WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD **EB113/12**
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Influence of poverty on health

Report of the Secretariat

1. The present report focuses on several elements of WHO's work in relation to poverty and health, including follow-up of the report prepared by the Commission on Macroeconomics and Health;[1] support for countries seeking to ensure that health is effectively represented in national Poverty Reduction Strategy Papers; and the current state of development of Sector-Wide Approaches for health. The aim of the paper is to demonstrate the linkages and enhanced coherence between these streams of work by setting them in the context of lessons learned from implementing the principles adopted by the Declaration of Alma-Ata; developments in the field of human rights – specifically the right to the highest attainable standard of physical and mental health; and WHO's contribution to achievement of the Millennium Development Goals.[2]

POVERTY AND HEALTH

2. The debate about the relationship between poverty and health has a long history. It is generally the case that higher death rates occur in the poorest areas of any country, and that healthy populations tend to be more economically productive. It is recognized that the arrows of causality between health and poverty run in both directions, and that the relationship is better described as either a vicious or virtuous circle – depending on whether health or economic circumstances are improving or deteriorating for the population concerned.

3. Currently, however, poverty is no longer viewed purely in economic terms, but understood to be the result of a combination of factors, of which income is only one. It is better defined in terms of deprivation or lack of access to the means by which individuals can realize their full human potential. Thus lack of access to health care, information, or to an environment which enables people to lead more healthy lives is, in itself, part of the definition of poverty. This understanding is reflected by the prominence given to health in the Millennium Development Goals.

4. Further, the work of the Commission on Macroeconomics and Health has provided a first *quantitative* estimate of the global economic returns of greater investment in health. Although its

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[1] *Macroeconomics and health: investing in health for economic development.* Geneva, World Health Organization, 2001.

[2] See also documents EB113/11 and EB113/11 Add.1.

report provided only a rough global figure,[1] subsequent work continues to refine these first estimates in individual countries. It should be noted that the purpose of the Commission's report was to bring the importance of greater investment in health to the attention of those making allocative decisions: ministries of finance and planning, and bilateral and multilateral partners. The Commission also worked to influence civil society, including academics, policy analysts, and campaigners, who in turn influenced national processes for setting priorities. Making the case in *economic* terms for better health as a key component of a poverty reduction strategy underpinned this process.

5. Efforts to address those health conditions that have the greatest overall national and international economic impact have been the focus of much political attention. The severity of the HIV/AIDS epidemic demonstrates the potential of widespread ill-health to undermine macroeconomic policy. Controlling the pandemic thus has human, economic and security benefits. Investment in surveillance systems to prevent and control further outbreaks of SARS can be seen in similar terms. The international response, although slow and inadequate in relation to HIV/AIDS, is now beginning to accelerate, not least through the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

6. There is still, however, the need to tackle far more effectively the health needs of poor people. This issue has been masked by a lack of data on the health status of poorest groups and their use of health services; only disaggregated data will show whether particular segments of the population are getting too little (or too much) health care or are experiencing poor health outcomes at a higher (or lower) rate. Tackling inequities in health outcomes is less a question of identifying the so-called "diseases of the poor" than of designing policies and systems that ensure that poor people have access to the benefits of health technologies, irrespective of their specific health condition. It also points to the need for a closer examination of the values that underpin WHO's work on health policies and systems, and for attention to the cross-sectoral determinants of health, such as the environment, nutrition, access to and quality of water and use of tobacco.

7. **Values and principles**. The Declaration of Alma-Ata was, above all else, a statement of political principles. Although the context in which these principles have to be applied has evolved over the past 25 years, their primacy in health and more generally in development has not changed. They include universal access according to need, equity, participation of the population, and an intersectoral approach to improving outcomes.

8. WHO's underlying concern for social justice – clearly expressed in the Declaration but deriving originally from the Organization's Constitution – not only influences continuing work on the development of health systems but underpins virtually all aspects of WHO's work – from increasing access to antiretroviral drugs in resource-poor countries, to formulation of a global strategy to address the growing burden of noncommunicable diseases and injuries, to a special concern for disadvantaged people.

