

POVERTY, EQUITY, AND HEALTH: SOME RESEARCH FINDINGS

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This chapter will deal with research that is of general interest both to the industrialized and countries that are not part of the Organization for Economic Cooperation and Development (OECD). It will cover poverty, equity, and health, and how we can link research to policy-making. Let's start with the goals we are trying to pursue in the health sector and how these relate to the notions of poverty and equity. I have listed here two broad goals, goals that keep coming up time and time again in health documents.

The first is, obviously, the improvement of health; not just improving health, however, but also improving it equitably. Now that means different things to different people. It would mean, for example, at least, making sure that you promote the health of the poor and, possibly, even more strongly making sure that the health of the poor improves faster than the health of the non-poor. This would probably entail two things: promoting access to health care, especially among the worse-off, and focusing on the nonmedical determinants of health—those things that lie outside of what we traditionally think of as the health care sector.

A second strand of policy objectives in the health field involves income protection; essentially, making sure the poor don't suffer large

reductions in their living standards through out-of-pocket payments and through loss of earnings when they fall sick. The second element of this income protection goal is to build risk-pooling mechanisms that result in protection payments being linked to ability to pay. As we'll see in a moment, there are different ways of providing people with protection against out-of-pocket payments, and each has different distributional consequences.

Let me start with the income protection goal. A poignant example of the need for income protection is described in "Voices of the Poor," in which a 26-year-old man from Vietnam moved from being the richest member of his community to being the poorest member of his community, simply because he incurred very large health care expenses associated with his daughter's illness. If you read "Voices of the Poor," this is an issue that comes through very strongly. When people think about designing health care systems, the poor feel very strongly that one of the important dimensions of that debate is how to protect their income and livelihood.

Among OECD countries, with the exception of Portugal, very few countries raise more than 20% of their revenues from out-of-pocket payments. Among non-OECD countries, the picture is quite different. In Bangladesh, for example, more than 60% of health care revenues are paid from out-of-pocket.

One issue, then, is how regressive these payments are. What 'regressiveness' means is

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what proportion of a family's income these payments represent. If, as we move up through the income distribution, the proportion of income spent on out-of-pocket payments declines, then you have a regressive structure. If, on the other hand, it increases—that is, the rich pay a larger share of their income in out-of-pocket payments than the poor—that is a progressive structure. Most of the evidence on this issue comes from OECD countries, but we now are getting some numbers in from the non-OECD countries. What is emerging is that there are two distinct groups of countries. There are countries such as China, Rumania, and Bulgaria, where people are seeking care and obtaining care, but paying for it in a very severe way. For example, there is a very high degree of regressiveness in the out-of-pocket payment structure in China. At the other end of the spectrum, we have countries where out-of-pocket payments are actually slightly progressive, as they absorb a larger share of the income of wealthy households than they do of poor household incomes. There are two possibilities here, of course. One is that people who cannot afford care are simply not getting it; the other possibility is that they are getting it, but there are systems or mechanisms in place to reduce the impact of out-of-pocket payments.

Regressiveness is only one part of the story. Another part of the story is whether households are plunged into poverty through out-of-pocket payments. According to our estimates, many households fall into poverty through out-of-pocket payments, and the tendency for this is greater among those who don't have insurance. So, it is not just a question of regressiveness; it is a question of households being put into poverty through out-of-pocket payments.

How can we provide households with protection against out-of-pocket payments? Different countries raise their health care revenues in different ways. We have some countries, specifically the United States and Switzerland, which have a very strong emphasis on private insurance, while the Netherlands has some

emphasis on private insurance. Social insurance, which is, of course, very common in Latin America, represents a big portion of expenditures in Latin American countries, but also in countries like France, Germany, and the Netherlands. The rest of the expenditures are generated through tax revenues.

These different ways of providing households with protection have different distributional consequences in relation to the income that households have to spend on things other than health care and also on private health care. If we're interested both in the consumption possibilities for private health care as well as the extent to which households can purchase things other than health care—if we're concerned, for example, about poverty—then these distributional consequences are important to take into account.

