



IMPROVE DAILY LIVING CONDITIONS



The first of the Commission's three principles of action is:

Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.

Inequities in how society is organized mean that freedom to lead a flourishing life and to enjoy good health is unequally distributed between and within societies. This inequity is seen in the conditions of early childhood and schooling, the nature of employment and working conditions, the physical form of the built environment, and the quality of the natural environment in which people reside. Depending on the nature of these environments, different groups will have different experiences of material conditions, psychosocial influences, and behavioural options that make them more or less vulnerable to poor health. Social stratification likewise determines differential access to and utilization of health care, with consequences for the inequitable promotion of health and well-being, disease prevention, and illness recovery and survival.

Implicit in the work of the Commission is a lifecourse perspective on how the social determinants of health operate at every level of development – pregnancy and childbirth, early childhood, childhood, adolescence, and adulthood – both as an immediate influence on health and to provide the basis for health or illness later in life.

The following chapters, Chapters 5–9, focus on the conditions of daily life and make recommendations for action, sequentially, relating to the conditions of early life and through the school years, the social and physical environment with a focus on cities, and the nature of both employment and working conditions. The nature of social protection, and in particular income protection, is considered here as an essential resource for daily living. The final chapter in Part 3 relates to the health-care system.



CHAPTER 5

Equity from the start

“Each one of you is your own person, endowed with rights, worthy of respect and dignity. Each one of you deserves to have the best possible start in life, to complete a basic education of the highest quality, to be allowed to develop your full potential and provided the opportunities for meaningful participation in your communities.”

Nelson Mandela and Graça Machel (UNICEF, 2000)

EARLY CHILD DEVELOPMENT AND EDUCATION – POWERFUL EQUALIZERS

Worldwide, 10 million children die each year before their fifth birthday (Black, Morris & Bryce, 2003). The vast majority of these deaths occur among children born in low- or middle-income countries, and within these countries, among children of more disadvantaged households and communities (Houweling, 2007). Even in high-income countries such as the United Kingdom, infant mortality is higher among disadvantaged groups (Department of Health, 2007). There is an urgent need to address these mortality inequities. Equally important, at least 200 million children are not achieving their full developmental potential, with huge implications for their health and for society at large (Grantham-McGregor et al., 2007). The figure of 200 million is certainly an underestimate, as it is based on a definition of poverty at US\$ 1/day, whereas there is a stepwise effect of wealth on child development (ECDKN, 2007a). Experiences in early childhood (defined as prenatal development to 8 years of age), and in early and later education, lay critical foundations for the entire lifecourse (ECDKN, 2007a). It is better for the individual child, and for society – in rich and poor countries alike – to provide a positive start, rather than having to resort to remedial action later on. Building on the child survival agenda, governments can make major and sustained improvement in population health and development, while fulfilling their obligations under the UN Convention on the Rights of the Child, by using a more comprehensive approach to the early years of life (ECDKN, 2007a).

A more comprehensive approach to the early years in life

The science of ECD shows that brain development is highly sensitive to external influences in early childhood, starting in utero, with lifelong effects. The conditions to which children are exposed, including the quality of relationships and language environment, literally ‘sculpt’ the developing brain (Mustard, 2007). Raising healthy children means stimulating their physical, language/cognitive, and social/emotional development (ECDKN, 2007a). Healthy development during the early years provides the essential building blocks that enable people to lead a flourishing life in many domains, including social, emotional, cognitive, and physical well-being (ECDKN, 2007a).

Education, preschool and beyond, also fundamentally shapes children’s lifelong trajectories and opportunities for health. Yet despite recent progress, there are an estimated 75 million

children of primary-school age not in school (UIS, 2008). Educational attainment is linked to improved health outcomes, partly through its effects on adult income, employment, and living conditions (Ross & Wu, 1995; Cutler & Lleras-Muney, 2006; Bloom, 2007). There are strong intergenerational effects – educational attainment of mothers is a determinant of child health, survival, and educational attainment (Caldwell, 1986; Cleland & Van Ginneken, 1988).

