POLICY BRIEF

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Poverty and Health in Developing Countries: Key Actions

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Introduction

Health is higher on the international agenda than ever before and improving the health of poor people is a central issue in development. Poor people suffer worse health and die younger. They have higher than average child and maternal mortality, higher levels of disease, and more limited access to healthcare and social protection. But health is also a crucially important economic asset, particularly for poor people. Their livelihoods depend on it. When poor people become ill or injured, their entire household can become trapped in a downward spiral of lost income and high healthcare costs.

By the same token, the benefits of good health spread beyond a single healthy generation. This is particularly important for the poor as they tend to have more children and fewer resources to invest in the education and health of each child. But with the spread of better healthcare and education, family size declines. Children are more likely to escape the cognitive and physical consequences of childhood diseases and to do better in school. These children are less likely to suffer disability and impairment in later life and so are less likely to face catastrophic medical expenses and are more likely to achieve their earning potential. Then, as healthy adults, they have more resources to invest in the care, health and education of their own children.

The current high-level focus on health by the international community recognizes this strong relationship between poverty and health. Three of the eight Millennium Development Goals call for specific health improvements by 2015: reducing child deaths, reducing maternal mortality and slowing the spread of HIV/AIDS, malaria and tuberculosis. Moreover, health is increasingly viewed as fundamental to the first Millennium Development Goal, eradicating poverty and extreme hunger. This is partly due to the work of the Commission on Macroeconomics and Health (CMH) which demonstrated the link between health and economic development. Governments and the private sector came together to establish a Global Fund on AIDS, TB and Malaria in 2002 and in 2003 the G8 reaffirmed their commitment to improve the health of poor people and to make available the necessary resources. ■

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Can improved health reduce poverty?

Investment in health is an important means of economic development. As the CMH has shown, substantially improved health outcomes are a prerequisite for developing countries to break out of the cycle of poverty. Good health contributes to development in a number of ways:

Higher labour productivity. Healthier workers are more productive, earn higher wages, and miss fewer days of work. This raises output, reduces turnover in the workforce, and increases enterprise profitability and agricultural production.

Higher rates of domestic and foreign investment. Increased labour productivity in turn creates incentives for investment. In addition, controlling endemic and epidemic disease, such as HIV/AIDS, is likely to encourage foreign investment, both by increasing growth opportunities for investors and by reducing health risks for their personnel.

Improved human capital. Healthy children learn better. As health improves, absenteeism and early school drop-outs fall, leading to growth in the human-capital base.

Higher rates of national savings. Healthy people have more resources to devote to savings, and people who live longer save for retirement. These savings in turn provide funds for capital investment.

Demographic changes. Improvements in both health and education contribute to lower rates of fertility and mortality. Ultimately, fertility falls faster than mortality, slowing population growth and reducing the "dependency ratio" (the ratio of active workers to dependents). This "demographic dividend" has been shown to be an important source of growth in per capita income for low-income countries. However, low and middle-income countries with high rates of HIV/AIDS have high death rates among people of working age, which increases the dependency ratio and reduces growth. In contrast, higher income countries have little room for the birth rate to decline further and a growing number of retirees; so their dependency ratios are increasing. ■

What is a "pro-poor" health approach?

Although the technical knowledge to address the main causes of ill-health already exists, the poor continue to carry a disproportionate burden of disease. If the health of poor people is to improve, a "pro-poor" health approach, or one that gives priority to promoting, protecting and improving the health of the poor, is needed. Such an approach should be promoted in developing countries, and priorities for development co-operation should be identified in this context.

A pro-poor health approach includes quality public health and personal care services, with equitable financing mechanisms. But it goes beyond the health sector and includes policies in areas that disproportionately affect the health of the poor, such as education, nutrition, water and sanitation. Finally, it is concerned with global action on the effects of trade in health services, intellectual property rights, and the funding of health research as they affect the health of the poor in developing countries.

