# What constitutes a pro-poor health policy?

The literature on the causal chain running from low incomes to low health status is now quite rich, even for developing countries. The literature on public policy interventions which would improve health status for poor people is sparse and generally non-didactic. No agency has yet made a formal pronouncement of its understanding of what constitutes a pro-poor health policy, nor has there been a coherent exchange of views among the many agencies which are interested in the subject.

As a step towards mobilising a consensus around a limited number of propositions as to what constitutes a pro-poor health policy in the context of developing countries, the following have been garnered from a limited number of sources. (1) a series of papers by Davidson Gwatkin at the World Bank (2) the HNP PRSP Toolkit version 1 (3) the DFID consultation document, "Better Health for Poor People" (4) "Which health policies are Pro-Poor? IHSD for the Interagency Consultation, London, January 2000 (5) an EC Discussion Document, "Pro-Poor Health, HIV/AIDS and Population Policies and Poverty Reduction, and (6) internal WHO drafts generated by the study of National Policies on Poverty Reduction and Health.

In highly summarised form, there appears to be a consensus that implementing these policy thrusts would be pro-poor:

- Improve the supply of relevant personal health services and make them more accessible to the poor
- Improve the supply and effectiveness of non-personal public health services
- Reduce the financial burden of health care utilisation on poor people
- Promote policies in other sectors which bear on the wider determinants of health with particular benefits for the poor.

Before proceeding to an elaboration of these policy thrusts, two further observations are required. The first is that, in the sense in which the term is used here, for a policy to be pro-poor, it is not necessary that the poor capture all its benefits, but only that the poor benefit disproportionately. The second is that much of the literature (including that quoted above) is concerned with policies whose primary inspiration is the search for efficiency gains. The position taken here is that efficiency is a necessary but not sufficient condition for benefits to poor people to be realised. It is a separate, and intrinsically desirable, good. But efficiency improvements are in intent distributionally neutral, and they are not therefore part of pro-poor policy.

**Improve the supply of relevant personal health services and make them more accessible to the poor**

Under this broad heading, at least three different strategies may be grouped:

- Targeting service delivery on poor people
- Combating the diseases of the poor
- Reallocating resources in favour of poorer geographic areas

Targeting service delivery on poor people

There are several variants on this theme, among them:

- Expansion of infrastructure to provide more service delivery points (pro-poor because existing under-served populations are predominantly remote, rural and therefore poorer communities)
- Provision of outreach clinics (this and the above reduce time and travel costs of utilisation, and so make services more accessible)
- Provision of tailor-made services to vulnerable groups, eg slum dwellers, labour migrants

Combating the diseases of the poor

The disease burden of the poor is disproportionately and differentially concentrated in certain areas. It follows that concentration of service delivery effort on these conditions will automatically be pro-poor in its effect:

- Communicable diseases (malaria, TB, HIV/AIDS, immunisable diseases, schistosomiasis,etc)
- Reproductive health, including family planning
- Diseases of childhood
- Malnutrition

In addition to its impact on infant and maternal health, the provision of family planning services has a direct effect on poverty through reducing the number of families burdened by excess child dependants.

Reallocating resources in favour of poorer geographic areas

Given the evidence from existing benefit incidence studies, any reallocation of resources to the geographic periphery, or to lower tiers of the service delivery hierarchy, will facilitate expanded service delivery to the poor. Mechanisms include:

- Population-related resource allocation formulae to distribute resources to regions and districts (may be modified by differential needs and cost considerations, and in some forms of government, by local revenue potential equalisation)
- Systematic shifts in expenditure distribution between tertiary, secondary and primary care
- Subsidies to non-government providers to develop services in currently under-served locations

**Improve the supply and effectiveness of non-personal public health services**

Because the poor are disproportionately affected by adverse environments, hazardous working conditions, exposure to contaminated food and water supplies, and limited knowledge and understanding of risks to health, it follows that any programme concentration on the classic public health functions is likely to be pro-poor in its impact. (It is notorious that the performance of these classic public health functions has atrophied in most poor countries). Examples of pro-poor interventions include:

- Environmental control (enforcement of planning and building regulations, waste disposal, water and air pollution control)
- Setting and enforcing standards for water supply, excreta disposal and food hygiene
- Health and safety in workplaces
- Provision of public information on risks to health, health promotion, and appropriate use of health services
- Regulation of health service providers, including trade in pharmaceuticals
- Food fortification programmes

**Reduce the financial burden of health care utilisation on poor people**

Direct payment at the point of use of services has two adverse effects. It deters use of services, especially by poor people. When services are used, especially for severe illness or injury involving high treatment costs, patients are impoverished, and may be forced to borrow heavily or sell significant assets to meet medical bills. It follows that shifts away from direct out of pocket payment (user fees) to other payment mechanisms (insurance, general taxation) give greater protection against financial loss. Where user fees are imposed, the burden on the poor can be mitigated (but not entirely removed) by well-designed non-discretionary exemption schemes (as recommended in the Addis Ababa Consensus on Principles of Cost Sharing in Education and Health, 1997). Appropriate policies include:

- Increasing the share of general revenue (including external assistance) in overall financing of the sector
- Administrative action to eliminate unofficial fees
- Appropriately graduated fee structure, with categorical (non-discretionary) exemptions
- Long term and non-stigmatising certification of exemption status, with assessment by community or general government agencies
- Extension of social insurance coverage to vulnerable groups by means of tax subsidy (NB Applicable only to (mostly lower middle income) countries with pre-existing widespread but incomplete social insurance coverage. The benefits of introducing or extending social insurance to the formal sector in low income countries are more equivocal)
- Community health insurance schemes (these function mostly as pre-payment schemes, which make the financial burden more manageable by spreading it over time, or concentrating it at a predictable and acceptable time, eg post harvest)

**Promote policies in other sectors which bear on the wider determinants of health, with particular benefits for the poor**

Recognising that the health outcomes of the poor derive to a greater extent from the wider determinants of health (incomes, education, fertility, nutrition, lifestyles) than from the provision of health services, but that the health authorities do not have direct responsibility (jurisdiction) in these matters, the appropriate role for health policy is to define and advocate actions in the health interest. These actions potentially cover a very wide range, from the discouragement of tobacco consumption to the prevention of road traffic accidents, or from supporting income protection to the encouragement

of female education. The general argument in favour of such interventions is that they have the potential to enhance the health status of the whole population, but some among them are likely to be pro-poor by analogy with the arguments deployed above, that the poor are disproportionately affected by existing adverse conditions. Examples of advocacy likely to have a pro-poor impact are.

- Extension of coverage of water supply and sanitation services (where the better off are already served)
- Universal or higher percentage enrolment in schools, gender equality in enrolment ratios (it is the female children of the poor who are least likely to be enrolled when ratios are less than 100%)
- Road traffic accident prevention (in poor countries, the majority of RTA victims are pedestrians)
- Discouraging tobacco consumption (on the argument that the social class differential which already exists in rich countries will soon apply to poor countries)