Many challenges in adult society have their roots in the early years of life, including major public health problems such as obesity, heart disease, and mental health problems. Experiences in early childhood are also related to criminality, problems in literacy and numeracy, and economic participation (ECDKN, 2007a).

Social inequities in early life contribute to inequities in health later on, through ECD and educational attainment. Children from disadvantaged backgrounds are more likely to do poorly in school and subsequently, as adults, are more likely have lower incomes and higher fertility rates and be less empowered to provide good health care, nutrition, and stimulation to their own children, thus contributing to the intergenerational transmission of disadvantage (Grantham-McGregor et al., 2007). The seeds of adult gender inequity are also sown in early childhood. Gender socialization and gender biases in the early years of life have impacts on child development, particularly among girls. Early gender inequity, when reinforced by power relations, biased norms, and day-to-day experiences, go on to have a profound impact on adult gender inequity (ECDKN, 2007a).

Much of child survival and development depends on factors discussed in other chapters of this report. In the early years, the health-care system has a pivotal role to play (ECDKN, 2007a). Mothers and children need a continuum of care from pre-pregnancy, through pregnancy and childbirth, to the early days and years of life (WHO, 2005b) (see Chapter 9: *Universal Health Care*). Children need to be registered at birth (see Chapter 16: *The Social Determinants of Health: Monitoring, Research, and Training*). They need safe and healthy environments – good-quality housing, clean water and sanitation facilities, safe neighbourhoods, and protection against violence (see Chapter 6: *Healthy Places Healthy People*). Good nutrition is crucial and begins in utero with adequately nourished mothers, underlining the importance of taking a lifecourse perspective in tackling health inequities (ECDKN, 2007b). It is important to support the initiation of breastfeeding within the first hour of life, skin to skin contact immediately after birth, exclusive breastfeeding in the first 6 months of life, and continued breastfeeding through the second year of life, as is ensuring the availability of and access to healthy diets for infants and young children through improving food security (PPHCKN, 2007a; Black et al., 2008; Victora et al., 2008).

More distally, child survival and development depend on how well and how equitably societies, governments, and international agencies organize their affairs (see Chapters 10

and 14: *Health Equity in All Policies, Systems, and Programmes; Political Empowerment – Inclusion and Voice*). Gender equity, through maternal education, income, and empowerment, plays an important role in child survival and development (see Chapter 13: *Gender Equity*). Children benefit when national governments adopt family-friendly social protection policies that allow an adequate income for all (see Chapter 8: *Social Protection Across the Lifecourse*) and allow parents and caregivers to balance their home and work life (see Chapter 7: *Fair Employment and Decent Work*). Political leaders, nationally and internationally, should play a key role in averting acute threats to the development of young children, including war and violence, child labour, and abuse (WHO, 2005a). Yet global inequities in power influence the ability of poor countries in particular to enact policies that are optimal for child development (ECDKN, 2007a) (see Chapters 11, 12, and 15: *Fair Financing; Market Responsibility; Good Global Governance*).

Children need supporting, nurturing, caring, and responsive living environments. And they need opportunities to explore their world, to play, and to learn how to speak and listen to others. Schools, as part of the environment that contributes to children's development, have a vital role to play in building children's capabilities and, if they are truly inclusive, in achieving health equity. Well-designed ECD programmes can help to smooth the transition of children to primary school, with benefits for subsequent schooling (UNESCO, 2006b).

Creating the conditions for all children to thrive requires coherent policy-making across sectors. Parents and caregivers can do a lot, but support is needed from government, civil society organizations, and the wider community. The neglect of children worldwide has occurred largely in the watch of governments. Civil society organizations therefore have an important role to play in advocating and improving the conditions for healthy child development.

While environments strongly influence ECD, children are social actors who shape, and are shaped by, their environment (ECDKN, 2007b). The appreciation of the relational nature of the child and the environment has implications for action and research, with the need to recognize the importance of giving children greater voice and agency (Landon Pearson Resource Centre for the Study of Childhood and Children's Rights, 2007).

