EUROPE

Regional Committee for Europe
Fifty-second session

Copenhagen, 16–19 September 2002

Provisional agenda item 7(a)

EUR/RC52/8
+ EUR/RC52/Conf.Doc./4
18 June 2002
22499
ORIGINAL: ENGLISH

POVERTY AND HEALTH – EVIDENCE AND ACTION IN WHO'S EUROPEAN REGION

Resolution EUR/RC51/R6 recognized the link between poverty and ill health, and the responsibility of the health sector to contribute to multisectoral efforts to reduce poverty.

The Regional Office's response to this resolution has been to initiate a process of systematically collecting, validating, analysing and disseminating information on specific actions taken in Member States to address a wide range of issues related to the role of health systems in alleviating poverty and improving the health of the poor.

This document outlines the main areas of intervention and the poverty-related issues addressed by health systems, in twelve selected case studies from ten of WHO's European Member States. The document includes a summary of the main conclusions from the work done so far and points to a number of key actions that the Regional Office could undertake in the future.

A draft resolution is attached for consideration by the Regional Committee.

WORLD HEALTH ORGANIZATION • REGIONAL OFFICE FOR EUROPE
Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark Telephone: +45 39 17 17 17 Telefax: +45 39 17 18 18 Telex: 12000 who dk
Electronic mail: postmaster@who.dk World Wide Web address: http://www.euro.who.int

Contents

Background

1. In recent years, there has been a growing realization that poverty, health and economic development are very closely related. In September 2000, the largest-ever gathering of world leaders adopted the United Nations Millennium Declaration which, in addition to proposing steps aimed at development and poverty eradication, contained commitments to make the right to development a reality for everyone *(1)*.

2. More recently, during the International Conference on Financing for Development (the Monterrey Poverty Summit, March 2002), several countries pledged considerable increases in overseas development assistance to tackle the gap between rich and poor *(2)*.

3. In WHO, the Commission on Macroeconomics and Health was established in 2000 to examine the role of health in economic development and propose the next steps to be taken. The report was a turning point, moving health to the centre stage of current efforts and "mainstreaming" it within the flow of resources supporting more equitable economic development worldwide *(3)*.

4. Resolution EUR/RC51/R6 recognized the link between poverty and ill health and the responsibility of the health sector to contribute to multisectoral efforts to reduce poverty. The Regional Director was requested:

(a) to establish a process to develop, analyse and disseminate knowledge on the causes of poverty and on effective actions to decrease the effect of poverty on health status;

(b) to mobilize resources in order to carry out activities on poverty and health within a coherent regional framework;

(c) to put this item on the agenda of the fifty-second session of the Regional Committee.

5. In order to provide immediate follow-up to the resolution, the Regional Director mobilized resources in the Regional Office to meet these requests, enabling the Office to undertake two main lines of actions:

(a) initiation of the systematic collection of specific examples of how the health system is addressing issues of poverty and health in European Member States; and

(b) preparations to instigate an ongoing process of scientific reviews, aimed at analysing and disseminating knowledge of poverty and its policy implications for health systems in the European Region.

6. These actions are being carried out mainly by the WHO European Office for Investment for Health and Development, based in Venice. The initial results of the first line of action are presented below. The scientific reviews of pathways to poverty and ill health in the European Region will be initiated in 2003.

Aims of the document

7. The aims of this document are to:

- provide a short description of the steps taken in 2002 to follow up resolution EUR/RC51/R6;
- outline the main areas of intervention and issues addressed by health systems, in twelve selected case studies in ten Member States;
- summarize the main conclusions of the work done so far; and
- propose a number of key actions that the Regional Office could undertake in the future, in collaboration with Member States, in the area of poverty and health within the framework of resolution EUR/RC51/R6.

Methodology and process adopted

8. The response to resolution EUR/RC51/R6 has been to initiate a process of systematically collecting, validating, analysing and disseminating information on specific actions currently being taken in Member States to address a wide range of issues related to the role of health systems in alleviating poverty and improving the health of the poor. The process has been a participatory one, involving Member States, technical units and programmes at the Regional Office and country Liaison Officers. Links have also been forged with specialized media professionals, health professionals, nongovernmental organizations working in the field and the scientific community.

