HEALTH AND SOCIAL PROTECTION: MEETING THE NEEDS OF THE VERY POOR

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February 2005

There has been a great deal of work on the formulation and implementation of strategies to reduce both poverty and the burden of disease, since the publication of landmark World Development Reports in 1990 and 1993. This paper explores the policy implications of bringing these parallel areas of work together, focusing particularly on the very poor.

REDUCING THE BURDEN OF DISEASE

Health policy has mostly been defined in terms of reducing the burden of sickness and premature death. The first major international policy statement from this perspective was the Alma Ata Declaration of the late 1970s, which prioritised measures to prevent sickness and treat common health problems, largely on an outpatient basis. There has been a lot of work since then to refine this basic policy prescription by analysing the burden of ill-health and identifying interventions that reduce it.

The World Bank and WHO have invested heavily in measuring the geographical spread of the burden of specific diseases. One difficulty is that diseases cause different kinds of suffering and debility. The attempt at comparability led to the development of the disability adjusted life year (DALY), an index that consolidates estimates of excess mortality with a single measure of the degree to which a particular medical condition reduces the "value" of life in terms of productivity loss and suffering. There has been a lot of debate about how to measure disability and excess mortality; the commonly accepted definition gives more weight to the health problems of the young than the elderly, and to measurable losses in productivity. Nonetheless, health policy has tended to focus on reducing this burden, however defined.

There has been a lot of progress in measuring the cost-effectiveness of strategies for reducing the burden of particular diseases. This has led to the identification of packages of cost-effective interventions. The report of the Commission of Macroeconomics and Health (2001), for example, describes and estimates the cost of packages appropriate to countries at different levels of development. For low-income countries, they include measures to prevent disease, and provide outpatient treatment of common illnesses and basic inpatient care for treatable conditions. The Millennium Development Goals embody a simplified version of the conclusions of burden of disease analysis by setting explicit targets for child and maternal mortality and reductions in the burden of some infectious diseases.

Three kinds of question have been raised about the formulation of health policy solely to achieve the MDGs and reduce the burden of disease. First, the focus on average mortality and morbidity could lead health systems to

concentrate on the "easier" groups and neglect the very poor or those most excluded from services. It may be costlier to achieve the same health improvement for people living in remote locations or who are otherwise excluded from routine health services. Gwatkin (2002) recommends that health strategies take into account the needs of the very poor by setting objectives for equity of access to essential health services.

Second, the exclusive focus on treatment and cure diverts attention from the role of the health enterprise in providing care and support to people unable to look after themselves. One factor behind the early development of hospitals was the increasing cost of domestic servants and the search by middle-class families for alternatives to home-based care for sick family members. The exclusive focus on treatment has diverted attention from the provision of nursing care and other forms of support to the acutely ill and chronically debilitated or disabled. This support could take the form of cash transfers, community-based care and low cost hospitals and nursing homes.

Third, health policy needs to take into account how sickness and the high cost of care contribute to household impoverishment (Xu et al 2003). People often go to great lengths to secure medical care for a very sick family member, even if the person is "unproductive" or the available treatment is not cost-effective. Meesen et al (2004) have labelled poverty caused by the medical enterprise as "iatrogenic", to mirror Ivan Illych's concept of "iatrogenic illness". These three questions have led to an increasing interest in the inter-relationship between health policies and poverty reduction, the topic of this paper.

COPING WITH SHOCK

There is a growing literature on the deleterious impact of certain unforeseeable events. The basic idea is that an important aspect of the capacity of individuals, households, communities and societies to prosper is their ability to avoid major shocks, mitigate their impact and cope with the consequences of those that occur. One important aspect of being poor is a high level of exposure to risk of adverse events and a lack of the means to cope with them. This applies to individuals, households, communities and nations.

Studies have shown that many people in low income countries fall in and out of poverty as they experience shocks and recover from them. The consequences of severe misfortune can be long-lasting and recovery may be difficult. Some people become trapped in chronic poverty and they may transmit disadvantages to their children, in the form of chronic malnutrition, poor education, lack of a social network and low expectations. These understandings have led to a search for appropriate social responses to reduce the adverse consequences of shock. They fall into two broad categories: disaster relief in response to major shocks affecting large numbers of people, and social protection, which concerns more frequent events with a localised impact. This section focuses on the latter.

Some recent World Bank publications have strongly influenced current understandings of social protection (Holzmann and Jorgensen, 2000; World Bank 2003). They define it as: public interventions to (i) assist individuals, households and communities to manage risk better and (ii) provide support to the critically poor. They give much more emphasis to the former, which they analyse in terms of the social risk management (SRM) framework.

The SRM framework proposes a systematic approach towards the analysis of risks and the design of responses appropriate to the specific risks and the social, economic and political context. It analyses risk in terms of the *intensity* of its deleterious impact, the *frequency* of shocks and the degree to which the impact on different individuals is *correlated*. It categorises the responses as *prevention* - to reduce the possibility of downside risk, *mitigation* - to decrease the potential impact of a future downside risk and *coping* - to relieve a shock's impact. These responses may be mediated through household and community structures, markets or the public sector, involving a variety of local and national actors.