Early child development: a powerful equalizer

Investments in ECD are one of the most powerful that countries can make – in terms of reducing the escalating chronic disease burden in adults, reducing costs for judicial and prison systems, and enabling more children to grow into healthy adults who can make a positive contribution to society, socially and economically (ECDKN, 2007a; Engle et al., 2007; Schweinhart, Barnes & Weikart, 1993; Schweinhart, 2004; Lynch, 2004). Investment in ECD can also be a powerful equalizer, with interventions having the largest effects on the most deprived children (Scott-McDonald, 2002; Young, 2002;

Engle et al., 2007). If governments in rich and poor societies were to act while children were young by implementing quality ECD programmes and services as part of their broader development plans, these investments would pay for themselves many times over (Schweinhart, Barnes & Weikart, 1993; Schweinhart, 2004; Lynch, 2004). Unfortunately, most investment calculus in health and other sectors discounts such future benefits and values disproportionately those benefits seen in the immediate to short term.

Reducing health inequities within a generation requires a new way of thinking about child development. An approach is needed that embraces a more comprehensive understanding of the development of young children, including not just physical survival but also social/emotional and language/cognitive development. Recognizing the role of ECD and education offers huge potential to reduce health inequities within a generation. It provides a strong imperative for action early in life, and to act now. Inaction has detrimental effects that can last more than a lifetime.

ACTION TOWARDS A MORE EQUITABLE START IN LIFE

The Commission argues that a comprehensive approach to child development, encompassing not just child survival and physical development but also social/emotional and language/cognitive development, needs to be at the top of the policy agenda. This requires commitment, leadership, and policy coherence at the international and national level. It also requires a comprehensive package of ECD interventions for all children worldwide.

Changing the mindset

The Commission recommends that:

- 5.1. **WHO and UN Children's Fund (UNICEF) set up an interagency mechanism to ensure policy coherence for early child development such that, across agencies, a comprehensive approach to early child development is acted on (see Rec 15.2; 16.8).**

The development of young children is influenced by actions across a broad range of sectors, including health, nutrition, education, labour, and water and sanitation. Similarly, many players within and outside the UN system have a bearing on ECD. These include UNDP, Office of the UN High Commissioner for Refugees (UNHCR), UNICEF, UN Population Fund (UNFPA), World Food Programme (WFP), UN Human Settlements Programme (UN-HABITAT), International Labour organization (ILO), the Food and Agriculture Organization of the UN (FAO), UN Educational, Scientific, and Cultural Organization (UNESCO), WHO, Joint UN Programme on HIV/AIDS (UNAIDS), the World Bank, International Monetary Fund (IMF), and International Organization for Migration (IOM), as well as civil society

EQUITY FROM THE START : ACTION AREA 5.1

Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development.

organizations. Many of these agencies do not have improving ECD as an explicit goal, yet they can have an important bearing on it, positively or negatively.

An interagency mechanism should be set up to ensure a comprehensive, coherent approach to ECD. The interagency mechanism can take various forms. A good model is a so-called sub-committee, such as the UN System Standing Committee on Nutrition (SCN) (Box 5.1). Such a committee would bring together not only relevant UN agencies and government actors, but also civil society organizations and professional ECD networks (see Chapter 15: *Good Global Governance*).

Following the SCN model, key activities of the interagency mechanism could include: (i) the development and implementation of a strategy for high-level advocacy and strategic communication, (ii) tracking and reporting on progress towards a healthy start in life for all children, (iii) facilitating the integration of ECD into MDG-related activities at the country level through the UN coordination system, (iv) mainstreaming human rights approaches – in particular, the rights in early childhood as embodied in General Comment 7 on Implementing Child Rights in Early Childhood (UN, 2006a) – into the work of the interagency mechanism, and (v) identifying key scientific and operational gaps (Standing Committee on Nutrition, nd,b). At the country level, the interagency group can promote an approach in which policy makers, practitioners, researchers, and civil society actors form integrated ECD networks to ensure open-access sharing and dissemination of research and practice findings.

