Editorial

Poverty and inequity: a proper focus for the new century

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Human health has probably improved more over the past half century than over the previous three millennia. This is a stunning achievement — never to be repeated and, it is to be hoped, irreversible. Despite the devastating impact that human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is having in Africa and will increasingly have in south and east Asia, it is likely that, overall, human health will continue to improve steadily during the coming decades.

A dark cloud, however, threatens to blot out the sun from this landscape. Almost everywhere the poor suffer poor health and the very poor suffer appallingly. In addition, the gap in health between rich and poor remains very wide — as it does also between other advantaged and disadvantaged groups defined, for example, by ethnicity, caste, or place of residence. Addressing this problem, both between countries and within countries, constitutes one of the greatest challenges of the new century. Failure to do so properly will have dire consequences for the global economy, for social order and justice, and for civilization as a whole.

A major focus on the health of the poor is now evident in the strategies of the major international and bilateral development agencies and of those governments that have a clearly articulated health strategy. This is appropriate and important. Poor health is a common consequence of poverty and poverty can be a consequence of poor health. The vicious cycle takes its inexorable toll.

Recent thinking has sought to bring health to the centre of the development debate by asserting that poor health is a component, rather than a consequence or cause, of poverty. This is a desirable trend but caution is necessary. Low income is clearly a necessary and sufficient condition of poverty, but poor health is neither. It is the explicit goal of many health sector interventions to transform poor unhealthy populations into poor healthy populations, thus breaking the link between disease and poverty. Some societies have made great strides down this road, and rising incomes should follow their improving health status.

A second major focus, discussed at length in this issue of the *Bulletin*, is health inequities and inequalities. In simple terms, an inequity is an unfair and remediable inequality. Inequities and inequalities refer to relative health status — between rich and poor, men and women, ethnic groups, regions or simply between the most healthy and the least healthy. They measure not how well the disadvantaged group is doing in absolute terms, but how well it is doing relative to the advantaged group. Thus, decreases in inequality could be bad news — they could signal that previous improvements in the health of the advantaged group have slowed down, stopped, or even reversed. For policy-makers, tracking inequalities in health must therefore be accompanied by measurements of the levels and trends in absolute health status of the groups of interest. This is particularly important in rich/poor comparisons, since the health of the rich continues to improve steadily, with human life expectancy ever on the increase. The poor could therefore be experiencing similar worthwhile health improvements while measures of inequality remain stagnant.

The crucial next steps are to move from analysis to policy and from policy to action. In this context, there is some good news. Many of the most cost-effective interventions available to health workers are targeted at the very diseases from which the poor suffer disproportionately. Therefore, in many situations, equity and efficiency walk hand-in-hand.

Beyond this simple truth lies difficult territory for public policy-makers. What exactly should be the role of government in improving the health of the poor?

- To adopt economic policies which contribute to poverty decline? — Certainly!
- To provide information on health and health services? — Certainly!
- To control infectious diseases? — Certainly!
- To legislate for better health?— Certainly!
- To finance health services for those who cannot afford them? — Yes, but which services and how?
- To provide health services for the poor? — Perhaps, but experience tells a sorry tale of these endeavours in many countries.

This debate about the financing and provision of health services for the poor quickly becomes a debate about targeting. How does one ensure that the expenditures and services intended for the poor actually reach and benefit the poor? There is much evidence, including that published in this issue of the *Bulletin*, that public subsidies — be they for health, education, water, power, food or whatever — intended to promote equity and benefit the poor are largely captured by the non-poor , especially by the middle class. Provision of free university education provides a classic example of this. Because of this difficulty there have been many experiments in targeting by geographical area or by individual — but the results have often been disappointing. Targeting by disease has merit for some diseases. For example, a tuberculosis control programme that everyone can access (a rare phenomenon) will be pro-poor and pro-equity because it is the poor who suffer disproportionately from tuberculosis. Commonly, however, the poor, and especially the very poor and socially marginalized, do not enjoy equal access to the programme concerned, which therefore achieves neither its epidemiological nor poverty-related objectives.

In the Theme Section of this issue of the *Bulletin* — the first of "*Bulletin 2000*" —

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Ref. No. **0410**

Davidson Gwatkin reviews the field of poverty and health in a Critical Reflection and has assembled a collection of specially commissioned articles that provide new insights on the question of poverty, equity, and health. Also published in this issue is a Round Table debate focusing on the policy implications of the currently available information on health and poverty. The Theme Section concludes with a Public Health Classic (with an accompanying commentary) drawn from the writings of William Farr — a nineteenth-century British pioneer of the study of inequalities in health.

Our hope is that this collection of material will inform and stimulate. In forthcoming issues we intend to publish a new rubric — *Bulletin 2000 Feedback* — containing responses to the articles contained in this and subsequent Theme Sections. ■