CEDE Foundation

Possible relationships between poverty and ill health - identifying some factors limiting access to healthcare by the poor

August 24

2012

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CEDE FOUNDATION

Acknowledgements
Edited by Nnadozie C. Ihedinmah (Nnamdi Azikiwe University Awka), Peter-Clever C. Nwaiwu (Shell Petroleum Development Company of Nigeria) and Sheteh Newuh (CEDE Foundation)

Working Paper 1.3

Abstract

Poverty and ill-health are directly related, as well as manifest in a cyclical pattern. An understanding of this relationship will help the health authorities in the design and implementation of health intervention policies that would ameliorate the inequality in healthcare suffered by the poor. Poverty limits healthcare options available to the poor, with the implication that the poor are made poorer, thereby exacerbating poverty related ill-health problems. Three key factors are identified as having profound contributions to the situation, and these include; poverty, geographical factors and weak, failing or failed states. The government should recognize her obligations to provide basic social services to the citizens, which include clean water and basic health infrastructures. An affirmative action could also be used to reduce the limitation faced by the poor in their access to healthcare services. In addition, a programme of national healthcare campaign should be used to educate the masses about their rights, as well as healthcare opportunities available to them.

This paper discusses the possible relationships between poverty and ill-health, identifying some of the factors which limit access to healthcare by the poor. It suggests measures to overcome some of the identified limitations. It is divided into five sections starting with the introduction. Section two examines the links between poverty and ill-health. Section three looks at the factors limiting the poor in their access to healthcare. Section four suggests measures to overcome the identified factors that put the poor at a disadvantage in healthcare accessibility. The conclusion summarises the key arguments discussed in the paper.

Keywords

Malaria, Tuberculosis, HIV/AIDS, Diarrhea, Ill-health, Poverty, Deprivation, Epidemiologic

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1. Introduction

The economic depression of the 1930s, popularised the concept of a direct relationship between poverty and ill-health (Starfield, 1982), in explaining the disparity in healthcare accessibility between the poor and the rich. This lead to a unanimous agreement by healthcare professionals and researchers that a bidirectional relationship between poverty and ill-health (Gwatkin et al, 2005; Grant, 2005; Starfield, 1982; Wagstaff, 2002; World Bank, 2001; Dodd and Munck, 2002) exist, arguing that, higher poverty rate, leads to higher ill-health and vice versa. This has captured growing donor attention, on health outcome and improvement strategies (Wagstaff, 2002), recognising the peculiar disadvantage suffered by the poor in their access to healthcare (Carter-Pokras and Baquet, 2002).

Efforts aimed at establishing a correlation between poverty and ill-health suffer contextual differences, which result from variations, in the measurement of poverty, Laderchi et al. (2010), however, called for clarity in approach and understanding of the concept of poverty. Poverty in this paper is construed as, "pronounced deprivation in well-being," (World Bank, 2001). According to United Nations,

> Poverty is a denial of choices and opportunities, a violation of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and clothe a family, not having a school or clinic to go to; not having the land on which to grow one's food or a job to earn one's living, not having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence, and it often implies living on marginal or fragile environments, without access to clean water or sanitation [1].

Ill-health, on the other hand, is a psychological or physical state of body in-balance, which impairs the ability of a person to perform normal activities. Grant notes the catalytic role of ill-health in engendering poverty and asserts, that, "effective production, reproduction and citizenship" (Grant, 2005, p. 4) are dependent on satisfactory physical and mental health. Dodd and Munck (2002) argue that the contributory role of poverty to ill-health manifest through

1 United Nations Statement of June 1998, which was signed by the heads of all UN agencies

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reduction in life choices for the poor, limiting their access to clean water, adequate shelter, decent and hygienic living environment. These limitations further exacerbate poverty.

Links between poverty and ill-health

Establishing a link between poverty and ill-health would involve the analysis of disease occurrence, severity of disease, and receipt of medical-care.