Ensuring policy coherence for ECD, nationally and internationally, requires that international organizations, WHO and UNICEF in particular, strengthen their leadership on and institutional commitment to ECD. Within these organizations, many programmes have a bearing on child development, including programmes on child survival, immunization, reproductive health, and HIV/AIDS. ECD should explicitly be taken into account in these programmes. This requires dedicated staff and financing for ECD, in order to:

- play a critical role in advocacy for ECD as a key social determinant of health;
- provide technical support for inclusion of ECD in national-level policies and international development frameworks (such as the Poverty Reduction Strategy Papers [PRSP]);

- provide technical support to regions, countries, and partners for integration of simple ECD interventions (such as Integrated Management of Childhood Illness [IMCI] Care for Development, see Box 5.7) in health services and community health initiatives;
- take responsibility for gathering evidence on the effectiveness of ECD interventions, especially those that are connected to the health-care system;
- support countries in gathering national statistics on and setting up monitoring systems for ECD.

Ensuring a comprehensive approach to ECD requires that international organizations and donors support national governments in building capacity and developing financing mechanisms for implementation of such an approach. A global funding strategy needs to be established to assist countries that are signatories of the Convention of the Rights of the Child to truly implement the UN Committee on the Rights of the Child's General Comment 7, regarding child rights in early childhood.

A comprehensive approach to early childhood in practice

The Commission recommends that:

- 5.2. Governments build universal coverage of a comprehensive package of quality early child development programmes and services for children, mothers, and other caregivers, regardless of ability to pay (see Rec 9.1; 11.6; 16.1).**

An integrated policy framework for early child development

A healthy start for all children is best served by an integrated policy framework for ECD, designed to reach all children. This requires interministerial coordination and policy coherence, with a clear articulation of the roles and responsibilities of each sector and how they will collaborate. Better collaboration between the welfare and education sector, for example, can facilitate the transition from pre-primary programmes to primary education (OECD, 2001). ECD should be integrated into the agendas of each sector to ensure that it is considered routinely in decision-making (see Chapter 10: *Health Equity in all Policies, Systems, and Programmes*).

BOX 5.1: EXAMPLE OF AN INTERAGENCY MECHANISM – THE UN SYSTEM STANDING COMMITTEE ON NUTRITION

The mandate of the SCN is to promote cooperation among UN agencies and partner organizations in support of community, national, regional, and international efforts to end malnutrition in all of its forms in this generation. It will do this by refining the direction, increasing the scale, and strengthening the coherence and impact of actions against malnutrition worldwide. It will also raise awareness of nutrition problems and mobilize commitment to solve them at global, regional, and national levels. The SCN reports to the Chief Executives Board of the UN. The UN members are the Economic Commission for Africa, FAO, International Atomic Energy Agency, International

Fund for Agricultural Development, ILO, UN, UNAIDS, UNDP, UN Environment Programme, UNESCO, UNFPA, UNHCR, UNICEF, UN Research Institute for Social Development, UN University, WFP, WHO, and the World Bank. The International Food Policy Research Institute and Asian Development Bank (ADB) are also members. From the outset, representatives of bilateral partners have participated actively in SCN activities, as have nongovernmental organizations (NGOs).

Reproduced, with permission of the UN, from Standing Committee on Nutrition (nd,a).

Implementing a more comprehensive approach to early life includes extending quality interventions for child survival and physical development to incorporate social/emotional and language/cognitive development. ECD programmes and services should comprise, but not be limited to, breastfeeding and nutrition support, comprehensive support to and care of mothers before, during, and after pregnancy – including interventions that help to address prenatal and postnatal maternal mental health problems (Patel et al., 2004) (see Chapter 9: *Universal Health Care*) – parenting and caregiver support, childcare, and early education starting around age 3 (see Action area 2, below) (ECDKN, 2007a). Also, services are needed for children with special needs, including those with mental and physical challenges. Such services include early detection, training caretakers to play and interact with their children at home, community-based early intervention programmes to help children reach their potential, and community education and advocacy to prevent discrimination against children with disabilities (UNICEF, 2000; UNICEF, 2007a). Interventions are most effective when they provide a direct learning experience to the children and their caretakers and are high intensity, high quality, of longer duration, targeted towards younger and disadvantaged children, and built onto established child survival and health programmes to make ECD programmes readily accessible (Engle et al., 2007).