Strengthening the public sector's capacity to carry out the core functions of policymaker, regulator, purchaser and provider of health services is central to developing and implementing pro-poor health systems. Strong institutional and organisational capacity, moreover, is needed to track the use of resources, and to improve human-resource strategies. These key issues go beyond the health ministry and reflect the necessity of placing health-sector reform within the context of broader governance reform.

Developing good quality public- and private-sector services that respond to the health needs of poor people requires a focus on those diseases that affect the poor disproportionately. This means diseases such as malaria, TB, and HIV/AIDS but also reproductive health and non-communicable diseases, such as those linked to tobacco. This approach should be complemented by strategies to reach out to poor and vulnerable groups, and by measures that stimulate demand for health services and increase their accountability to poor communities. To accomplish these objectives, the voices of the poor, as well as those of NGOs and civil society organisations, must be heard in the planning and implementation process.

Better partnership with the private sector is also critical. Poor people make heavy use of private, for-profit and not-for-profit services (NGO and faith-based). In many developing countries, the public sector lacks the capacity either to deliver health services to the entire population or to ensure that

health services delivered by the private sector promote pro-poor health objectives. The type of partnership that governments can develop with private providers will vary according to patterns of use and their relative strengths and qualities. Governments may choose to contract out particular services to NGOs, or seek to improve the quality of services available in the private-for-profit sector. If governments select this policy option they will have to strengthen their capacity for regulating, contracting out and monitoring.

Equitable health financing systems are an essential part of improving access to healthcare and protecting the poor from the catastrophic cost of ill health. This requires effective social protection strategies, moving towards systems such as prepayment and away from out-of-pocket “fee for service” payment for primary healthcare, which discourages use by poor people. ■

How can policies outside the health sector help?

Ensuring that the poor have access to affordable, quality health services is not enough by itself to improve their health because the major determinants of their condition lie outside the health sector. To start with, implementing effective pro-poor economic growth policies as outlined in the *DAC Guidelines on Poverty Reduction* is crucial: without higher incomes, poor people will not be able to afford health services. And without growth in revenue, governments will not increase their funding of health services.

Policies in other sectors are also critically important, especially education, food security, safe water, sanitation and energy. The health of the poor can also be improved by reducing their exposure to the risk of addiction to tobacco or alcohol, road traffic or other injuries, and the devastating impacts of conflict and natural disasters. Governments in developing countries and aid agencies should assess the extent to which policies in key sectors such as education, nutrition and the environment undermine or promote health and broader poverty-reduction objectives and implement appropriate responses. This would include efforts to strengthen capacity related to health objectives within those sectors.

Achieving the three health-related Millennium Development Goals, for instance, depends to a large extent on reaching the goals of gender equality and universal primary education.

Gender equality or inequality is a major determinant of poverty and ill health. Poor women are doubly disadvantaged; they live in poverty and are worse off than men within poor households. Socio-cultural beliefs about the roles of men and women contribute to this inequality. Poor women and girls may experience even deeper disadvantage in access to resources for health, such as cash, financing schemes or services, and in their ability to express their needs and opinions. Some categories of women and children are especially vulnerable – for example, elderly widows, unsupported female and child-headed households, and street children. Women are also major producers of healthcare through their roles as household managers and carers. But the health, including the reproductive health, of poor women and girls suffers from inadequate nutrition, heavy workloads and neglect of basic healthcare, factors aggravated by exposure to sexual abuse, wife-beating and other interpersonal violence. Action on gender inequality is therefore an essential element of an approach to health aimed at helping the poor.

Education is also vital. Education of women and girls is closely linked to improved healthcare for children, families and communities, and to lower fertility rates. Education is also one of the most effective means of combating the spread of HIV/AIDS. At the same time, health is a major determinant of educational attainment since it has a direct impact on cognitive abilities and school attendance. There is therefore a mutual interest in identifying strategies for collaboration between health and education efforts, both within the formal school system and through non-formal education.