9. The process was initiated by the Regional Director, who invited all Member States to indicate relevant initiatives taken by their health systems to address specific aspects of poverty and health. Experts, both in countries and in WHO, were also consulted. This resulted in the selection of a series of 12 case studies. These case studies have been researched and written by a specially constituted team of professional scientific journalists. Each case study aims to provide a factual description of the activity undertaken by the Member State and to document evidence that the health system can take effective action in this complex area. The case studies are not necessarily always examples of "best practice" or innovation. Nevertheless, they serve to document the way in which activities are currently being implemented in European countries. The content of the case studies was analysed and validated at an expert meeting organized by the Regional Office with the kind support of the German Federal Ministry of Health (Düsseldorf, 18–19 April 2002). This consisted of a multidisciplinary group of experts in public health, policy-making and poverty-related research, as well as from the media and nongovernmental and intergovernmental organizations.

Issues covered by the case studies

10. A list of the case studies selected for 2002 is given in Annex 1. Participants in the fifty-second session of the Regional Committee will also receive abstracts summarizing the main findings of the 12 case studies (in the four working languages of WHO's European Region) and the full text of the case studies (in English only).

11. When selecting this first series of case studies, the main aim was to clearly identify which specific aspects of poverty and ill health can be directly addressed by action taken within the context of the health system. The 12 case studies can accordingly be grouped under four broad headings.

Affordability of essential health services

12. These case studies describe action taken to lower or eliminate the financial barriers to access to health services. Analysis of the case studies under this heading at the Düsseldorf expert meeting generated preliminary evidence that there are at least two main dimensions to this issue. First, poor people may not be able to afford the health service they need when they fall ill, so they delay seeking care until their illness becomes more severe or chronic and consequently affects their livelihood. Second, they may be forced to find financial resources, either to pay service fees or to meet indirect costs related to service utilization (or both). In these circumstances, people may be compelled to take out loans, get into debt, sell assets or pursue other courses of action that make them either poor or more vulnerable to poverty. Hence, the (direct or indirect) costs associated with health services may indeed push people into poverty or deepen already existing poverty. When this happens, the health system itself becomes one of the causes of poverty. In order to tackle or avoid this problem, Member States are looking at how essential health services are financed and trying to ensure that payment requirements do not prevent the use of health services when needed. The analysis of the case studies in this "cluster" indicates that there is also a need to consider how the health system is structured and regulated, to ensure that the way in which the system operates does not interfere with people's jobs and livelihoods.

13. Two case studies illustrate interventions to address this problem. The French one focuses on the health system at national level, where the costs of some services were not covered for certain vulnerable population groups, while the procedure for claiming the costs of others was so complex and/or stigmatizing that many people were put off claiming. The intervention involved a change in the law and the national regulations. It should be emphasized that this intervention was originally triggered by concern for marginalized population groups, but the resulting change in policy now benefits a much broader range of the population experiencing financial hardship.

14. The Kyrgyzstan case study addresses questions of health system financing, including payment of health professionals and patient fees – issues being faced in many European Member States. It documents an attempt to alleviate the problem of unpredictable costs of health care (in the form of "under the table" patient payments) by introducing an explicit co-payment for inpatient care, as well as by increasing the overall transparency of the system. Although the case study analyses a still imperfect solution to the complexities of health care financing, it illustrates arrangements that tend to reduce the unpredictability of health care costs while providing extra resources for the very poor.

Lack of cultural and/or geographic access to health services

15. Even when health services are officially free, as is the case with many preventive services (such as those for controlling communicable diseases) in most European countries, the services may not be provided in a form or manner that is culturally acceptable or geographically accessible to poor people in general, and to marginalized groups in particular. Certain sections of society may in effect be excluded from utilizing the services they need, and their health may suffer in the long run, pushing them further into a cycle of ill health and poverty. According to the analysis of the case studies in this cluster, interventions to address this type of problem may include:

- organizational adjustments such as those portrayed in the German and Polish case studies, providing outreach services to marginalized groups or hard-to-reach rural populations, rather than waiting for them to come to the services;
- adapting the timing and staffing of services to fit in with religious or cultural practices, and training or employing staff with additional language and cultural-anthropological skills to overcome communication barriers, as described in the case studies from Italy and Croatia;
- professional development and guidance/regulations on equal opportunities, to enhance the attitudes of professional staff in dealing with poorer patients and to cut out overt discrimination, as outlined in the case study from Hungary.