Shepherd et al (2004) suggest that the SRM framework does not pay enough attention to the long-term impact of shocks. They recommend that social protection should include measures to (i) contribute to the ability of the very poor to emerge from chronic poverty and (ii) enable the less active poor to live a dignified life. They also argue that the framework does not take adequate account of the dynamics of recovery from shocks and the factors that facilitate or impeded recovery. They illustrate with the case of a post-conflict country, where effective social protection depends on the re-establishment of a social contract that includes widely accepted behavioural norms underpinned by rules-based government and legal systems. Devereux and Sabates-Wheeler (2004) make a similar point in their discussion of transformative social protection, which would include measures to reduce structural and legal factors that disadvantage certain groups.

Bloom (2004a) points out that some societies have been more resilient than others in response to major shocks. Germany and Japan recovered from the devastation of the Second World War to return to positive growth paths, while much of Southern Africa is caught in a situation of low growth, high poverty and poor health. Societies have coped differently with the introduction of HIV to the ecosystem. There is little systematic evidence about the factors that contribute to resilience. Possible candidates are the capacity of the state to respond to challenges, the degree of trust in national leadership, the degree of social solidarity and the existence of shared behavioural norms. The situation in Southern Africa may reflect the cumulative effects of a sequence of shocks from regional conflict, periodic crop failures and the HIV epidemic on regimes that were managing a difficult post-colonial transition. We need to know more about how governments, civil society and the international community can help societies become more resilient.

Devereux and Sabates-Wheeler (2004) provide a useful typology of social protection measures. Those aimed at assisting the very poor include targeted transfers of cash or goods, vouchers or exemptions from fees and welfare

programmes to meet the needs of particular groups. Those aimed at enabling people to deal with risk include diversification of livelihoods, forms of risk-sharing, relief during periods of severe difficulty and easier access to credit. The success of these measures depends on the existence of a legal, institutional and political framework that responds to the interests of the poor.

Shepherd et al (2004) identify a number of issues that countries need to take into account in formulating social protection strategies including the relative advantages of targeted and universal benefits, the advantages and disadvantages of earmarking programmes for specific risks, the relative roles of sector-specific services and overall social protection, the interaction between informal arrangements and government interventions and ways to ensure coordination between sectors in the formulation and implementation of social protection strategies

Most recent discussions of social protection pay little attention to health. This is surprising, since participatory poverty assessments consistently find that poor people identify ill-health as a major threat to their well-being (Narayan et al 2000; Milimo et al 2002; Smith and Subbarrao 2003). Also, health was an early concern in the development of social protection arrangements in the advanced market economies.[1] One explanation is the way that national and international bureaucracies split these functions between ministries or departments of health and social welfare. This has led to parallel analyses and policy prescriptions and competition for resources. In practice, both sides of this split have to be involved in strategies to meet the health-related needs of the very poor. This involvement must be based on a common understanding of needs and the likely impact of alternative responses.

ANALYSING HEALTH-RELATED SHOCKS

Sickness can seriously impair a household's livelihood. It diminishes the affected person's well-being and productivity, diverts household effort from productive work and imposes heavy financial burdens. The effects can be long term, contributing to a sequence of events leading to destitution. Severe poverty, in turn, may impair a household's ability to prevent and mitigate the impact of health-related shocks, thereby reinforcing the illness-poverty trap.

It is misleading to treat all illnesses as the same type of shock. For example, there has been a rise in interest in *catastrophic health expenditure* and interventions to mitigate its impact. When one unpacks the concept, it becomes clear that acute hospitalisation of young adults and chronic diseases of the elderly require different responses, although both may rapidly deplete household resources. The following paragraphs analyse health shocks along the dimensions of the SRM framework.

Intensity/severity

The severity of an illness can be measured in terms of the degree of suffering and impaired productivity. During the acute phase of a severe illness, the

[1] In the history of the development of the British social relief system during the early 19th Century, sickness was the first factor that entitled people to support above the barest minimum provided by the workhouse, on the grounds that households could recover their productivity after the sickness episode.

individual may be unable to carry out the most basic functions and may have to depend on someone else to keep them alive. The caring may be provided by a family member, a paid worker or a special institution, such as a hospital or nursing home. This care can be costly. The same applies to debility associated with progressive illness and to severe disability.

Another aspect of severity is the availability and cost of treatment. If little can be done, an individual will suffer, but the financial cost may be minor. A couple of decades ago Robert Chambers pointed out that the construction of modern hospitals in India meant that poor families had to choose whether or not to purchase expensive care for sick parents. The heavy publicity around anti-retroviral drugs faces family members of people with AIDS with a similar dilemma. Almost everyone has access to information about medical care through the media and/or migration of family members. The spread of information about possible treatments can create new demands and expose the poor to exploitation by providers of goods and services, unless governments regulate them and make subsidised treatment widely available.