In the United Kingdom, direct taxes contribute progressively towards the total financing burden. As a matter of fact, this also is the case in Ireland, Egypt, and Bulgaria. If we also consider indirect taxes—as we know from our studies of OECD countries—countries such as the UK and Spain, which greatly emphasize indirect taxes, these structures become regressive, which tends to reduce or offset the progressivity of direct taxes. Interestingly, what emerges for some of the non-OECD countries is that indirect taxes actually end up being progressive. This is not true in Mexico, where the scheme is marginally regressive, but it is true of those other countries. What is occurring there is that those countries are relying on a graded structure where luxury items are taxed at a higher rate. In the case of social insurance, the level of progressivity and regressivity pretty much depends on what the scheme is. In the Netherlands, Germany, and Mexico, for example, social insurance programs are regressive. In countries like China, they are actually progressive.

If we substitute private insurance as the financing mechanism, we see that in the two big countries where this is an important source of finance, the system is very regressive. In other countries it is regressive, too, but either

because it is less important, or because it is not as regressive, it doesn't feature so prominently in this chart. In almost all the OECD countries, out-of-pocket payments are regressive, and in the non-OECD countries it varies a little bit. In countries like Egypt, out-of-pocket payments are progressive, but in countries like China, where they're very important, they are very regressive.

EQUITABLE HEALTH PROMOTION

Poorer people are more often sick, sick for longer periods of time than the less poor; so, they just sleep and groan.

—Malawan woman, quoted in
“Voices of the Poor”

Is the burden of illness unequally distributed in these countries? In almost all these countries inequalities and mortality in children under 5 years old are concentrated among the poor to a statistically significant degree. There are differences across countries: the degree to which mortality in children under 5 is concentrated among the poor is not fixed; it varies across countries. Brazil, for example, comes out with an especially high degree of inequality.

In the case of stunting, countries like Peru, Brazil, and Nicaragua, which we know have very unequal income distributions, also have a very unequal distribution of childhood stunting. The poor in these countries are much, much more likely to be stunted than the non-poor. What can we do to remove these inequalities, or at least promote the health of the poor?

Another quote from “Voices of the Poor” points out the importance of access to health care. “It is precisely those who are most exposed to health risks, whose work entails the greatest risks of accidents or debilitation, and who are most dependent on the strength of their bodies—in short, those who need health care most—who are the least able to afford and obtain it.”

Is health care distributed unequally? In most of the OECD countries, it is actually the poor who get more health care than the non-poor. One might claim, in response, that this is not taking into account the fact that the poor need more health care. If we standardize the distributions, the pro-poorness is reduced substantially, but not eliminated, except in the United States and Switzerland. In other words, we don't have to throw up our hands in despair and say it's never going to be possible to get health care to the poor. There are countries in the world that manage to do it.

In China, the picture is quite different from the picture for the OECD countries. Inpatient care in particular is highly skewed, not towards the poor, but towards the better-off. It is a less pronounced disparity in the case of outpatient visits, but overall what we see is a picture where the Chinese are failing to get health care to the poor.

One might say, well, that's sometimes because the rich choose to purchase more, but let's look at what happens to the public subsidy, which surely ought to be going to the poor. There are some data from a variety of different countries that show how the poor compare to the non-poor, showing the concentration index for public subsidies. There are many countries where the subsidies are actually going to the better-off, including Brazil and Peru. Some Latin American countries seem, on this criterion, to be doing quite well, but what I suspect we're picking up right here are only the ministry of health's subsidy, not the subsidies going through the social security systems. Data from Peru and from Honduras are much more comprehensive, and I think you'd get a much better picture from those data.

Why do the poor get less, then? Well, if we look at econometric work, and this is backed up by consultation studies with the poor, what's going on seems to be lack of income, low education, poor understanding of what there is to be gained from the system, money prices, and insurance status, all of which are clearly important. But things we tend to for-

get include distance to travel, ease of transportation, waiting time, and opening hours. Very often the poor will say, "I don't go to the clinic, because when I get there it's never open." Quality of care is fundamentally important and comes through very strongly in some recent econometric work. Often the poor don't go to clinics because when they get there, even if the place is open, the clinic has no drugs. They prefer to pay out-of-pocket and go somewhere that is closer and well stocked. Staff attitudes also are important. The poor complain about things like being slapped by staff or, if not being physically abused, of being verbally abused.