Implementing an integrated policy framework for ECD requires working with civil society organizations, communities, and caregivers. Civil society can advocate and initiate action on ECD, and can be instrumental in organizing strategies at the local level to provide families and children with effective delivery of ECD services, to improve safety and efficacy of residential environments, and to increase the capacity of local and relational communities to better the lives of children (ECDKN, 2007a).

Most countries do not have an integrated policy framework for ECD. At the same time, there are examples of interventions from around the world that illustrate what can be done.

From single to comprehensive packages of ECD services

The implementation of programmes and services that seek to improve the development of young children can follow a number of models. Some are directed to single issues, such as early literacy (Box 5.2), while others deal with ECD more comprehensively (see Boxes 5.3 and 5.4).

Interventions that integrate the different dimensions of child development, among others by incorporating stimulation (interaction between caregivers and children, which is related to brain development) and nutrition, are particularly successful (Engle et al., 2007). They tend to result in sustained improvements in physical, social/emotional, and language/cognitive development, while simultaneously reducing the immediate and future burden of disease, especially for those who are most vulnerable and disadvantaged (ECDKN, 2007a). This is illustrated in Fig. 5.1, which shows that the mental development of stunted children who were given both food supplementation and psychosocial stimulation was about as good as that of non-stunted children (Fig. 5.1).

BOX 5.2: STIMULATING READING OUT LOUD – UNITED STATES

Reach Out and Read is a United States national non-profit organization that promotes early literacy by giving books to children and advice to parents attending paediatric examinations about the importance of reading aloud for child development and school readiness. At every check-up, doctors and nurses encourage parents to read aloud to their young children, and offer age-appropriate tips and encouragement. Parents who may have difficulty reading are encouraged to invent their own stories to go with picture books and spend time naming objects with their children. Also, providers give every child between the ages of 6 months and 5 years

developmentally appropriate children's books to keep. In literacy-rich waiting-room environments, often with volunteer readers, parents and children learn about the pleasures and techniques of looking at books together. Parents who have received the intervention were significantly more likely to read to their children and have more children's books at home. Most importantly, children who received the interventions showed significant improvements in preschool language scores – a good predictor of later literacy success.

Source: ECDKN, 2007a

Even more integrated packages of services can be provided, including stimulation, nutrition, parental education, and various forms of family support (Box 5.3).

Starting early in life, using a lifecourse approach

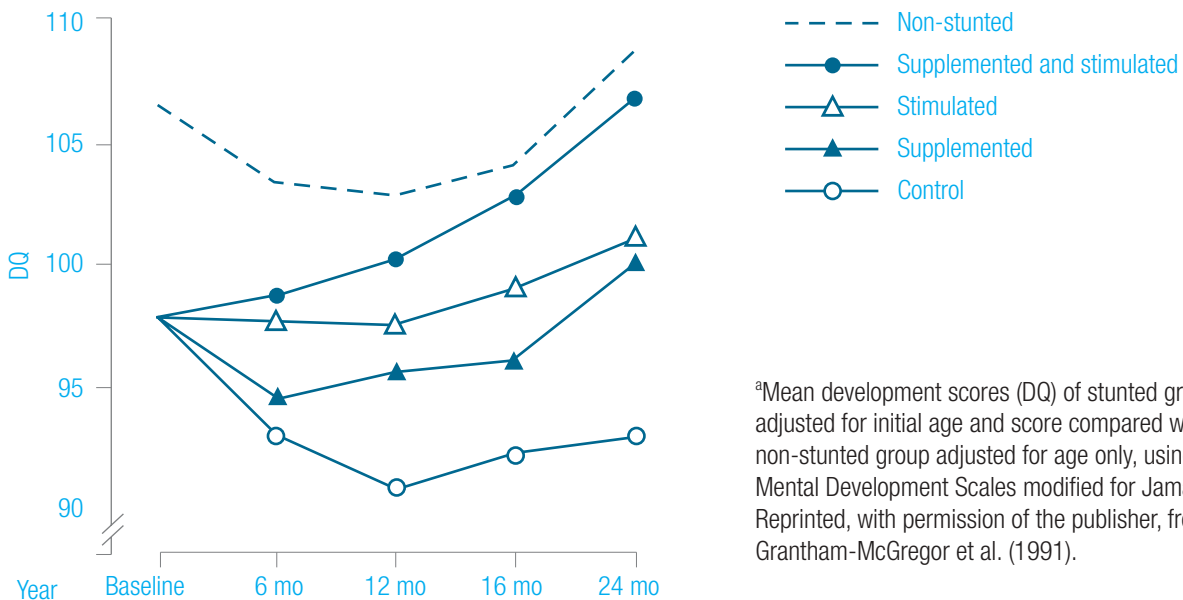
Younger children tend to benefit more from ECD interventions than older children, emphasizing the importance of providing programmes and services as early in life as possible (Engle et al., 2007). Some factors need to be addressed before birth – even before conception. Box 5.4 illustrates how child development and nutrition problems can be addressed through a lifecourse perspective, including not just children, but also pregnant and lactating mothers and adolescent girls.