Frequency/duration

A second dimension of illness is the degree to which suffering and debility persists. When an illness is time-limited, households may recover quickly from the impact. This is not the case with repeated episodes or prolonged illness. For example, where water is contaminated, children suffer frequent bouts of diarrhoea, which exacerbate poverty-related malnutrition. This makes them more susceptible to other infectious diseases in a vicious circle of worsening health and well-being.

Permanent disability and a continuing need for treatment can lead to a constant drain on household resources. The ageing of the population has been associated with a rise in the prevalence of chronic, non-communicable diseases, which account for an increasing proportion of the burden of disease. HIV/AIDS is another chronic disease. Many governments are struggling to formulate appropriate responses to the growing prevalence of chronic disease.

Correlation

Illness-related shocks can be highly correlated Transmissible diseases tend to be prevalent in localities with similar climate, insect vectors, nutrition and so forth. The widespread nature of an endemic disease may put pressure on informal coping arrangements. This is the case for communities heavily affected by HIV/AIDS. The same applies to malaria, sleeping sickness and river blindness amongst others (Gallup and Sachs 2001). The response must combine measures to reduce the burden of disease and support economic recovery.

Some infectious diseases can spread rapidly to become an epidemic. This is a big risk during crises, when the capacity to prevent outbreaks or mitigate their impact is impaired. For example, analyses of the impact of major crop failures suggest that a large proportion of mortality is due to infectious

disease. Epidemics, in turn, exacerbate the degree of social stress and reduce resilience.

RESPONSES TO HEALTH-RELATED RISKS AND SHOCKS

The SRM framework suggests that responses to risk are mediated by informal arrangements, markets and/or the public sector. This categorisation works well in countries with ordered institutional arrangements, strong public sector management and high levels of trust in government systems.

Many places, where poor people live, do not share these characteristics. They have large structural inequalities and highly segmented health and social protection systems. Pluralistic arrangements have emerged with blurred boundaries between the public sector and markets and between formal and informal arrangements. Bloom and Standing (2001) argue that we can better understand pluralistic health systems in terms of their degree of social organisation. Organised health sub-systems are structured by a legal framework of rules and regulations, which are enforced and mostly adhered to. This applies to both the public and private sectors. Unorganised sub-systems operate largely outside the law and are subject to local norms of behaviour and enforcement mechanisms. Table 1 categorises health-related goods and services in terms of the degree of organisation. The better off tend to benefit from organised systems and the poor depend more on goods and services that operate outside the law (Bloom 2004).

The long-term goal of policy-makers may be to expand the organised system to cover the entire population. However, they can also act to improve the performance of the unorganised system. The creation of institutional arrangements underpinned by shared expectations and behavioural norms is essential to the construction of an effective health system. It is an important aspect of local and society-wide resilience. Governments need to maintain a balance between measures to meet these long and short-term objectives.

Stakeholder behavior strongly influences policy outcomes (World Bank 2004). One argument for a shift to demand-side funding, for example, is the hope that channeling funds to the poor will counterbalance the influence on public health services of employees and powerful clients (Standing 2004; Ensor 2004). Debates about the relative merits of universal or targeted programmes similarly reflect judgments about the political acceptability of different targeting arrangements (Graham 2002; Matin 2002). The more competent is public sector management and the clearer is government's commitment to the poor, the more predictable is the outcome of an institutional innovation. Where administrative systems and governance arrangements are weak, outcomes are highly influenced by local power structures.

Political economy considerations are particularly important in countries with large structural inequalities and segmented health and social protection systems (Bloom 2001). It is important to understand an intervention's impact on the distribution of risk between social groups. A measure that improves the performance of the organised health sector could have negative consequences for the poor. For example, expansion of health insurance could

lead to increased hospital costs for the uninsured. Specific measures are needed to reduce the unintended consequences for the poor.

Table 1: Pluralistic health systems at the beginning of the 21st Century

Health-related function	Unorganised health care economy		Organised health care economy
	Non-marketised	Marketised	
Prevention			
Public health	• Household/community hygiene		• Government public health service and regulations • Private supply of water and other goods
Mitigation			
Skilled consultation and treatment	• Use of health related knowledge by household members • Some specialised services such as traditional midwifery provided outside market	• Traditional healers • Unlicensed and/or unregulated health workers • Covert private practice by public health staff	• Public health services • Licensed health workers and facilities • Licensed/regulated NGOs
Medical-related goods	• Household/community production of traditional medicines	• Sellers of traditional and western drugs	• Government pharmacies • Licensed pharmacies
Management of inter-temporal expenditure	• Inter-household/inter-community reciprocal arrangements to cope with health shocks	• Money lending • Funeral societies/informal credit systems • local health insurance schemes	Organised systems of health finance: • tax-based • Compulsory insurance • private insurance • bank loans • micro-credit
Coping			
Physical support of acutely ill, chronically ill and disabled.	• Household care of sick and disabled • Community support for AIDS patients, people with disabilities	• Domestic servants • Unlicensed nursing homes	• Government hospitals • Licensed or regulated hospitals and nursing homes
Treatment and financial support for the very poor	• Community support arrangements		• Special health programmes • Cash transfers, vouchers, fee exemptions

Source: Adapted from Bloom and Standing (2001), table 2.