WHO'S WORK ON POVERTY AND HEALTH

9. WHO's work on poverty and health takes many forms. For instance, in the areas of reproductive health, child health, tuberculosis and malaria efforts are being made to identify bottlenecks in health

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[1] The Commission estimated that an additional investment in health of US$ 66 000 million annually by low-income countries and external development assistance would lead to economic benefits of at least US$ 360 000 million per year during the period 2015 to 2020.

systems and programmes that make it difficult to reach the poorest groups with technical interventions, and evidence is being compiled of good practice for overcoming these constraints. Increasingly, this work will need to become more integrated with that on health policy and systems, for example by building on efforts to influence national health policies in order to focus more clearly on the poorest groups and communities. A concern for the health of poor populations also underlies WHO's work on trade policies – particularly in relation to the Agreement on Trade-Related Aspects of Intellectual Property Rights, and in assessing the potential impact of the General Agreement on Trade in Services. The several streams of work which will influence WHO's overall approach are outlined below.

10. **Follow-up to the report of the Commission on Macroeconomics and Health.** Since the report was published, over 40 countries have taken steps to act on its recommendations, with support from WHO. Actions taken by countries have two elements in common: a concern to improve the health of poor people, and the active engagement of higher levels of government – particularly ministries of finance and planning.

11. Much activity at country level focuses on the development of a health investment plan. This process begins with an assessment of the socioeconomic and health situation in order to identify national health priorities, cost the achievement of targets, and catalogue the internal and external resources for health. An investment plan is then drawn up, linked to poverty reduction activities and attainment of the Millennium Development Goals. Some countries are starting to implement their investment plan, which will necessitate monitoring growth in domestic health financing, and securing increased and more efficient partner commitments aligned with the plan. Further follow-up will include pursuing new ways of developing and financing health-investment plans in several self-selected countries and, on the basis of experience of country work to date, building capacity in WHO and creating external networks in order to provide support to a wider range of countries.

12. **Health as a component of national poverty reduction strategies.** Poverty reduction strategies have the potential both to increase resources for the health sector and to catalyse country-led re-examination of existing health strategies in order to gauge how effectively they are reaching the poor. A study undertaken by the International Monetary Fund indicates that health spending as a percentage of gross national product is projected to rise in programmes supported by its Poverty Reduction and Growth Facility, but only slightly, from 1.8% in 1999 (actual spending) to 2.1% in 2001 to 2002 (projected rise).[1] This suggests that poverty reduction strategies are unlikely to bring about sharp increases in resources for health.

13. Overall, the health components of the strategies are consistent with a primary health care approach and therefore respond, in broad terms, to the health needs of the poor. Typical actions set out in the strategies include expanding provision of a basic package of services (immunization, maternal health, control of communicable diseases) and strengthening health services in rural areas. Although this focus is welcome, little attention is paid to constraints which have hampered the implementation of such strategies in the past. In addition, few strategies explicitly aim to improve the health needs of the poorest members of society, for example, through population-based or rural-based targeting. In this sense they tend to reflect existing national health strategies and plans in low-income countries, without taking them forward.

14. **Pro-poor health policies.** WHO's work aims to provide support to Member States to shape their health agendas with a pro-poor focus, and implement them in the broader context of poverty and

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[1] WHO meeting on health in poverty reduction strategy papers, April 2003. IMF presentation.

development. To this end, a consultative approach to planning has been used, which has led to three distinct but interrelated and reinforcing areas of work. The first is developing a framework for use by countries in building a disaggregated health profile to identify those health problems that have the greatest impact on the poor; the second, formulating context-specific strategies for resolving the identified problems on the basis of analysis of pro-poor policy; and the third, garnering this technical work, together with other international and national efforts, in order to strengthen capacity at country level effectively to address the health needs of the poor.