Disease occurrence

It is often said that 'poverty is a disease', although this might have different interpretations, depending on the context of usage. However, it is a widely held notion that ill-health and poverty are directly related (Dodd and Munck, 2002). Rowson (2001) argues that, poverty is the world's number one killer; this argument is supported by a number of commentators who have approached the link between poverty and ill-health from different perspectives. For instance, Starfield noted the high frequency of sickness by children from poor families compared with children from non-poor families (Starfield, 1982). Although, the focus of the report was children, it, however, gives some insight into the health gap between poor and rich adults. Grant's bidirectional relationship between poverty and ill-health developed from Kyegombe (2003 cited in Grant, 2005, p. 5; Hulme and Lawson, 2006, pp. 9-10) suggests five poverty manifestations that interact with ill-health. These include; (1) Poor nutrition, ` which weakens and lowers the body immune system, with the implication that the body will not be able to fight diseases. (2) Poor shelter and living conditions that lead to deterioration in health conditions as a result of reduced resource availability which is necessary to maintain and sustain hygienic living environment, it also increase the outbreak of opportunistic diseases. (3) Poor working conditions with its bidirectional link with ill-health which reduces employability opportunities, thereby fuelling chronic poverty and its consequent poor health implications. (4) Low income, low earning opportunities and healthcare cost, leaving the poor susceptible to poverty associated healthcare problems, as they are less able to purchase adequate healthcare. (5) Reliance on livelihood strategies as a result of ill-health which often results in the erosion of investments and income opportunities, with the implications that basic necessities of life are forfeited (Grant, 2005, p. 5; Hulme and Lawson, 2006, pp. 9-10).

Some scholars have identified some sicknesses associated with poverty, such as Malaria, Tuberculosis, HIV/AIDS, diarrhea, etc. (Rowson, 2001; Widdus and

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White, 2004). These types of ill-health are usually associated with income related deprivation, which affects the capacity of the poor in their access to clean water and sanitation, food and hygiene etc. Although, these sicknesses also affect the rich, however, their prevalence increases with poverty (European Commission 2002). Epidemiologic studies have found a high correlation of health related problems with the poor, when compared with non-poor (Starfield, 1982). These illnesses exacerbate poverty through their crippling effect on the economic capability of the poor (Bartley, 1994; Rowson, 2001), which manifests in two ways; through the erosion of savings expended on healthcare purchases and secondly, through unemployment of labour.

Severity of disease

The severity of ill-health is believed to be more pronounced among poor people when compared to none poor, this is evident in the ground breaking analysis of ill-health severity among poor children by Starfield. His analysis showed consistently high levels of health disadvantages for children from low social class comparative to children from middle or high social classes (Starfield, 1982, p. 246). Hulme and Lawson (2006, p. 10) have also identified two other dimensions through which poverty interacts with ill-health. These are; (1) poor to ill-health coping strategy, where poor families in coping with ill-health, abandon long term income generating opportunities as a result of the severity of their ill-health. For instance, the implication of HIV/AIDS where the poor know fully well that the chances of survival are not guaranteed, could be a rational for abandoning savings efforts or investment pursuit. (2) Poverty engendered social behaviours, which undermine health and wellness, for example, the consumption of tobacco which reduces family disposable income available for life basic necessities (Semba, 2006), while aggravating health related risks (Hulme and Lawson, 2006, p. 10). Furthermore, ill-health and erosive livelihood (Kyegombe, 2003 cited in Grant, 2005, p. 5; Hulme and Lawson, 2006, p. 10) often result in pursuit of livelihood strategies that worsen the severity of diseases as the poor cut corners for survival, such as abandonment of medication or seeking risky medical care alternatives capable of endangering life. These are re-enforced in Starfield's argument, which suggest a causation, between receipt of medical care and severity of diseases (Starfield, 1982, p. 247).