Food security and nutrition are also critical factors influencing the health of the poor. Nearly 800 million people in developing countries are chronically under-nourished. Under-nutrition affects the immune system, increasing the incidence and severity of diseases and is an associated factor in over 50% of all child mortality. Development agencies should focus on improving food security in rural and urban areas through interventions that aim to increase income

Table 1. **Health-related Millennium Development Goals**

Goals and Targets of the Millennium Declaration	Indicators for Monitoring Progress
Goal 4: Reduce child mortality	
Target 5: Reduce by two-thirds, between 1990 and 2015	• Under-five mortality rate the under-five mortality rate • Infant mortality rate • Proportion of one-year-old children immunised against measles
Goal 5: Improve maternal health	
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	• Maternal mortality ratio • Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	• HIV prevalence among 15/24 year-old pregnant women • Condom use rate of the contraceptive prevalence rate[a] • Number of children orphaned by HIV/AIDS
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	• Prevalence and death rates associated with incidence of malaria • Proportion of population in malaria risk areas using effective measures for malaria prevention and treatment • Prevalence and death rates associated with tuberculosis • Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS)
Goal 8: Develop a Global Partnership for Development	
Target 17: In co-operation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	• Proportion of population with access to affordable, essential drugs on a sustainable basis

a. Among contraceptive methods, only condoms are effective in reducing HIV transmission. The contraceptive prevalence rate is also useful in tracking progress in other health, gender and poverty goals.

World Bank (2002)

and access to social services, as well as through targeted maternal and child-nutrition programmes.

Poor people's health and mortality are directly affected by exposure to environmental threats. Poor people often live in low-quality urban settlements, or in remote villages where they have limited access to safe water and sanitation, and are exposed to indoor as well as outdoor air pollution. These environmental conditions are a major cause of ill health and death among poor people. The importance of these basic causes of poor health must be integrated into development policies.

A poverty reduction strategy (PRS) developed and owned by the partner country, should be the central framework for formulating the broad lines of a pro-poor health approach. Most poverty reduction

strategies recognise health as a dimension of poverty, but they need to demonstrate a clearer understanding of the causal links between better health and poverty reduction, and to include explicit health objectives in the key sectors that influence the health outcomes of poor people.

Reports from the WHO indicate that health ministries in particular have not yet contributed in any large measure to the overall development of poverty reduction strategies, and, in some cases, even to their health content. Development agencies should support strengthening the capacity of health ministries to contribute to an analysis of the relationship between health and poverty reduction. Development agencies can also support efforts to ensure that the health concerns of civil society (parliament, local government, community organisations, advocacy groups for women's health, trade unions, and the private sector) are reflected in policy choices and priorities.

The development of a poverty reduction strategy can provide an opportunity to take a fresh look at health programmes to ensure that health outcomes improve for poor people. The process can be a first step in reassessing existing health strategies from a poverty perspective. ■

What are global public goods for health and why are they important?

Global public goods are products, services and conditions that are under-supplied by the market, are of broad international concern, and require international public action. Global public goods for health are a good example because the health problems of the poor do not stop at national borders. In a globalised world, people and information travel across borders with increasing speed and ease. This presents new risks to health, as is indicated by the rapid spread of HIV/AIDS or the recent outbreak of severe acute respiratory syndrome (SARS). Globalisation also provides new opportunities to prevent, treat or contain disease, by countries working together, often in partnership with the private sector, to address common threats to health.

Health research offers one such opportunity. Currently, diseases or conditions that account for 90% of the global disease burden receive less than 10% of global funding of health research. This means that managing diseases such as trachoma, which affects 145 million people and can lead to irreversible blindness, is unlikely to be successful unless there is additional financing for international initiatives to plug the research gap.

Development agencies have a central role to play in correcting the "incentive gap" for the production of global public goods for health. Recent developments suggest that appeals for financing and developing them help increase support for aid for health and for aid overall. Since the benefits derived from global public goods for health accrue to rich countries as well as poor, funding should come, where feasible, from sources other than official development assistance (e.g. national health sector or research budgets in OECD countries, as well as increased international aid budgets). This diversity of sources could provide increased funding and technical support to help tackle critical global health problems.

