

Chapter 4

The Poverty-Health Interaction: Old Problem, New Perspectives

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Summary

Around 1.3 billion people in the world live in extreme poverty, surviving on less than US\$ 1 a day for all their needs. These people have little or no access to health services and education and limited prospects for a better life. They are far removed from decisions that affect their day-to-day lives. Increasingly, they are the victims of crime, conflict, and violence.

It is important in both the generation and use of health R&D that the interests of the poor be made explicit. The Global Forum will support the promotion of health R&D to help correct the 10/90 Gap, with special attention to the health of the 1.3 billion poor and the development of strategies that can better serve their needs.

Data from the Global Burden of Disease Study (GBD 1990) have been used to study the burden of disease among the global poor and the results were presented at Forum 2. This study revealed that:

- Although the poor represent a quarter of the world's population of over five billion people, they share a disproportionately large burden of ill-health.
- An evaluation of the poorest 20% of the world's population indicates that they suffer more from all causes of ill-health, especially communicable diseases, than the richest 20%.
- Predictions for the future are dependent on the assumptions used, but reflect that any acceleration in the decline of death rates would benefit the poor. However, this does not question the need for priority setting.

These data confirm what health and development professionals have believed for decades: that poverty is a cause, an associated factor, a catalyst, and a result of ill-health. This kind of data is essential for any intervention in the complex health and poverty relationship. However, it is the appropriate use of such data for decision-making that will change the 10/90 Gap.

Meanwhile, there is a critical need to focus on the ability of the poor to voice their concerns and participate in making decisions that affect their lives. Health and development programmes have a poor record of ensuring that this participation is both effective and sustainable. Mechanisms to enable the poor and the vulnerable to be involved and work towards a better future for themselves are central to overall health and development.

The global community should recognize that good health is a way out of poverty. It results in a greater sense of well-being and contributes to increased social and economic productivity. The impact of ill-health on productivity affects not only the poor but societies and economies as well. The issue of health and poverty is not just a moral issue, it is an economic issue as well. It is more cost-effective in the long run to reduce poverty by improving health and development interventions for the poor than to face the heavy costs of poverty on the community as a whole.

Section 1:

Poverty, health, and the poor

Health and poverty are inextricably linked. Poverty is often associated with ill-health, while ill-health can lead to poverty. More importantly, however, good health can lead people out of poverty. And that alone is sufficient reason for global efforts to focus on this area.

Around 1.3 billion people in the world live in extreme poverty, surviving on less than US\$ 1 a day for all their needs.¹ These people have little or no access to health services and education and limited prospects for a better life. They are far removed from decisions that affect their day-to-day lives. Increasingly, they are the victims of crime, conflict, and violence.

Over the past millennium, and the last decade in particular, global health status has improved dramatically. In developing countries, child death rates have been cut by half since the 1960s, the percentage of people with

access to clean water has doubled, people have more food to eat, and life expectancy has increased in every country.² Despite these advances, there is a continuing need to intensify efforts to develop new strategies to ensure further gains in health care and health status, especially for the world's poor.

Although the global community recognizes a wide range of human rights and obligations, these cannot be freely exercised in many parts of the world. The rights to security, freedom, and dignity, regardless of race, gender, belief or religion are not upheld; basic needs for water, food, education, and health are not met; and every day decisions are taken that involve the inappropriate allocation of resources. The Global Forum will pursue the promotion of health R&D with a prime focus on the health of the large majority of the world's population, particularly the poor, and the development of strategies that can better serve their needs.

¹ At 1985 purchasing power parities. *World Development Indicators*, 1997.

² *Eliminating World Poverty*, Department for International Development, UK, 1997.

Section 2:

The facts

1. Poverty: how big a problem?

There are many definitions of poverty. Yet, whichever definition is used, the results do not change significantly: poverty is a global phenomenon. According to the 1997 World Development Indicators, of the 5.5 billion people on earth, 1.3 billion – nearly a quarter of the world's population – are poor. This definition is reflective of absolute poverty and not only relative poverty in each country.

2. Where are the poor?

More than two thirds of the people designated as poor live in Asia and the Pacific, 17% in Africa, and 10% in the rest of the world (Insert 4.1). This geographical distribution indicates much more than the physical presence of the poor in some parts of the world. It is a measure of the differential opportunities for people to realize their full potential to become healthy and of all of the additional factors that prevent or facilitate the development of such an environment.

Insert 4.1

*Regional distribution of the poor**

Region	% of the poor living in region
South Asia	39
East Asia & Pacific	34
Sub-Saharan Africa	17
Other	10
Total	100

* Those living at less than US\$ 1 per day at 1985 prices.