Prioritizing the provision of interventions to the socially most disadvantaged

Within a framework of universal access, special attention to the socially disadvantaged and children who are lagging behind in their development will help considerably to reduce inequities in ECD. An important reason is that ECD interventions tend to show the largest effect in these disadvantaged groups (Scott-McDonald, 2002; Young, 2002; Engle et al., 2007).

Unfortunately, children in the poorest households and communities are usually least likely to have access to ECD programmes and services (UNESCO, 2006b). When new interventions are introduced, the better off tend to benefit

Figure 5.1: Effects of combined nutritional supplementation and psychosocial stimulation on stunted children in a 2-year intervention study in Jamaica.^a



BOX 5.3: A COMPREHENSIVE APPROACH TO ADDRESSING EARLY CHILD DEVELOPMENT CHALLENGES IN JAMAICA

Young children in poor Jamaican communities face overwhelming disadvantages, among others of poverty. The Malnourished Children's Programme addresses the nutritional and psychosocial needs of children admitted to the hospital for malnutrition. Hospital personnel observed that, before initiation of their outreach programme, many children who recovered and were sent home from the hospital had to be readmitted for the same condition shortly after. To address this, follow-up home visits were set up to monitor children discharged from hospital. During home visits, staff focus on stimulation, environmental factors potentially detrimental to the child's health,

the child's nutritional status, and the possible need for food supplementation. Parents participate in an ongoing weekly parenting education and social welfare programme. They are helped to develop income-generating skills, begin self-help projects, and find jobs or shelter. Unemployed parents are also provided with food packages, bedding, and clothing. In addition, there is an outreach programme in poor communities, including regular psychosocial stimulation of children aged 3 and under, supported by a mobile toy-lending library.

Adapted, with permission of the publisher, from Scott-McDonald (2002).

first (Victora et al., 2000; Houweling, 2007). This seems to be the case for the Integrated Management of Childhood Illness programme which, when implemented under routine conditions, does not preferentially reach the poor (PPHCKN, 2007a). On the other hand, examples from, among others, the Philippines illustrate that reaching disadvantaged children is feasible (Box 5.5). In countries where resources are limited, priorities must be set such that the most vulnerable children are reached first, while universal coverage should remain the longer-term goal (ECDKN, 2007a).

Reaching all children

A core objective should be universal coverage for quality ECD interventions (Box 5.6), with special attention to the most deprived. Universal access must include equal access for girls and boys as a matter of course. Low-income countries should strive to progressive realization of universal coverage, starting with the most vulnerable. Governments need to develop strategies for scaling up effective programmes from the local to the national level, without sacrificing the characteristics of the programme that made it effective. It is important that implementation integrity and accountability at the local level are sustained, even when programmes are scaled up to the national level (ECDKN, 2007a).

BOX 5.4: STARTING INTERVENTIONS BEFORE CONCEPTION – THE INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS), INDIA

The ICDS is one of the largest child development and child nutrition programmes in the world, currently serving more than 30 million children. The services include support for pregnant and lactating mothers and adolescent girls, among others through improving their access to food. They also include childcare centres, preschool education, growth monitoring for children aged 0-5 years, supplementary feeding for malnourished children, assistance for child immunization, and some emergency health care (Engle et al., 2007). The results of the programme appear to be mixed, with positive results on malnutrition

and child motor and mental development in some states (Engle et al., 2007; Lokshin et al., 2005). Within states, poorer villages were more likely to be served. However, states with high levels of child malnutrition have lowest programme coverage and lowest budgetary allocations from the central government (Das Gupta et al., 2005). An evaluation by the World Bank found “only modest positive effects, probably because of low funding, work overload of community workers, and insufficient training” (Engle et al., 2007).