The following paragraphs explore responses to health-related risks, structured in terms of the categories of response in the SRM framework: prevention, mitigation and coping. They discuss how these responses take into account the type of health shock and the special needs of the very poor.

Reduction of health-related risks

There is a long-established set of public health interventions to reduce the risk of infectious disease. These include measures to provide clean drinking water, dispose of human wastes safely, monitor the safety of food, isolate outbreaks of certain diseases and immunise against common infections. The OECD countries have complex legal frameworks to regulate these matters and public sector institutions to implement them.

Most middle and low-income countries have passed public health legislation, but many do not implement it. This is an area where a rights based approach could be useful. This could involve holding governments responsible for meeting minimum public health standards, which are often incorporated in national legislation and could be included in international agreements. These standards would be widely publicised and their implementation monitored.

Some governments are under political pressure to strengthen their public health role. Scandals about the safety of food and water, counterfeit drugs, and so forth have highlighted the importance of regulation. The recent outbreak of SARS and the growing concerns about biological terrorism have highlighted the need to respond to outbreaks of infectious disease. They have also raised issues about the appropriate balance between the interests of the international community and local residents. For example, the slaughter of chickens to reduce the threat of an influenza pandemic has a deleterious impact on the livelihoods of poor people, who could be compensated for their loss. Recent events, including the resistance to polio eradication campaigns in Nigeria, have demonstrated how the degree of public trust affects the capacity of governments to respond effectively to public health challenges. This is an important aspect of social resilience.

The failure of many governments to ensure basic public health has stimulated innovative approaches. One is the emergence of partnerships between civic groups and local and national governments around public health activities. This kind of partnership is most effective when governments play an active facilitating role (Loewenson 2003). Another is the greater involvement of individuals and communities in public health through social marketing of soap and insecticide impregnated bed nets and participatory methods to engage poor rural communities in improving the disposal of human waste (Kar 2003).

Despite the participation of individuals and organisations in public health partnerships, governments have to define their own responsibility and allocate sufficient funds to provide what is essentially a public good. This is particularly important concerning the very poor, who often derive few benefits from public health measures, due to geographical isolation, lack of access to relevant information or inability to make necessary payments. Special programmes may be needed to meet their needs.

Mitigating the impact of health shocks

Advances in medical science have created effective treatments for many illnesses. Some low and middle-income countries have well-organised health services, which provide access to these treatments at an affordable cost. One

finds a variety of combinations of public and private providers and tax or insurance-based finance. These health services face similar challenges to those in OECD countries, associated with economic growth, demographic change and the emergence of vulnerable groups. The organisational responses to these challenges are similar. The following discussion concerns the other countries, where a large proportion of health transactions by the poor are outside (or on the fringes of) the organised health economy. It discusses measures to improve the performance of unorganised health systems, expand coverage of organised services and reduce the financial burden of major illness.

Improving the performance of unorganised health systems

Treatment obtained in unorganised markets can be expensive, low quality and sometimes dangerous. Over-prescription of steroids or antibiotics, for example, can result in life-threatening complications. The long-term strategy for addressing this problem is to expand the organised system to cover the entire population. Meanwhile, measures are needed to bring the unorganised system within the legal and regulatory framework.

One strategy is to give people the information they need to be effective consumers, including the treatment of common diseases. There has been a reluctance to spread this kind of knowledge to avoid encouraging people to treat themselves. This reluctance also reflects the belief by professionals that they are the only legitimate possessors of expert knowledge. However, if powerful products, such as anti-retroviral drugs, are made available in localities with large unorganised markets, people must be empowered to protect themselves. This will become a growing problem for global disease initiatives.

A second strategy is to train informal providers of goods and services to perform more competently. This has also been criticised as legitimising illegal practices. However, the role of these providers is firmly established in many countries and measures are needed to reduce the risks to their clients. There is a tension between the need to regulate the services poor people use and the long-term aim of extending highly regulated professional services to the entire population.

There has been a lot of discussion about the need to establish a regulatory framework, but many governments are unable or unwilling to enforce regulations that mostly concern the poor. New kinds of partnership between government, community organisations and stakeholder groups are emerging to address perceived threats, such as counterfeit drugs. They could potentially become involved in efforts to reduce a variety of dangerous and exploitative practices.

Expanding coverage of organised services

A second strategy for mitigating the impact of disease is to expand access to organised health services. This raises questions about how governments should set priorities for the use of public funds and ensure they reach the intended beneficiaries.

The burden of disease approach allocates funds for the treatment of diseases for which cost-effective interventions are available. This involves a combination of measures to subsidise basic health facilities and specific disease programmes. A recent study in Tanzania has shown that a high proportion of the burden of disease can be addressed by basic health services (de Savigny et al 2004). One problem with disease-related health programmes is that they do not explicitly target the very poor. This can lead to a bias towards the easier to reach and a neglect of the impact on those who depend on unorganised markets for care.