Poverty and the wider determinants of health

16. "Disease weighs heavily on economic development … But economic development requires more than just healthy individuals … Economic development is a multi-sectoral process, and the strategy for economic development must build on a broad range of social investments as well as strategies to encourage private-sector business investments"*(3)*.

17. If the conditions necessary for the fulfilment of a person's capabilities (e.g. employment, good housing, security) are not available, the health system may cure patients only to have to admit them if they become sick again. But can health systems contribute to economic development in its broader sense?

18. At first glance, people working in the health system may consider that it is outside their sphere of influence to provide more financial resources for poor people or help find them jobs to increase their income. However, some of the case studies collected show that, with creative thinking, it is possible to conceive of ways in which the health system can have an important influence. However, this often involves forming partnerships with bodies or agencies outside the health sector to bring about poverty reduction.

19. Three case studies fall into this category. The one on “Fit for Work” in Newham, United Kingdom, is linked to a government policy initiative to reduce inequalities in health. Many local health authorities in the United Kingdom are realizing that in deprived areas, local units of the national health service (NHS) are both a major employer and a major purchaser of goods and services. One agency of this kind (Newham in London) has been making deliberate attempts to stimulate employment and provide job opportunities within the deprived community that it serves, for example by setting up “back-to-work” training schemes and by encouraging local recruitment to NHS job vacancies. It has also been using its considerable purchasing power to buy goods and services from suppliers in surrounding disadvantaged areas, thus helping to stimulate the local economy.

20. Again in the United Kingdom, a case study from Blackpool provides evidence of the advantages of delivering welfare rights advice and debt counselling sessions in a primary care setting. Millions of pounds of state social security benefits are not claimed each year in the country. Studies show that this may be related to the fact that the procedures for obtaining benefits are perceived as being difficult or, particularly with elderly patients, that people don’t like to ask for what they see as “charity”, even though they are legally entitled to the benefits concerned. Unclaimed benefits include income support, disability and invalidity allowances, and payments for carers who look after patients at home. Trained welfare rights workers conduct sessions in health centres, in which they assess the patients’ entitlements to state benefits and help them claim what is due to them. They also negotiate on the patient’s behalf with various statutory agencies, if the patient has run into debt (e.g. with the local housing department for overdue rent). In recent years, initiatives such as that described in the Blackpool case study have helped each patient gain hundreds of pounds and, once claimed, this benefit uptake often continues for years. These types of initiatives are therefore a very direct way of increasing the income of poor people, while helping social programmes to reach their target populations. The impact of initiatives such as the one described in the Blackpool case study is often not limited to the very poor but may also benefit middle-income people who are chronically ill and who may lose income – and become poor – because they have to pay for transport or “home helps”.

21. The “hanging gardens” of St Petersburg, in the Russian Federation, are another example of directly tackling the issue of poverty and its determinants. The case study shows that groups within “civil society” can help alleviate food shortages and malnourishment by working in partnership with statutory agencies, nongovernmental organizations and local communities to improve access to supplies of fresh fruit and vegetables for poor communities. In doing so, these groups are also creating opportunities for economic activity to flourish.

“Diseases of poverty”

22. A few major diseases, such as malaria, HIV/AIDS, tuberculosis and diseases of childhood, are considered to be key health threats affecting the economic growth of many countries. At the same time, a number of effective health interventions exist to counter such health threats *(4)*.

23. Two case studies specifically target the so-called “diseases of poverty”. In Orel *oblast* (province) in the Russian Federation, a partnership between the provincial Health Commission, WHO, the Russian Red Cross, the International Federation of Red Cross and Red Crescent Societies and others is implementing a social and nutritional support network for tuberculosis sufferers. Using the strategy of directly observed treatment, short-course (DOTS) as a basis, this two-pronged approach is helping to increase the efficacy of tuberculosis treatment, especially among the poorest part of the community.