(Source: World Development Indicators, 1997)

3. What is the health status of the poor?

The magnitude of the burden of ill-health on the poor is shown in Insert 4.2. The sheer numbers of people who are without basic health services, or of children who are under-

nourished is overwhelming. This profile of the poor is true for South Asia, East Asia, sub-Saharan Africa, and Latin America. The poor everywhere are in worse health than those who are not poor.

Insert 4.2

Health Status of the Poor in Developing Countries (number of people in millions)

Health Indicator	Developing World*	South Asia	Sub-Saharan Africa	Latin America and Caribbean	South East Asia and Pacific	Arab States	Oriental Asia
People lacking access to health services	766	264	205	55	69	29	144
Malnourished children under 5 years of age	158	82	28	5	20	5	17
People not expected to survive to age 40	503	184	124	36	52	26	81
People lacking access to safe water	1202	230	249	109	162	54	398

* Total for all regions.

(Source: Human Development Report 1997)

4. How can this health status be defined?

In the absence of current information, existing data needs to be analysed to determine the impact of ill-health on the poor. The Global Burden of Disease Study (GBD 1990) provided estimates of the morbidity and mortality impact of diseases on the world population for 1990. This data has been used to study the

burden of disease among the poor and the results were presented at Forum 2.³ This analysis (Insert 4.3) provided a description of the disease burden for the poor and investigated the relationship between health estimates for the global population and those for poor people.

³ Gwatkin D. and Guillot M., *The Burden of Disease Among the Global Poor. Presented at the Second Annual Meeting of the Global Forum for Health Research, 25-26 June 1998, Geneva.*

Insert 4.3

(i) The burden of disease among the global poor

This study provides information about the burden of disease among the poor to complement data about society as a whole, the principal focus of most burden of disease work to date. The information presented deals with the 1990 situation and with trends between 1990 and 2020.

The 1990 Situation.

Communicable diseases are found to be considerably more important for the poorest 20% of the world's population than suggested by global averages.

They account for 58% of deaths and 66% of DALY loss among the world's poorest 20% compared with 34% of deaths and 44% of DALY loss in the overall global population.

Communicable diseases are responsible for 77% of the mortality gap and 79% of the DALY gap between the poorest and richest 20% of the global population, compared with 15% and 9% attributable to non-communicable diseases.

The projected trend 1990-2020.

An accelerated overall decline in communicable diseases would benefit the world's poor much more than the rich.

An accelerated decline in mortality from communicable disease, distributed evenly across all social classes, would benefit the world's poorest 20% about ten times as much as it would the world's richest 20%.

Implications:

Findings like these argue for basing research and policies designed to help the poor:

- on burden of disease information specific to the poor.
- on information about the distributional impact of alternative policies or research strategies on anticipated future disease trends.

(Source: Edited from Gwatkin D. and Guillot M., The Burden of Disease Among The Global Poor, 1998)

(ii) Distribution of Death by Cause In Different Population Groups, 1990

Cause	Percentage of deaths		
	Entire Global Population	Poorest 20% of the Global Population	Richest 20% of the Global Population
Communicable, Maternal, Perinatal, Nutritional (Group I)	34.2%	58.6%	7.7%
Noncommunicable (Group II)	55.7%	32.0%	85.2%
Injuries (Group III)	10.1%	9.4%	7.1%
TOTAL	100.0%	100.0%	100.0%

(iii) Distribution of DALY Loss by Cause in Different Population Groups, 1990

Cause	Percentage of DALY Loss		
	Entire Global Population	Poorest 20% of the Global Population	Richest 20% of the Global Population
Communicable, Maternal, Perinatal, Nutritional (Group I)	43.9%	63.6%	10.9%
Noncommunicable (Group II)	41.0%	23.3%	75.8%
Injuries (Group III)	15.1%	13.1%	13.3%
TOTAL	100.0%	100.0%	100.0%

Results that emerge from this work include the following:

- Although the poor represent a quarter of the world's population of over five billion people, they share a disproportionately large burden of ill-health.
- An evaluation of the poorest 20% of the world's population indicates that they suffer more from all causes of ill-health, especially communicable diseases, as compared to the richest 20%.
- Predictions for the future are dependent on the assumptions used, but reflect that any acceleration in the decline of death rates

would benefit the poor proportionately more than other groups. However, this does not question the need for priority setting.