A second principle for targeting is on the basis of location. There are plenty of examples of governments providing special funds for basic health services in poor and/or remote areas or for localities where vulnerable people gather, such as camps for refugees. The challenge for governments is to scale up these efforts through special public sector programmes or the use of non government or community-based organisations.

A third principle is on the basis of characteristics associated with special needs such as age, ethnicity and poverty. This involves making households eligible for special services or for routine services at a reduced cost. It is particularly difficult to target poor households. One option is to subsidise facilities or services that are mostly used by the poor. This works best where there is a geographical divide between social groups. Otherwise, households are selected on the basis of indicators of income and/or wealth or on informal community decision processes.

Countries with well developed administrative and governance systems are more likely to select beneficiaries well. Other countries face great challenges in establishing a system of household targeting that is fair, and seen to be so (Smith and Subbarao 2003; Revallion 2003). There are a variety of approaches to the provision of targeted benefits, including exemption from service fees, distribution of vouchers for services or allocating funds to an agency, which purchases services on behalf of beneficiaries (Bitran, R. and Giedion 2003; Hardeman et al 2004). The move towards demand-side approaches raises questions about the degree to which funds should be earmarked for health. The alternative is simply to provide cash transfers to eligible households (Tabor 2002).

One risk with a focus on resource allocation and targeting is that the additional funds may not result in a commensurate improvement in access to health services or reduced financial burdens. Mitigation strategies need to include both demand and supply-side measures and arrangements to make the relevant institutions accountable for their performance to the population.

Reducing the financial burden of major illness

The heightened interest in poverty dynamics has led to the recognition that episodes of major illness are important causes of poverty. Several studies have shown that households can spend a very high share of their income on medical care (Wilkes et al 1997; Gertler and Gruber 2002; Xu et al 2003;

Wagstaff and van Doorslaer 2003). This has stimulated interest in strategies to mitigate this impact. This has coincided with a rise in the political profile of this issue. China and India have introduced major new rural health insurance schemes as part of a shift in government policy in favour of the rural poor. Ghana and Kenya are giving health insurance high political priority. The high cost of AIDS treatment is a political issue in a number of countries.

The OECD countries' approaches for sharing the risk of major illness are to provide universal access to tax-funded government hospitals or organise insurance and safety nets to reduce the impact of major illness. Some low and middle-income countries have successfully adopted these approaches. Many others have highly segmented health and social protection systems which provide this kind of protection to only a minority of the population. The remainder depend on the unorganised economy to respond to these shocks. A recent review of the experience of a number of Asian countries suggests that countries with comprehensive coverage of hospital care provide better protection against the financial impact of major illness (Rannan-Eliya and Somanathan 2005).

Policy-makers need to ensure that new insurance schemes do not crowd out existing informal arrangements to cope with health-related risk (Morduch and Sharma 2002). Extended families commonly help pay high hospital costs. Larger social networks support burial societies that insure against the cost of funerals. A small proportion of these societies also cover health-related risks (Mariam 2003). These informal arrangements seldom cover the high cost of major illness fully (Dercon and de Weerdt 2002) and they are vulnerable to covariate risks.

A number of countries have experimented with voluntary community health insurance (ILO 2002; Carrin 2002). These schemes are mostly quite small. They cover inpatient and/or outpatient treatment and often set low limits on total benefits. The poorest people often cannot afford to join. These schemes face several problems. First, they need to ensure that resources are used properly. A study in China found that a major reason for the reluctance of people to contribute to voluntary health insurance was their doubts about the governance arrangements (Wang et al 2001). Second, they may favour better off beneficiaries, who can afford co-payments. Third, they may stimulate increases in hospital costs. Fourth, voluntary schemes are subject to selection bias, whereby the healthy will be unwilling to contribute. Finally, they have a limited capacity to insure against large risks. This has led to experiments with schemes to re-insure local ones. Despite these problems, a number of schemes have reputations for competence and probity in an environment of low trust in public institutions. This provides an important basis for expanding their role.

A number of countries are introducing compulsory social health insurance. These are complex institutions that work better where administrative competence and trust in governance arrangements is high. In societies that have experienced economic crises and radical changes in economic and institutional arrangements, it will take time for people to believe that an

insurance scheme will last long enough to provide benefits to young and healthy contributors. Also, there is a risk that these schemes will respond to stakeholder pressure, resulting in an unfair distribution of benefits between providers and users of services or different beneficiary groups. They could also crowd out community schemes and informal arrangements, putting their clients at risk, should the new schemes run into trouble. These issues need to be taken into account in scheme design.

Many receive subsidies from government or donor agencies. They are more appropriately regarded as combining elements of risk-sharing with elements of demand-side finance. One of their potential strengths is as a mechanism to influence provider behaviour. If they perform well, they may establish the trust and expectations necessary for a successful insurance scheme. Additional measures are needed to ensure that the very poor are covered.