Receipt of medical care

The fundamental of wellbeing is contingent on satisfactory healthcare, which is dependent on availability and affordability of quality medical services. This forms the central argument in the 'modern medicine availability to ill-health'

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(Starfield, 1982) paradigm of the 1920s. Starfield's analysis suggests that poor children have few medical services available to them when compared to children from rich families. This situation is compounded by low disposable family income, especially for those families who do not qualify for government benefits, which in most cases, include, free medical care (Starfield, 1982). In the United Kingdom, this problem might not be so pronounced due to the availability of free NHS services. However, it will be the case in most other countries around the world, where access to healthcare is dependent on the ability of the patient to pay for medical services. Eibner and Evans (2005) argue that income and health may not be closely related, at least in rich and developed countries, based on their study of 'Relative Deprivation, Poor Health Habits, and Mortality' in the United States. Their finding reveals that, United States, performs poor among OECD countries in terms of 'population health' despite having the highest 'per capita health care expenditures' (Eibner and Evans, 2005). On the contrary, Nixon and Ulmann (2006) suggest the existence of a direct correlation between healthcare expenditure and improved health outcomes, although, Nixon and Ulmann cautioned that while improved quality of healthcare improves an individual's wellbeing, it does not, however, translate to longer life (Nixon and Ulmann, 2006). The work of Kyegombe (2003 cited in Grant, 2005, p. 5; Hulme and Lawson, 2006, p. 9) argue that unaffordability of health care is capable of complicating already existing health condition, which could result from, missed prescription.

Factors limiting the poor in their access to healthcare

The factors which limit healthcare accessibility by the poor are mainly the drivers of poverty, these include, Poverty, geographical location, weak, failing or failed states (Chronic Poverty Research Centre, 2004).

Poverty

Poverty in all its ramifications limits opportunities for healthcare accessibility as a result of economic disempowerment. Poverty in this context includes income poverty, material deprivation, social exclusion and capability deprivation, (Chambers, 2006; Laderchi et al., 2010; Willitts, 2006). Income dimension, measures monitory equivalent below a stated threshold (Chambers, 2006; Laderchi et al., 2010; Willitts, 2006), while the material deprivation approach measures poverty in terms of material lack, with quality of materials and accessibility of services forming part of the measurement criteria (Chambers, 2006; Willitts, 2006). Such materials according to Willitts (2006) are societally considered necessity and those who could not afford them are considered poor. However, Willitts (2006) stresses the need to distinguish between 'enforced'

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deprivation and 'unenforced' deprivation. This is in the realisation that, unenforced deprivation arises from decisions and principles of an individual not to accept service or material help, due to personal conviction or religious faith belief. For example, Jehovah's Witnesses church members do not accept blood transfusions and neither do they donate blood (Elder, 2000; TowerWatch Ministries, nd). Elder (2000) concludes that the lack of adequate information on which to make autonomous decision about blood treatment may have contributed to the dilemma faced by most Jehovah's Witnesses members in receiving blood treatments. The implication of this is that, any study of healthcare accessibility and availability without isolating cases of 'unenforced' deprivation would produce misleading conclusions about the link between poverty and ill-health.

Another poverty related factor that disadvantages the poor, is the capability deprivation which focuses on poverty, based on what an individual "can or cannot do, can or cannot be", (Chambers, 2006, p. 3) taking into consideration human capabilities, as well as material welfare. Human capability has a direct bearing on human welfare and it affects an individual's income level. Laderchi et al. (2010) suggest the need for context dependent categorical breaks in capability distribution in order to segregate the poor from the non-poor. The implication of this is that, capabilities such as education and knowledge could affect the level of exposure and awareness and subsequently affects one's ability to seek for healthcare service, for example, educated people are more inclined to seek orthodox healthcare solutions to illnesses, compared to no-educated people. Social exclusion is another aspect of poverty which disadvantage the poor in accessing healthcare, it forms part of any social relations (de Haan, 2001; Laderchi et al., 2010), which suggest that the poor may suffer multiple forms of deprivation simultaneously. Social exclusion compared with capability deprivation, manifests in multidimensional ways, which Stewart et al. (2007) described as horizontal inequalities. It is "inequalities among groups, with common felt cultural identities" (Stewart et al., 2007, p. 4). Ill-health and social exclusion are directly related while "health status is a determinant of social position" (Social Exclusion Unit, 2004, p. 2) and vice versa.