The data from these studies confirm what health and development professionals have believed for decades: that poverty is a cause, an associated factor, a catalyst, and a result of ill-health. This kind of data is essential for any interventions in the complex health and poverty relationship. However, it is the appropriate use of such data for decision making that will change the 10/90 Disequilibrium.

Section 3:

The facts: research on poverty and health

Estimation of the burden of disease and health determinants provides an opportunity to study the interaction between health and poverty.⁴ When available data is disaggregated by factors that define poverty, then the differential impact of the burden on the poor can be studied. Disaggregation of data by age, gender, residence, and socioeconomic status as defined by income, ownership of commodities or land holdings, for example, allow a deeper understanding of the burden of disease on:

- children of both sexes
- economically active young adults of both sexes
- women of reproductive age
- rural versus urban populations
- high versus low socioeconomic status
- various combinations of the above.

A methodological challenge to the study of the health-poverty relationship has been the lack of individual level data. Participants to Forum 2 were introduced to efforts to over-

come this problem by developing methods that allow the use of aggregate data to study the effect of poverty on health and vice versa.⁵ These methods have been used to assess inequalities between the poor and the non-poor, using multi-country data sets, a number of health indicators, and uniform definitions of poverty. The results:

- confirm that the poor have a greater risk of ill-health than the non-poor, irrespective of age, residence, and gender
- indicate that the magnitude of the health inequality between the poor and non-poor can vary, depending on the health status indicator; and
- reveal a high inter-country variation between the health inequality of the poor and the non-poor.

Further work on both the methods and their application are necessary to help define the health inequality/poverty relationship and indicate potential areas for interventions.

⁴ *Health Research: Essential link to equity and development. Commission on Health Research for Development, 1990.*

⁵ *Jamison D., Health, Poverty and Development. Presented at the Second Annual Meeting of the Global Forum for Health Research, 25-26 June 1998, Geneva.*

Section 4:

Poverty and sustainable development

A perspective on poverty and health within the larger context of health and socio economic development was also presented at Forum 2.⁶ This explored issues that directly affect the nature of the poverty/health relationship. Some of the concerns to be addressed include:

- institutional frameworks of government institutions that may hamper or assist health development
- explicit consideration of the poverty impact of health policies, and the health impact of poverty reduction policies
- public/private partnerships for reducing inequities in health and increasing the welfare capital of vulnerable groups
- the cause/effect relationship between internal (within country) and external (international) migration on poverty and health
- inter-sectoral approaches that utilize the most appropriate strategies from a

wide array of disciplines for poverty reduction and health gains.

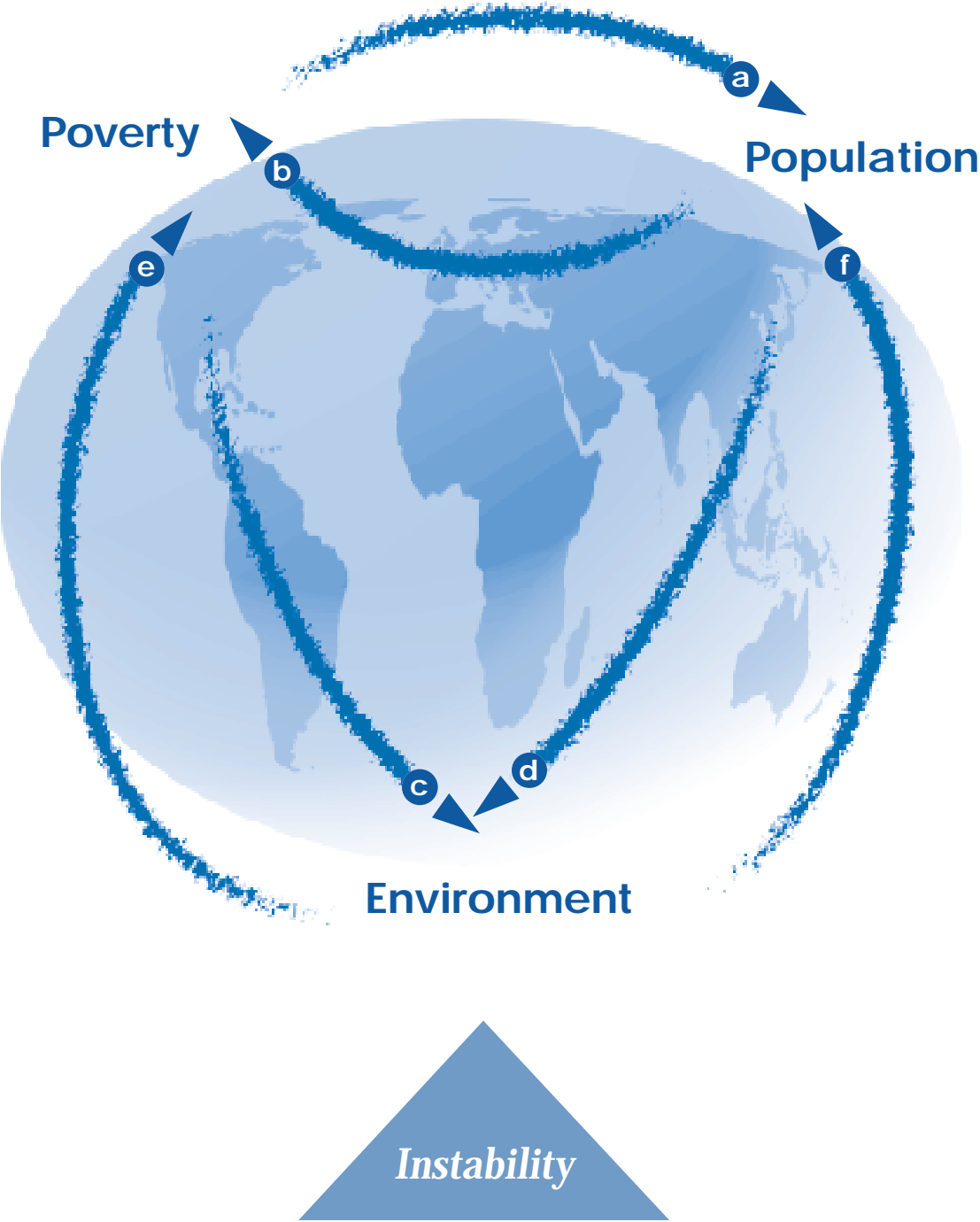
Although the above list is by no means exhaustive, it illustrates the complexity of the health/poverty relationship and its influence on a large number of other factors.