Development agencies can also provide critical financial support for international initiatives to produce new vaccines, drugs and knowledge focused on the health problems of the poor. According to the WHO's Commission on Macroeconomics and Health, USD 3 billion are required by 2007 and USD 4 billion by 2015 for the development of new vaccines and drugs. It is important that this funding be consistent. It can come through direct funding and through incentives that 'push' research per se or 'pull' research by increasing demand for the products to be developed by research. Development agencies can also urge other relevant government agencies to give higher priority in health research to diseases of importance to developing countries. ■

How do trade agreements affect health in poor countries?

Trade in goods and services, and multilateral trade agreements, have a direct bearing on the health of the poor. Of particular significance are those agreements that affect access to medicines, including trade-related aspects of intellectual property rights (TRIPS), and developments under the General Agreement on Trade in Services (GATS).

Intellectual capital is an important component of the value-added of medicines and drugs. The Doha Declaration on the TRIPS Agreement and Public

Health adopted at the WTO Ministerial Conference in November 2001 made a number of important clarifications to the TRIPS agreement. It affirmed that each WTO member has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted. Under compulsory licensing, a government can authorize production of a patented product or use a patented process without the consent of the patent owner in the case of a national emergency. Further, each member has the right to determine what constitutes a national emergency or other circumstance of extreme urgency. It was understood that these may include public health crises relating to e.g. HIV/AIDS, tuberculosis, malaria and other epidemics.

TRIPS compulsory licensing rules require that products made under such licences be "authorised predominantly for the supply of the domestic market of the member authorising such use" (Article 31.f). The Doha Declaration recognised that WTO members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement, and instructed the Council for TRIPS to find an expeditious solution to this problem but to date no solution has been agreed.

As for GATS, WTO members have a range of policy options to allow them to liberalise services trade on a gradual basis, in line with their development objectives. GATS negotiations under way in the WTO aim to achieve progressively higher degrees of liberalisation of trade in services. The negotiations do not exclude a priori any service sector, although each WTO member is free to choose which sectors it will liberalise and the extent of liberalisation it will undertake. In determining whether or to what extent they wish to liberalise trade in health services, WTO members need to consider the potential benefits and risks to poor people's access to health services.

Increased foreign investment in private health facilities may improve the quality of care in recipient countries, especially in the tertiary sector (i.e. university or highly specialised hospital services). But if this investment is on a large scale and supports hospitals and services that offer more attractive wages and working conditions, it may exacerbate medical and nursing staff shortages in the rural and public facilities on which poor people rely. Moreover, the lack of empirical evidence on the impact of privatisation on access to health services by the poor in low-income countries suggests that more research and monitoring are called for. Lessons from other sectors on the sequencing of reform suggest that the achievement of pro-poor health goals requires that countries put effective regulatory frameworks in place before privatising health services and opening the market to foreign investors.

As international trade in health services grows and diversifies, and as agreements concerning services trade expand to cover healthcare, developing countries require capacity and assistance on how to assess the benefits and risks, and the implications for the regulation of health systems. Development agencies may consider how to support the needs of low-income countries for specialised technical assistance on trade in health services and encourage dialogue between health and trade ministries to ensure national policy coherence. Agencies might also search for opportunities to support credible research on the effects of trade liberalisation on access to health services by the poor, to expand the body of knowledge on this issue.Health professionals in developing countries often emigrate to benefit from better salaries and working conditions. Such emigration may be temporary or permanent. In either case, their professional education has usually been highly subsidised by their home government to enhance the supply of qualified staff in their own health system. Some OECD countries facing their own shortages of professional staff have encouraged this migration, with active recruitment of people from/in developing countries with appropriate professional and language skills. Unless explicitly considered and mitigated, this practice will have repercussions on the health systems in the source countries, exacerbating their shortages of professional staff. Some OECD countries are taking steps to address these issues, particularly that of active recruitment, and to enhance policy coherence for pro-poor health. It has also been suggested that the WHO develop an ethical chart on the international recruitment of health professionals, including support for improved employment conditions in low-income source countries. ■

How much money is needed to improve health in developing countries?