Geographical location

Geographical location affects healthcare availability and accessibility, especially in the rural villages where there are inadequate or no healthcare facilities and, where the option available to the rural dwellers is to travel to other geographical locations, which most often involves long distance journeys to the urban centres or to neighbouring village(s). This results to reduced demand for healthcare services (Chan et al., 2006) by patients living in rural

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villages, with inadequate healthcare facilities. Such reduction in usage is usually due to long travel and other geographical factors (Mazumdar et al., 2009), rather than apathy to healthcare. Geographical disadvantage reduces the opportunity to information and better economic connections which are *sine qua non*, to helping the poor to improve their chances and opportunities in life, especially, in seeking better healthcare services. Chronic Poverty Research Centre (2004, p. 82) asserts that, "residential location severely limits the possibilities of upward mobility" resulting from limited opportunities, limited service provision and, increased vulnerability in all aspects of life. Notable studies have suggested the adverse link between poor road and lack of communication networks to healthcare accessibility and outcome, especially in poor, rural villages (Baker and Gesler, 2000; Mazumdar et al., 2009; Rahman and Smith 2000; Peters et al., 2008). In contrast, however, Arcury et al. (2005) argues that the impact of geographical location is only context specific, stressing that those that have serious medical needs would travel for healthcare services irrespective of distance.

Weak, failing or failed states

The withdrawal of government in most states around the world from social service provisioning in the 1980s (Feldman, 1997; Vedder, 2003) following the introduction of the Structural Adjustment (Clarke, 1998) widened the limitation in healthcare accessibility by the poor. More recently, the global economic crises has necessitated a global trend in public expenditure cut by most governments, leading to reduced access to healthcare by the poor in most countries. A weak, failing or failed state is characterised by low economic opportunities, lack of social protection and poor healthcare services (Chronic Poverty Research Centre, 2004), which makes the poor more vulnerable to ill-health prone situations, considering the unavailability of basic services, which limits the opportunities available to the poor to assert their rights.

Measures to overcome some of the Limitations

One of the most credible ways to overcome some of the limitations faced by the poor in healthcare accessibility is through the provision of basic public goods and social services, such as healthcare services. In England, for example, where NHS services are freely accessible, it reduces the health burden on the poor, as they are able to access these services without spending much of their economic resources. Governments should also "recognise obligations to provide resources" (Chronic Poverty Research Centre, 2004, p. 50) to the poor, through the provision of public goods. There is a need to pursue aggressive resource

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redistribution strategy by the government, which could be achieved through the provision of free public services to the poor and most vulnerable in society. The provision of social security could help in reducing the health impact of poverty on the poor. There should also be a number of state benefits designed to assist the poor, such as unemployment benefits, low income benefits. The introduction and implementation of universal healthcare programme could help in reducing the disadvantages suffered by the poor. Programmes of this nature would reduce the chances of common opportunist diseases that are highly preventable with adequate vaccination.

The prioritization of livelihood security (Chronic Poverty Research Centre, 2004) should be one of the strategic goals of the government, as a means of reducing adverse impact of poverty on the poor. This will involve the integration of the poor into the society in a way that will empower them to take advantage of opportunities, as well as assert their rights as members of the society, such policies could be implemented in a number of ways including the removal of barriers that lead to social exclusion and marginalization (Chronic Poverty Research Centre, 2004). Government could also introduce affirmative actions that will give priority over services and welfare to disadvantaged members of the society. The government should as well embark on employment creation programmes which will help empower the poor by improving their economic welfare. Issues such as gender discrimination should be addressed, in order to reduce the disadvantage faced by poor people, who by virtue of their gender class are discriminated against. There should be a programme of infrastructure provision, such as clean water, that would help improve the quality of life for the poor, while public health education, should also be pursued, with the aim of educating the rural poor people about healthcare opportunities available to them as well as things they should know about their health.

Conclusion

This paper provides a rich analysis of how poverty leads to ill-health by examining ways in which poverty limits healthcare options available to the poor, with the implication that the poor are made poorer, thereby exacerbating poverty related ill-health problems. The situation identified in the paper is caused by three key factors which include; poverty; geographical factors and the consequence of weak, failing or failed states. The government should therefore recognise her obligations to provide basic social services to the citizens, which include clean water and basic health infrastructures. An affirmative action could be used to address this disadvantage faced by the poor in their access to healthcare services. A programme of national healthcare campaign should be

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introduced to educate the masses about their rights as well as healthcare opportunities available to them.

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