24. The case study from the Republic of Moldova concerns the regulations governing the treatment of sexually transmitted infectious diseases (compulsory inpatient treatment and associated contact-tracing procedures), which were often causing patients to lose their jobs and sometimes their homes – hence pushing them deeper into poverty. The intervention involved changes to national practices, as well as new treatment and tracing protocols.

Conclusions

25. From the analysis of this sample of 12 case studies conducted at the expert meeting in 2001, a number of conclusions were reached. The three main conclusions are summarized below.

The health system can take effective action

26. The issue of poverty and health, though differing in its magnitude and the ways in which it relates to poverty, is present in all Member States. The case studies provide clear evidence that the health system can take action at different levels, from policy-making at national level to local interventions. At present, there is no systematic collection of information, documentation and evaluation of the ways in which health systems can improve health outcomes by addressing issues related to the health of the poor and of the more marginalized groups in society. The case study exercise should therefore be continued and extended, with more case studies gathered from other Member States. They should be fed into a "European data bank of case studies", providing evidence (for the benefit of all Member States) of effective action that the health system can take to alleviate the impact of poverty on health. This responds to a clear demand from Member States, which have already requested information and know-how in this specific field.

The health system can be a problem

27. In some circumstances, the health system can become an obstacle and unintentionally cause or increase poverty. It is therefore important to have an information system that can detect this problem as and when it arises. Health systems should also be required to carry out regular reviews of their performance and their legislative basis, and to assess their impact in addressing various aspects of the poverty and health issue. Similarly, the organization of health services and the provision of, and access to, treatment and care in a given country should be periodically reviewed, to ensure that they do not negatively affect people in poverty.

Developing skills and know-how and mobilization of resources

28. Despite the fact that the issue of poverty and its impact on health is becoming an area of greater concern in European Member States, in most cases health systems do not have adequate human and financial resources to address this complex area. Knowledge about the repercussions of poverty and health on a wide range of issues related to hospital and medical treatment of poverty-related diseases, prevention of disease and health promotion are not included in the curricula or training of health personnel. Thus, in addition to mobilizing financial resources, there is an urgent need for the development of skills and knowledge among the professionals working in the health systems of European Member States.

29. Finally, the Expert Meeting also worked on refining the criteria to be used for selecting case studies. It recommended that the content and format of the selected case studies should continue to be scientifically based, they should be written in an interesting and engaging style that describes human experience (in addition to the actions taken by the health system), and they should present accurate data and information on specific issues related to poverty and health, and what the health system is doing to address them. In particular, continuation of the systematic collection, validation, analysis and dissemination of the information contained in the case studies should be characterized by the criteria summarized in Annex 2. One further outcome of the meeting was to identify a number of "missing" fields not covered by the initial set of 12 case studies, including in particular situations involving poverty in rural areas. Participants in the Expert Meeting also discussed the need to invest resources in an effective strategy of disseminating and making use of the case studies for a variety of purposes (including training and skill development).

Proposed next steps

30. In line with the findings of the Expert Meeting, a number of courses of action are considered appropriate and relevant, in order to bridge the information gap and develop the necessary know-how in this area of increasing concern for all Member States in the European Region. These recommendations are outlined below and are contained in the attached draft resolution (EUR/RC52/Conf.Doc./4). They are:

(a) to continue the process of developing, analysing and disseminating knowledge on the relationship between poverty and health, and in particular the systematic collection, validation and dissemination of case studies on the concrete role of the health system in addressing issues related to poverty and health;

(b) to establish a Regional Office data bank of case studies describing effective action taken by the health systems of Member States in the European Region in promoting the health and wellbeing of the poor and the most vulnerable groups;

(c) to assist Member States by providing summarized and clearly presented evidence-based information that would improve policy-making in addressing issues of poverty and health, including indicators to evaluate initiatives;

(d) to utilize available resources and mobilize new resources to develop activities related to poverty and health, including the provision of technical assistance to Member States in the form of training and skills development;

(e) to work closely with other relevant agencies (both intergovernmental and nongovernmental) working in the field, with the aims of producing comprehensive regular reports on the poverty and health situation in the European Region and monitoring progress;

(f) to create appropriate for a for discussion and sharing of knowledge among health, social and other policy-makers and practitioners involved in initiatives tackling poverty and health.