One of the major challenges for health insurance is the growth in chronic disease associated with demographic transition and the HIV/AIDS epidemic. The most effective strategy for mitigating the impact of chronic disease is to ensure that cost-effective treatment is widely available. This could take the form of subsidised care and/or cash transfers to affected households. The advantage of the former is that the funder can influence provider performance. The advantage of the latter is that it enables groups most likely to be affected, such as people with AIDS, pensioners and parents of young children to make the best use of the available resources. This illustrates the importance of combining demand and supply-side measures.

For example, the elderly poor often cannot afford basic food, housing and so forth (Gorman and Heslop 2002). They are also at risk of a number of chronic illnesses. They will certainly benefit from easy access to competent treatment of these illnesses. Ideally, this treatment would be subsidised, although the provision of an adequate pension would be an important first step. Similarly, people with AIDS benefit from access to drug treatment. However, if they have inadequate income to feed their family and make financial provision for their children's care after their death, they face difficult choices between their own and their family's interests, when given these drugs at a subsidised cost.

Other recent developments are schemes that subsidise treatment of major illnesses of very poor people. This is a major change from previous policies that gave priority to ambulatory care for the poor. Two examples are China's medical assistance scheme and Cambodia's health equity funds. The former is organised by the Ministry of Civil Affairs, whose local offices identify eligible households (Box 1). These households can claim reimbursement for a proportion of hospital costs. The Cambodian scheme is largely donor-funded (Hardeman et al 2004). The resources are paid to local NGOs, who purchase hospital care for people living below the poverty line. Both schemes raise difficult questions about the design of benefit packages, the identification of beneficiaries, the control of provider behaviour and the relationship between the scheme and other health-related interventions.

Measures to help people cope with adverse health events

The focus on treatment has diverted attention from the importance of measures to cope with acute or chronic loss of vigour. Important initiatives include community-based support for AIDS patients, the elderly and the disabled. The health sector can learn from welfare services in identifying strategies to provide relevant support at an affordable cost. These strategies include assistance for home carers (cash transfers, supervision, respite care), community-based support, low cost care in community nursing homes and a variety of support services for the disabled.

The impact of chronic malnutrition, high levels of HIV infection and acute episodes related to crop failures in a number of countries in sub-Saharan Africa has brought attention to the way that repeated shocks can reduce the coping capacity of communities and governments. In these circumstances, measures are needed to restore livelihoods and also social coping mechanisms at household, community and national levels.

RECONCILING THE HEALTH AND SOCIAL PROTECTION AGENDAS

This paper has explored the policy implications of two approaches to the analysis of the impact of disease. One focuses on the cost-effective prevention and treatment of disease, and the other gives more weight to the needs of the very poor and the impoverishing impact of shocks. This section outlines ways that governments and donor agencies can integrate these approaches. Box 1 illustrates with an example from China.

Countries need to define priorities on the basis of analyses of both burden of disease and the impact of health-related shocks and formulate strategies to address the highest priority problems. Table 2 identifies several types of protection and the interventions to achieve them.

We need more systematic knowledge about how different kinds of health-related shocks affect different types of household. We also need to know more about the informal arrangements that help people respond to health-related shocks or about the factors that contribute to a society's resilience in the face of repeated shocks. This kind of knowledge is needed in order to design effective interventions. This particularly applies to countries with large structural inequalities and highly segmented health and social protection systems.

The design of interventions should take into account the need for sustained efforts to build trusted and trustworthy institutions. When new organisational models are introduced, the potential adverse impact on existing arrangements should be assessed.

Strategies to prevent, mitigate and cope with health-related shocks should take into account the social and institutional context. This context includes the roles of individuals, informal social networks, arrangements outside the law and organised markets and social arrangements. Strategies for benefiting the poor will include measures to improve the performance of unorganised health

systems, extend access to high priority health services at an affordable cost and mitigate the financial impact of major illness.

Table 2, Types of response to health challenges and interventions to achieve this response

Type of protection	Type of intervention
prevention	
prevent large unexpected shocks	- early warning and capacity for rapid response - rules for open information enforced - compensation for adverse impacts on the poor
prevent adverse health consequences of major shocks	- investment in competent and accountable government systems to build resilience - relief programmes with a strong health component
prevent health-related shocks	- legal right to a minimum standard of essential public health measures - effective preventive programmes
mitigation	
mitigate impact of small health-related shocks	- subsidise government health services or provided targeted benefits to the poor - improve quality of organised services for the poor - community health insurance (with government or donor subsidies) - reduce useless and dangerous medical practices (regulation, training and provision of information on drugs)
mitigate the high cost of hospitalisation	- subsidise public hospitals - hospital insurance - health safety net for the poor - increase availability of credit - control quality and cost of hospital services
coping	
cope with the high cost of chronic disease	- improve capacity to treat these diseases - entitlements to specific treatments at subsidised cost - financial transfers to specific groups such as elderly, disabled (cash or vouchers)
cope with the cost of caring for a severely ill or disabled family member	- community support or nursing homes (with government subsidy) - cash transfers to specific groups
cope with the impact of major illness event	- special support for survivors - assistance in reconstruction of livelihoods

Interventions should be assessed in terms of their impact on the distribution of risk and measures should be taken to ensure that the very poor are not made worse off.