The fundamental point, though, is that health care is never going to be enough. Another person cited in "Voices of the Poor" says, "the poor frequently are disadvantaged by where they live due to geographical isolation; marginal land; . . . lack of transport, sanitation, water, and other services; isolation from information; environmental hazards; inadequate shelter; insecure rights to land; physical insecurity and crime. . . ." These are all important for health itself, not just in their own right.

Some figures from Cebu, the Philippines, show us the degree to which different determinants of health are concentrated among the poor or the non-poor. It's much more likely, for example, that poor households are those that will have no water supply. Mothers who only have elementary education are much more likely to be among the poor; households that don't have a toilet are much more likely to be amongst the poor; the poor take longer to travel to a health center; and poor women are more likely to have more pregnancies. In the case of Cebu, it seems that the local facilities in poor areas are actually more likely to offer immunization than those in the non-poor areas. Corn and rice seem to have slightly higher prices in poor areas. Among richer households, there tends to be access to a greater number of nurses in local facilities, mothers are more likely to have a high school education, and the better-off are more likely to have some form of health insurance.

We can estimate the impact of these factors on childhood survival using a survival model. Being a boy in Cebu is not that good in terms of childhood survival prospects, nor is having an old mother when you're born or having a mother who has had a lot of children by the time you are born. If you have a mother who's well educated, that's good for survival. Living in a low-income household is bad for survival, and not having a toilet is bad for survival. Having health insurance is good, and having a local facility that offers an immunization program also is good for your survival chances.

Now, none of these things come through as particularly surprising. You'd say, "but I knew all that, anyway, and I also knew that the poor didn't have toilets and that they had to travel further, and so on." But what we can do with these two sets of numbers is put them together and try and get a handle on this question of how important health care is. We say health care is just one of the factors, and we feel we ought to say that, but how important is it—50%, 60%? More precisely, if we were to reduce the inequalities that we saw a moment ago in each of these various determinants of health, what impact could we have on inequalities in health outcomes?

We saw, for example, that the poor tend to have to travel further, and it takes them longer to reach a health facility. What would happen if we had the poor and all the bottom four quintiles traveling the same amount of time as the top quintile? Not a lot. This shows that we get a slight reduction in the overall average rate and a slight improvement in the inequality, but it's not exactly something to write home about.

What if we improve the quality of medical facilities? In this case, because it's actually the poor areas that have better immunization facilities, the exercise brings everybody else down to the level of the top quintile. Not surprisingly, we actually worsen the outcome.

What if we could give everybody the same insurance coverage as the top quintile has? We

actually get a little bit further in the right direction. But if we could give the poor and the bottom four quintiles generally the same sanitation conditions as the rich top quintile, we would actually achieve quite a big jump.

If we could equalize mothers' schooling, and stop poor women from having children late in life and from having so many of them, we also would achieve a big impact.

The final exercise is to look at the effect of equalizing income distribution. Holding everything else constant, we would achieve a very large reduction in the average rates and a very big reduction in the inequalities. This gives us a sense of humility, if you like, by demonstrating how and how much we need to cooperate with people in other sectors, because it's not just simply that there are other things that matter. It's more important than that; it's that these other things matter tremendously when we are thinking about improving outcomes of the poor.

We've learned quite a lot about income protection: out-of-pocket payments very often hit the poor hardest and very often cause poverty. We can have different ways of linking protection to ability to pay and they have different income distribution consequences. We need to think those through. In the area of improving the health of the population we see dramatic differences between poor and non-poor. We see a difference between the OECD countries and the non-OECD countries in terms of who gets health care and who gets the subsidies to the health system. And when it comes to looking at the nonmedical determinants of health, the results we saw for Cebu suggest we need to think very carefully about the relative importance of different types of inequality for reducing health inequality. Increasing access to health services, promoting health insurance coverage, and so on, are definitely important, but there are other big things we need to really worry about, too.