behavior
   - Promote no smoking as socially acceptable norm for next generation
   - Prevent girls/young women from starting to smoke

Activities and results

- 4 communes, 1 town (Thanh Mien dist, Hai Duong province)
- Commune level interventions:
  - Meetings with women; men smokers; pregnant women, Farmer's Union, veterans, the elderly
  - Household visits
  - Communication corners at 5 commune health centres
  - Women's clubs activities on harms of smoking, SHS
- Awareness raised on harms of smoking, SHS:
  - Women recognize their right to protect themselves and homes from SHS, become more confident and skilled in convincing smokers to change their behaviors
  - Male smokers aware of harms of SHS, recognize their responsibility and are changing smoking behaviors
- Project communes banned smoking in workplaces, public places; smoke-free home a criterion for "cultured home"; weddings and funerals encouraged to be smoke-free.
- Project to be scaled up in 2010 to 18 communes and I town

THANK YOU