

Briefing from the EQUINET Secretariat

Equity, poverty and health – how do we make a difference at household level?

A key aim of policies promoting health equity should be to enable the targeting and redressing of the most vulnerable. To do this, a better understanding of the dynamics of poverty and health is required. EQUINET Policy Series no 3 co-published by EQUINET with Centre for Health Policy, Wits University and the Health Economics Unit, University of Cape Town (Jane Goudge and Veloshnee Govender) explores these links, particularly at household level.

Many studies show that the poor have serious difficulties in obtaining access to health care. The barriers to household access to health care range from health service charges, to costs of seeking care, to the social structures and norms that influence use of services. Households and individuals within poor communities face different levels of these barriers, influencing health equity outcomes. If health interventions are to reach poorer communities in ways that overcome these barriers, we need to better understand how poor households respond to ill health, the resource constraints they face, the coping strategies they use and the trade-offs they make. We also need to better understand the impact of poverty on health decision-making at household level.

While 'poverty' is often defined as a lack of access to economic assets and low levels of consumption, the actual experience of poverty is more multifaceted. The paper proposes wider concepts to better understand this: 'Vulnerability', signals the level of ability to withstand economic shocks without irreversible damage to one's productive capacity, and 'Deprivation', includes wider social aspects of poverty, such as isolation from social networks. Using the wider understanding of poverty, research suggests that poor people's interactions with ill health and access to health care are heavily shaped by certain conditions: Poor people:

- Spend a higher share of their income on health for the same level of health care,
- Have greater health need because of poor living and dietary conditions,
- Are more dependent on their physical / manual ability for income and so more affected by illness in terms of lost income
- Are less likely to have health insurance coverage.
- Often have insufficient information to weigh up treatment costs and benefits, self-manage of ill health, or to make effective demands on health care providers.
- Often receive a lower value for money from health services due to poorer quality care, weak referral services or cost barriers to treatment compliance
- May delay seeking treatment until the condition is serious, when treatment may be more expensive.
- Are more vulnerable to the impact of economic and health crises such as AIDS and structural adjustment programmes.

Responses to these factors call for a deeper understanding of household resources, 'coping' strategies, and the factors that influence household choices in use of scarce resources, including the social and cultural networks that influence health seeking behaviours in different households and in different household members.

The paper argues that if policy interventions are to be more supportive of poor households, we not only need to design health interventions that are more appropriate for poor

communities, but we also need to reduce the barriers poor households face to using those services. To do this we need to

- Map, using qualitative techniques, the different resources available to poor households, how these are converted into livelihoods and how they are affected by ill health;
- Understand the trade-offs in and influences on health decisions in poor households and how households respond to different sources of stress;
- Understand the social structures, and household and community relations that enable – or disable- household resources being used in responses to health shocks.

The health sector needs to better understand how different health interventions interface with household coping strategies, and the role played by community initiatives and networks. Health sector interventions should support, build on and strengthen local social resources and networks so that they also reduce future vulnerability.

In the next phase of its work EQUINET will be giving greater attention to this issue. We will be taking forward work done in the first phase on making resource allocations in the health sector more sensitive to measures of household deprivation. We will be deepening work on how health systems can strengthen the capacities and roles of social networks in health, including in decision making about health interventions. We will also be calling for proposals for improving the practical understanding of poverty-health-equity linkages, and what this means for ensuring and monitoring the implementation of pro-poor and equity oriented policies. There is great attention being paid in some countries to Poverty Reduction Strategy Papers, as a means of accessing funds from the World Bank HIPC or debt relief programme and using these funds for visible and targeted measures for poverty reduction. EQUINET will also seek to assess how far such PRSP measures do or could address wider equity oriented and pro-poor policies for health. Information on these various areas of work will be coming out in the next months, but if members have an interest in these areas and would like to help shape this work please contact the steering committee through the secretariat at TARSC. We are keen to hear your ideas!

EQUINET Policy Series #3 on A Review Of Experience Concerning Household Ability to Cope with the Resource Demands of Ill Health and Health Care Utilisation is available in hardcopy from the EQUINET secretariat at TARSC, 47 Van Praagh Ave, Harare, email tarsc@mweb.co.zw or as a downloadable pdf file from our website at www.equinet.org.zw. If you have input or comments on this issue please email these to the secretariat to loewenson@healthnet.zw.

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