Annex 1

LIST OF CASE STUDIES SELECTED FOR 2002

The case studies selected for 2002 describe a wide range of initiatives. Not only are they relevant in their own context, they also represent good models that could be adapted and applied in other parts of the Region.

Croatia	Bringing down barriers to communication in health care and disease prevention services for nomad populations: the experience of Medimurje County.
France	Complementary health insurance coverage: reaching the poorest.
Germany	The Mainz model for delivering health care to the homeless.
Hungary	Respect for the poor: the hospital and sanatorium in Budakeszi, where the poor and homeless are treated with an unusual but welcome respect, building up their self-esteem and helping to tackle social problems.
Italy	From misinformation and ignorance to recognition and care: tackling the issue of immigrants and homeless people in Rome.
Kyrgyzstan	Reducing individual payments and increasing solidarity: a national solution to tackle "under-the-table" payments, with a special focus on the reduction of payments for poor rural communities.
Poland	The health system of the city of Lodz mobilizing itself to provide care for the homeless.
Republic of Moldova	From segregation and loss of income to care and social inclusion: cultural and legal changes to treating sexually transmitted infections in the Republic of Moldova.
Russian Federation	Stop TB: providing incentives to prisoners, the poor and socially marginalized groups.
Russian Federation	The "hanging gardens" of St Petersburg: improving nutrition and food security in urban settings.
United Kingdom	"Treatment" for deprivation and social exclusion: the Citizens Advice Bureau in the Blackpool Primary Health Care Group.
United Kingdom	"Fit for Work": health systems supporting employment and regeneration in East London.

Annex 2

SUMMARY OF CRITERIA FOR CATEGORIZATION OF CASE STUDIES IN THE PROPOSED EUROPEAN DATA BANK

Criterion	Question to be addressed
Relevance	Does the initiative described in the case study address questions that are relevant to current public health issues related to poverty and health?
	Does the initiative contribute directly or indirectly to poverty reduction/alleviation?
Replicability	To what extent is the initiative replicable in other contexts?
	Are there any key preconditions for replicability?
Adequacy	Is the case study presented in a way that is useful to the main target audience?
	What aspects of the initiative need to be documented in order to increase proper understanding of what the initiative is about?
Sustainability	To what extent is the initiative described in the case study sustainable in the short, medium and long term?
Evidence-based	Are there data illustrating the impact of the initiative?
	What key lessons have been learnt from the initiative?
	Are there inconsistencies in the information made available?
	Is there a transparent account of how the information related to the case study was collected and utilized?
	Are there any aspects of poverty and health related to the case study that were not covered in its description? To what extent should they be further researched?
	Are there any “side-effects”, either positive or negative, associated with the initiative?

Annex 3

REFERENCES

1. *World leaders adopt "United Nations Millennium Declaration" at conclusion of extraordinary three-day summit*. New York, United Nations Department of Public Information, 8 September 2000 (press release GA/9758 on *www.un.org/News/Press/docs/2000/20000908.ga9758.doc.htm*, accessed 11 June 2002).

2. *Presidents Bush, Chirac announce recent increases in aid at Conference on Financing for Development*. New York, United Nations Department of Public Information, 22 March 2002 (press release DEV/M/14 on *http://www.un.org/ffd/pressrel/22b.htm*, accessed 11 June 2002).

3. *Macroeconomics and health: Investing in health for economic development. Report of the Commission on Macroeconomics and Health*. Geneva, World Health Organization, 2001.

4. *WHO calls for a massive effort against diseases of poverty*. Geneva, WHO Information Office, 3 October 2000 (press release WHO/2000/63 on *http://www.who.int/inf-pr-2000/en/pr2000-63.html*, accessed 11 June 2002).