BOX 5.5: REACHING MARGINALIZED COMMUNITIES IN THE PHILIPPINES

“A programme in the Philippines provides health, nutrition and early education services to young children in marginalized communities. Involving various ministries at the national level, and extension agents and Child Development Officers at the community level, the programme helps track every

child’s growth; monitors access to iodized salt, micronutrients, clean water and a toilet; and counsels parents on nutrition and child development.”

Reprinted, with permission of the author, from UNICEF (2001).

BOX 5.6: UNIVERSAL CHILD DEVELOPMENT SERVICES IN CUBA

Cuba’s Educa a Tu Hijo (Growing-up with your child) programme is generally thought to be an important factor in Cuba’s educational achievements at the primary school level (UNICEF, 2001). The programme, introduced in 1985, is a non-formal, non-institutional, community-based, family-centred ECD service under the responsibility of the Ministry of Education (Preschool Education). The programme operates with the participation of the Ministries of Public Health, Culture, and Sports, the Federation of Cuban Women, the National Association of Small Farmers, the National

Committee for the Defence of the Revolution, and student associations. This extended network includes 52 000 Promotres (teachers, pedagogues, physicians, and other trained professionals), 116 000 Executors (teachers, physicians, nurses, retired professionals, students, and volunteers), and more than 800 000 families. During the 1990s the programme was extended, reaching 99.8% of children aged 0-5 years in 2000 – probably the highest enrolment rate in the world.

Source: CS, 2007

Building onto established child survival and health programmes to make early child development interventions readily accessible

Health-care systems are in a unique position to contribute to ECD (see Chapter 9: *Universal Health Care*). Given the overlap in underlying determinants of survival/physical development and social/emotional and language/cognitive development, the health-care system can be an effective site for promoting development in all domains. The health-care system is a primary contact for many child-bearing mothers and, in many instances, health-care providers are the only professionals with whom families come into contact in the early years of the child's life (ECDKN, 2007a). Health-care systems can serve as a platform for information and support to parents around ECD, and they can link children and families to existing community-based ECD services. When ECD programmes and services become integral components of established health-care services, such as the IMCI (Box 5.7), they can become a highly effective way of promoting ECD (ECDKN, 2007a).

Acting on gender inequities

An important aspect of the quality of ECD programmes and services is the promotion of gender equity. Early gender socialization, the learning of cultural roles according to one's sex and norms that define 'masculine' and 'feminine', can have large ramifications across the lifecourse. Girls, for example, may be required to care for their younger siblings, which can prevent them from attending school. Preschool programmes that take care of the younger siblings can contribute to solving this problem.

An important strategy in promoting positive gender socialization for young boys and girls is through developmentally appropriate, gender-sensitive, and culturally relevant parenting programmes (Koçak, 2004; UNICEF, 1997; Landers, 2003). These seek to raise awareness among parents and caregivers of their role in helping their children to develop self-esteem and confidence as a boy or girl from the beginning of their lives. Gender-biased expectations of boys and girls can be brought up during group discussions with fathers and mothers as well as other caregivers and preschool teachers.

Involving fathers in child-rearing from their children's birth is another important strategy for improving child health and developmental outcomes, while promoting gender equity.

Fathers can enjoy their fatherhood roles while establishing a positive and fulfilling relationship with their children and can be a positive role model for both their daughters and sons. Parenting programmes in, for example, Bangladesh, Brazil, Jamaica, Jordan, South Africa, Turkey, and Viet Nam include specific activities to engage fathers more actively in the upbringing of their children (Koçak, 2004; UNICEF, 1997; Landers, 2003).