15. The empirical evidence thus compiled should make an important contribution to strengthening capacity to develop and implement the health sector component of poverty reduction strategies. Lessons from country-level work are fed into global debates, and within WHO, technical inputs are provided to facilitate the incorporation of pro-poor issues into the work of such programmes as Organization of health services, or Making pregnancy safer; and such disease-control initiatives as “3 by 5”.

16. **Sector-wide approaches.** Sector-wide approaches were originally conceived as a way of improving the interaction between governments and donors by aligning donor support around nationally defined priorities and reducing the transaction costs incurred by all parties. They also respond to a growing conviction on the part of many donors that budgetary support is the best way to improve the effectiveness of development assistance. Few countries have succeeded in formulating approaches that genuinely encompass all aspects of health and include all donors. Nevertheless, the basic principles are being applied in a growing number of situations. The establishment of sector-wide programmes is now a central part of efforts to simplify, harmonize and increase the effectiveness of aid. A growing body of country-level experience exists on instruments related to sector-wide approaches, such as Medium-Term Expenditure Frameworks and benefit incidence studies. Better understanding is needed of how these instruments – traditionally the reserve of international financial institutions – influence health sector development and the securing of improved health outcomes for the poor.

17. **The right to health**. Right to the highest attainable standard of physical and mental health, commonly referred to as the right to health, has evolved substantively in the past few years, in both international law and national legal frameworks. In 2000 the United Nations Committee on Economic, Social and Cultural Rights adopted General Comment No. 14 which clarifies the normative scope and content of the right to health. Importantly, the Committee interpreted the right to health as an inclusive right extending not only to accessible, affordable, culturally acceptable, and good-quality health care but also to the underlying determinants of health, such as access to safe and potable water, adequate sanitation, and health-related education and information. Further, in 2002 the United Nations Commission on Human Rights appointed a Special Rapporteur on the Right to Health. Together, WHO and the Special Rapporteur are committed to addressing the specific contribution of the right to health to reducing poverty.

18. The Millennium Development Goals provide clear markers towards realization of the right to health. The evolution of that right, in turn, is strongly influenced by the notion of universally available primary health care. Grounded in international human rights law, the right to health obligates governments to take, to the maximum of available resources, deliberate and concrete steps individually and through international assistance and cooperation towards its progressive realization. They also have to demonstrate, when reporting to international human-rights monitoring mechanisms, the progress being made towards achieving this goal. In this context, identification of appropriate indicators and benchmarks to monitor progress is an important task in which WHO is currently involved, together with concerned United Nations human rights bodies. In particular, efforts are being

made to ensure consistency between indicators of progress to the right to health, those for monitoring achievement of the millennium goals, and those related to primary health care.

COMPLEMENTARITY AND COHERENCE

19. The relationship between health and poverty is a key aspect of WHO's work. As it advances, several challenges become apparent. First, there is a need to seek complementarity between the several strands of work outlined above, and to ensure that lessons learned are made available and applied to new initiatives as they are developed.

20. Secondly, it is important to be clear that work on poverty and health really takes shape at country level. Building capacity, both within WHO and in Member States on the basis of experience gained, must be an essential component.

21. Thirdly, it is self-evident that addressing poverty through health, or targeting the health needs of poor people, requires a thorough review of health systems, from both the perspective of service delivery and that of the broader institutional and political issues that influence its effectiveness. The values of health for all provide a common base, even if the practical expression of health systems led by primary care varies according to national circumstances.

22. Fourthly, although the country remains the key level for implementation and achievement of results, global enabling actions are still needed in order to increase the effectiveness of work at local level. The outcomes of negotiations on trade, debt, aid, technology transfer and international law should make an essential contribution to tackling health and poverty in all countries.

23. Lastly, the Millennium Development Goals also emphasize the need for coherence in approach and interconnectedness among development objectives. Reduction in poverty is impossible without major gains in health status; improvements in education levels, gender equity and access to a safe and clean environment are prerequisites for better health. An effective – and equitable – partnership between the rich and poor world is the only way of reducing the divide between them.

ACTION BY THE EXECUTIVE BOARD

24. The Executive Board is invited to note the above report.

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