Health and social protection strategies should be part of a broader effort to address risks and improve household well-being. Sometimes, it is appropriate to earmark resources for health; sometimes, the intervention should cover a

number of risks. One important consideration is the need to avoid an unnecessarily complex mixture of interventions.

Special programmes are needed to meet the needs of the very poor. They can be based on a combination of targeting principles (disease, locality, household). Measures will be needed to ensure that resources reach the poor and are translated into effective services.

It is necessary to implement health and social protection strategies together. Demand or supply-side measures are unlikely to deliver effective protection, on their own. Mechanisms are needed to strengthen cooperation between government departments with complementary responsibilities.

Box 1, Reducing the illness-poverty link in China

China's political leaders have concluded that illness is a leading cause of poverty. They have announced a new health policy that prioritises measures to help households respond to major illness. This is an important element of a government initiative to address the needs of the rural poor.

The cornerstone of the policy is rural health insurance, organised at county level and financed equally by national and local governments and household contributions. The benefits mostly cover hospital care, reimbursing a proportion of the cost of an admission. There are concerns about the distribution of benefits between households with different income levels, the exclusive focus on hospital care and the danger of cost increases. The government has also introduced medical assistance for very poor people with a major illness. The Ministry of Civil Affairs is responsible for these schemes, which give the poorest five percent of the population cards that entitle them to reimbursement of a portion of the cost of a hospital admission. Where insurance schemes exist, medical assistance pays the premiums for poor households and supplements reimbursements. Assessments of pilot schemes have identified problems with the identification of eligible households, the lack of coverage for outpatient treatment, the lack of nearby facilities and the risk of cost increases.

The emphasis on major illness has diverted attention from other health interventions. Many poor people live in localities with undeveloped health systems. The government could subsidise basic health services and the provision of public health and preventive services. Measures are needed to improve the quality of services and reduce unnecessary and dangerous treatments.

One reason for the enthusiasm for demand-side finance is that government facilities are over-staffed and have a reputation for prescribing too many drugs. Insurance and medical assistance schemes could provide a counterweight to provider interests. The inclusion on the governing body of insurance schemes of senior officials from county anti-corruption departments indicates the importance of scheme success to policy-makers. However, they need to define clear objectives for these schemes in terms of quality and cost of care and equity of access to benefits, and strengthen the governing body's capacity to monitor performance. They also need to ensure that representative bodies and stakeholder groups have access to relevant information.

Health benefits need to be designed in the context of overall social protection arrangements. For example, China is well advanced in the demographic transition and there are important questions about how to prioritise pensions, hospital insurance and subsidies for other forms of medical care and support for the elderly.

The main lesson is that policy should be based on an assessment of the overall burden of disease and of health-related shocks. The responses are likely to include supply and demand-side measures. The former will include public health, prevention, subsidies for basic services in poor localities and measures to reduce inappropriate medical practices. The latter will include allocations to special health schemes and cash transfers. The different strands of public finance need to be brought together so that policy-makers can see the whole picture. Mechanisms are needed to ensure that relevant actors participate in policy formulation and implementation and that appropriate accountability structures are in place. Knowledge gaps should be identified and strategies for bridging them implemented.

Sources: Liu (2004) and documentation from World Bank/DFID Health 8/H8SP project

References

Bitran, R. and Giedion, U., 2003, 'Wavers and Exemptions for Health Services in Developing Countries', *Social Protection Discussion Series* No. 0308, World Bank, Washington

Bloom,G., 2001, 'Equity in Health in Unequal Societies: Meeting Health Needs in Contexts of Social Change', *Health Policy* 57(3): 205-224

Bloom, G., 2004a, 'Health in a Changing World', *IDS Bulletin* 35(3):38-41

Bloom, G., 2004b 'Private provision in its institutional context: lessons from health', *DFID Health Systems Resource Centre Issues Paper*

Bloom, G. and Standing, H., 2001, 'Pluralism and marketisation in the health sector: meeting health needs in contexts of social change in low and middle-income countries', *IDS Working Paper* No. 136

Carrin G., 2002, 'Social health insurance in developing countries: a continuing challenge', *International Social Security Review* 55: 57-69

Commission on Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: World Health Organization

de Savigny, D., Kasale, H., Mbuya, C. and Reid, G., *Fixing Health Systems*, IDRC, Ottawa

Dercon, S. and De Weerdt,J., 2002, 'Risk-sharing networks and insurance against illness', Centre for the Study of African Economies, Oxford

Devereux, S. and Sabates-Wheeler, R., 2004, 'Transformative Social Protection', *IDS Working Paper* 232