Other critical factors in the relationship between poverty and health are population and environmental health issues. Eighty per cent of the poor in Latin America, 60% in Asia, and 50% in Africa live on marginal lands of low productivity and high susceptibility to degradation. Similarly, in the world's cities more than one billion people live without facilities for garbage disposal or water drainage, and breathe polluted air. These are mostly the poor, especially in urban or peri-urban slums. It is important to recognize this complex interaction between poverty, population, health, and the environment and study potential interventions (Insert 4.4).

⁶ Carrin G. and Martin J., *Health and Socioeconomic Development: Pressing issues in Poverty and Health*. Presented at the Second Annual Meeting of the Global Forum for Health Research, 25-26 June 1998, Geneva.

Insert 4.4

The Poverty, Population, Environment (PPE) Spiral = Instability



a

- High child death rates lead parents to compensate by having many children.
- Lack of water supply, fuel, and labour-saving devices increase the need for children to help in fields and homes.
- Lack of security in illness and old age increases the need for many children.
- Lack of education means less awareness of family planning methods and benefits, less use of clinics.
- Lack of confidence in future and control over circumstances does not encourage planning, including family planning.
- Low status of women, often associated with poverty, means women are often uneducated and without power to control fertility.

b

- Unemployment, low wages, dilution of economic gain.
- Increasing landlessness; inherited plots divided and subdivided among many children.
- Overstretching of social services, schools, health centres, family planning clinics, water and sanitation services.

Outcome:

Instability

- Setbacks for democracy, repression, authoritarianism.
- Diversion of resources to military.
- Poor investment climate, loss of tourism revenues, etc.
- Disruption of health and education services.
- Disruption of trade and economic opportunity.
- National and international resources diverted to emergencies.
- Social divisions.
- Political unrest.
- Refugee problems, internal and international migration.

c

- Difficulty in meeting today's needs means that short-term exploitation of the environment must take priority over long-term protection.
- Lack of knowledge about environmental issues and long-term consequences of today's actions.

d

- Increasing pressure on marginal lands, over-exploitation of soils, overgrazing, overcutting of wood.
- Soil erosion, silting, flooding. Increased use of pesticides, fertilizer, water for irrigation; increased salination, pollution of fisheries.
- Migration to overcrowded slums, problems of water supply and sanitation, industrial waste dangers, indoor air pollution, mud slides.

e

- Soil erosion, salination, and flooding cause declining yields, declining employment and incomes, loss of fish catches.
- Poor housing, poor services, and overcrowding exacerbate disease problems and lower productivity.

f

- Loss of water or soil forces migration.
- Degradation of fisheries requires migration.
- Pollution makes cities uninhabitable.