Improving the health of the poor is an investment in economic growth and development and should be a priority for reducing poverty. The lack of resources allocated to health is not the only obstacle to the effective implementation of pro-poor health policies, but it is a major, and inescapable, part of the problem. A minimally adequate set of interventions to meet the basic health needs of the poor and the infrastructure necessary to deliver them is estimated to cost in the order of USD 30–40 per capita. This figure does not include important elements such as family planning, tertiary hospitals and emergencies, which would also need to be part of any operational health system.

In 2000, the WHO calculated a figure of USD 60 per capita for a more comprehensive health system. This compares with an average level of health expenditures in the Least Developed Countries of USD 11 per year. Current spending, much of which is not for the poor, falls far short of the minimum to meet basic needs. Scaling up financial resources for health should be a priority. Without money to buy vaccines and drugs, to build and equip facilities, to ensure adequate staffing, to manage the health system, and to increase investments in other sectors important for health, governments in low- and middle-income countries will be unable to meet the health-related MDGs and make progress in improving the health of the poor.

The additional resources necessary to protect, promote and improve the health of the poor should come from a combination of public, private, domestic and external sources, including official development assistance (ODA) and global health initiatives such as the Global Fund for AIDS, TB and Malaria. Some increases in government spending for health are possible in most partner countries. National health budgets should reflect the urgency of the poverty and health challenge, both in terms of the size of the budget for health and other social sectors, and the share of health resources allocated to the activities likely to benefit the poorest groups. A number of countries are aiming to increase the share of resources allocated to primary healthcare, including through channelling savings from debt relief under the Highly Indebted Poor Countries initiative (HIPC) into health.

In many partner countries, the distribution of resources benefits highly advanced services at the expense of primary healthcare and district hospital services. Resources need to be allocated appropriately so they benefit the poor and socially vulnerable. In almost all cases, though, the resources released through such means will be limited relative to health needs. The poorest countries will remain unable to provide sufficient resources to meet pro-poor health objectives without significantly increased external financing.

Total aid commitments from DAC members to health provided through bilateral and multilateral channels has averaged close to USD 3.7 billion per year for 1999-2001. Aid to health as a share of ODA has increased in recent years from 9% in 1996-98 to the current average of 11%. The recent increases, albeit from a low base, reflect the increasing importance given to health as a key dimension of poverty. The level of multilateral aid to health – particularly from the World Bank's International Development Association – has declined despite an increasing commitment to social development goals. Aid channelled through UN agencies such as WHO and UNICEF, aid flows at non-concessional terms, and flows from non-profit foundations brought the total estimated assistance to health to USD 6.7 billion per year in the late 1990s, according to WHO figures. However, despite the positive trends in aid to health, the current allocations are far below the estimated funding needs in the sector. Hopefully, the recognition by the G8 Summit in June 2003 of the need for significant additional funds for health and especially for HIV/AIDS, TB and Malaria will yield positive results. ■

For Further Information

This *Policy Brief* is based on the *DAC Reference Document on Poverty and Health*, prepared by the DAC Network on Poverty Reduction and jointly published by the OECD and the World Health Organisation (WHO) in 2003.

For more information on the OECD's work on poverty and health, contact Stephanie Baile, e-mail: Sephanie.Baile@oecd.org, tel: 33-1-45.24.90.30. ■

For Further Reading

- **DAC Guidelines and Reference Series: Poverty and Health**, 2003
  ISBN: 92-64-10018-0, €21, 96p.
- **The DAC Guidelines on Poverty Reduction,** 2001 -
  ISBN: 92-64-19506-8, €20, 125p.
- **Health Systems: Improving Performance**, The World Health Report, 2000
- **Macroeconomics and Health: Investing in Health for Economic Development**,
  Report of the Commission on Macroeconomics and Health, WHO, 2001
- **More information is available on our Internet site at** :
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