Ensor, T. and Cooper, S., 2004, 'Overcoming barriers to health service access: influencing the demand side' *Health Policy and Planning* 19: 59-79

Gallup, J.L., Sachs. J,D., 2001, 'The economic burden of malaria', *Commission on Macroeconomics and Health,* WG10

Gertler, P. and Gruber, J., 2002, 'Insuring consumption against illness', *The American Economic Review* 92: 51-70

Graham, C., 2002, 'Public Attitudes Matter: A Conceptual Frame For Accounting for Political Economy in Safety Nets and Social Assistance Policies', *Social Protection Discussion Series* No. 0233, World Bank, Washington

Gwatkin, D., 2002, 'Who Would Gain Most from Efforts to Reach the Millennium Development Goals for Health?', HNP Discussion Paper, World Bank, Washington

Hardeman W, Van Damme W, Van Pelt M, Por I, Kimvan H, Meessen B., 2004, Access to health care for all? User fees plus a Health Equity Fund in Sotnikum, Cambodia. *Health Policy Plan*. 19(1):22-32

Heslop, A. and Gorman, M., 2002, Chronic poverty and older people in the developing world, *Chronic Poverty Research Centre Working Paper* No. 10

Holzmann, R. and Jorgensen, S., 2000, 'Social Risk Management: A New Conceptual Framework for Social Protection and Beyond', SP Discussion Paper 0006, World Bank

ILO (2002). *Extending Social Protection in Health Through Community Based Health Organizations: Evidence and Challenges.* ILO-Universitas Programme, Geneva.

Kar, K, 2003, 'Subsidy or Self-Respect? Participatory Total Community Sanitation in Bangladesh', *IDS Working Paper* 184

Liu, Y 2004: Development of the rural health insurance system in China Health Policy Plan. 2004 19: 159-165

Loewenson R, 2003. *Overview of issues from the bibliography on civil society and health*. WHO/ TARSC Annotated bibliography of selected research on civil society and health, http://www.tarsc.org/WHOCSI/overview.php

Mariam DH, (2003). Indigenous social insurance as an alternative financing mechanism for health care in Ethiopia (the case of *eders*). *Social Science & Medicine*, 56(8): 1719-1726.

Matin, I., 2002, 'Targeted development programmes for the extreme poor: experiences from BRAC experiments', *Chronic Poverty Research Centre Working Paper* No. 20

Meesen, B., Zhang, Z., van Damme, W., et al., 'Iatrogenic Poverty', *Tropical Medicine and International Health* 8(7): 581-4

Milimo, J., Shilito, T. and Brock, K, 2002, *The Poor of Zambia Speak: Who Would ever Listen to the Poor?* Zambia Social Investment Fund, Lusaka

Morduch, J. and Sharma, M., 2002, 'Strengthening Public Safety Nets from the Bottom Up', *Social Protection Discussion Paper* No.0227, World Bank, Washington

Narayan, D., R. Chambers, M. Shah and P. Petsch (2000), Voices of the Poor: Crying out for Change. New York: Oxford University Press.

Rannan-Eliya, R. and Somanathan, A., 2005, 'Access of the Very Poor to Health Services in Asia: Evidence on the Role of Health Systems from Equitap', presentation to workshop on Meeting the Health-Related Needs of the Very Poor', Department for International Development, London, 14-15 February 2005

Revallion, M., 2003, 'Targeted Transfers in Poor Countries: Revisiting the Trade-Offs and Policy Options, *Social Protection Discussion Series* No. 0308, World Bank, Washington

Shepherd, A., Marcus, R., and Barrientos, A., 2004, 'General Reivew of Current Social Protection Policies and Programmes, ODI, London

Smith, W. and Subbarao, K., 2003, 'What Role for Safety Net Transfers in Very Low Income Countries? *Social Protection Discussion Paper* No.014, World Bank, Washington

Standing, H., 2004, Understanding the demand side in service delivery: definitions, frameworks and tools from the health sector, DFID Health Systems Resource Centre

Tabor, S., 2002, 'Assisting the Poor with Cash: Design and Implementation of Social Transfer Programs', Social Protection Discussion Paper 0223, World Bank

Wagstaff A, Van Doorslaer E (2003). Catastrophe and Impoverishment in Paying for Health Care: with Applications to Vietnam 1993-98. *Health Economics*, 12(11): 921-934.

Wang, H, Hu Yilie et al, 2001, 'Report on CMS in Yushe County, Shanxi Province', *Heifei Kayak Society and Health Development Institute, Hefei* pp 82-100

Wilkes, A., Yu, H., Bloom, G., and Gu, X., 1997 Coping with the Costs of Severe Illness in Rural China. IDS Working Paper No. 58 Brighton: Institute of Development Studies

World Bank, 2003 *Social Protection Sector Strategy: From Safety Net to Spingboard*

World Bank, 2004, *World Development Report 2004: Making Service Work for Poor People,* World Bank, Washingtong

Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray CJ., 2003. Household catastrophic health expenditure: a multi-country analysis. *The Lancet*, 362: 111-117.