(Source: Reprinted from Taylor-Ide, D., and Taylor, C., *Community Based Sustainable Human Development*, UNICEF, 1993)

In summary, the larger foundation on which health development and poverty alleviation are built must not be forgotten. The potential for change differs greatly among the world's people and the systems in which they live. Although these differences need to be

recognized, it is also becoming clear that there is a common vision of health and social development that includes equity, elimination of poverty, employment, social justice, and the basic needs for human welfare such as health, education, shelter, and food.

Section 5:

Women: the face of poverty

Of the 1.3 billion people living in extreme poverty in the world today, 70% or 0.9 billion are women. These women are not only poor but in poor health, and they are also caring for children and families. Poverty, and its complex array of contributing factors, has been identified as one of the key determinants of women's health. There is a need to study the health effects of poverty on women, and the impact of poverty alleviation on women's health. The cause-effect relationship of gender, health, and poverty is a challenging area that requires further investigation and

greater global investment in health R&D efforts.

In a paper presented at Forum 2, research on women's health from a gender perspective was defined as:

- investigating ways to improve women's health
- analysing why gender differences are affecting women's health
- how these differences affect women's health status.⁷

⁷ Jasis M., *Research from a Gender Perspective: Latin American Examples for Change*. Presented at the Second Annual Meeting of the Global Forum for Health Research, 25-26 June 1998, Geneva.

This perspective stresses the importance of recognizing women as active partners in the research effort, especially as subjects of the research. Innovative health research efforts developed in Latin America and elsewhere include gender as an integral part of health R&D.

Analysis of multi-country data is revealing the consequences for women of being ill, poor, and powerless, the so-called "triple burden." It is imperative that research on the relationship between health and poverty should not just include a gender element, but specifically focus on it.

Section 6:

The future

There is a need for focused research to better understand the transition between different poverty levels. What are the implications of the poor becoming poorer? Similarly, what is the nature of the transition from being very poor to being less poor, and what are some of the accompanying factors that have a health impact?

Appropriate policies linked to these research initiatives will result in the development of interventions. Examples of policies on poverty elimination which also incorporate health are shown in Insert 4.5. These policies are designed to alleviate poverty through economic development, and health and education programmes.

Insert 4.5

Statement of Purpose of DFID

DFID's aim is the elimination of poverty in poorer countries.

Objectives

We shall pursue this through the promotion of sustainable development and in particular by:

- building development partnerships with poorer countries
- working more closely with the private and voluntary sectors, and research community
- working with and influencing multilateral development organizations
- working with other government departments to promote consistent policies affecting poorer countries
- using our knowledge and resources effectively and efficiently.

Our specific objectives are:

1. Policies and actions which promote sustainable livelihoods

In particular we shall contribute to:

- sound policies and pro-poor economic growth
- the development of efficient and well-regulated markets
- access of poor people to land, resources, and markets
- good governance and the realization of human rights
- the prevention and resolution of conflicts
- the removal of gender discrimination.

2. Better education, health, and opportunities for poor people

In particular we shall contribute to:

- lower child and maternal mortality
- basic health care for all, including reproductive services
- effective universal primary education
- literacy, access to information, and life skills
- safe drinking water and food security
- emergency and humanitarian needs.

3. Protection and better management of the natural and physical environment

In particular we shall contribute to:

- sustainable management of physical and natural resources
- efficient use of productive capacity
- protection of the global environment.

(Source: Eliminating World Poverty: A Challenge for the 21st Century, Department for International Development, 1997)

Meanwhile, there is a critical need to focus on the ability of the poor to voice their concerns and participate in making decisions that affect their lives. Health and development programmes have a poor record of ensuring that this participation is both effective and sustainable. Mechanisms to enable the poor and the vulnerable to be involved and work towards a better future for themselves are central to overall health and development.

The global community should recognize that good health is a way out of poverty. It results in a greater sense of well-being and contributes to increased social and economic productivity. The impact of ill-health on

productivity affects not only the poor but societies and economies as well. As a result, both ill-health and poverty have far-reaching effects that extend beyond the individual or community and have a global impact.

In order to make a real difference, what is needed is a genuine *commitment* to the poor. The ability to stimulate research that benefits the poor, and to develop the capacity for the poor to be productive in health R&D, are challenges for the Global Forum. Efforts to better understand the risks of disease and ill-health, effective interventions to reduce them, and partnerships to sustain these efforts will be part of the main strategy of the Forum.