Involving communities

The involvement of communities, including mothers, grandmothers, and other caregivers, is key to the sustainability of action on ECD. This includes involvement in the development, implementation, monitoring, and reviewing of ECD policies, programmes, and services (ECDKN, 2007a). It can build a common purpose and consensus regarding outcomes related to the needs of the community, foster partnership among the community, providers, parents, and caregivers, and enhance community capacity through active involvement of families and other stakeholders (ECDKN, 2007a). Box 5.8 shows how an ECD project in the Lao People's Democratic Republic was community driven, at all stages, from identification of need to implementation. Community participation and community-based interventions do not absolve governments from their responsibilities. However, they can ensure stronger relationships between government, providers, the community, and caretakers (ECDKN, 2007a) (see Chapter 14: *Political Empowerment – Inclusion and Voice*).

The scope of education

While the Commission has not investigated education through a dedicated Knowledge Network, broad areas for attention have emerged from the Commission's work. The Commission recognizes the critical importance of education for health equity. Education, formal and informal, is understood as a lifelong process starting at birth. The focus in this section is on education from pre-primary to the end of secondary school, with an emphasis on extending the comprehensive approach to education that incorporates attention to children's physical, social/emotional, and language/cognitive development.

BOX 5.7: BUILDING EARLY CHILD DEVELOPMENT ONTO EXISTING HEALTH PROGRAMMES AND SERVICES

In partnership with UNICEF, WHO has developed a special early childhood development component, called Care for Development, intended to be incorporated into existing IMCI programmes. Care for Development aims to enhance awareness among parents and caregivers of the importance of play and communication with children by providing them with information and instruction during children's clinical visits. Evidence has shown that Care for Development is an effective method of supporting parents' and caregivers' efforts to provide a

stimulating environment for their children by building on their existing skills. Health-care professionals are encouraged to view children's visits for acute minor illnesses as opportunities to spread the messages of Care for Development, such as the importance of active and responsive feeding to improve children's nutrition and growth, and the importance of play and communication activities to help children move to the next stages in their development.

Sources: ECDKN, 2007a; WHO, nd,d

The Commission recommends that:

5.3. Governments provide quality education that pays attention to children’s physical, social/emotional, and language/cognitive development, starting in pre-primary school.

In every country children, particularly those from the poorest communities, would benefit immensely from early education programmes. Expanding and improving early childcare and education is part of the UNESCO Education for All strategy (UNESCO, 2006b; UNESCO, 2007a). The Commission supports the UNESCO Education for All goals (summarized in Box 5.9).

Providing quality pre-primary education

Extending the availability of quality pre-primary school, which adopts the principles of ECD, to all children and making special efforts to include those from socially disadvantaged backgrounds requires a commitment from the highest level

of government and from ministries responsible for care and education of young children. It requires joint working across health and education sectors, and review of existing pre-primary provision involving broad consultation with families, communities, nongovernmental and civil society organizations, and preschool providers to identify needs and develop a comprehensive strategy. Areas to be addressed in strategy development include: levels of funding, infrastructure (including buildings and facilities), support for children with special educational needs, ratio of staff to children, recruitment, support and training of preschool staff, and the nature of the preschool programme.

BOX 5.8: VILLAGE-BASED EARLY CHILD DEVELOPMENT CURRICULUM DEVELOPMENT IN THE LAO PEOPLE’S DEMOCRATIC REPUBLIC

The Women’s Development Project worked to promote various development initiatives for women in five Lao provinces. After 5 years, interest developed and a need was identified to address child development issues more directly. The Early Childhood and Family Development Project grew out of this. Project-planning workshops were organized in villages in the initial steps of development and implementation. Village-level planning resulted in agreement on needs and objectives, an understanding of overall design, assessments of resources and constraints, activity planning, setting up the project committee, and criteria for selecting village volunteers. The community-based curriculum-development process focused

on participatory input at the local level to create a curriculum that could be adapted to the particular needs of different ethnic groups. The process focused on village data collection and needs assessment. Analysis of existing traditional knowledge was used as a basis for curriculum development. One of the notable activities was a village engagement agreement signed by village members and the village development committee. It was based on a child rights framework and included actions that could be taken immediately while waiting for needed external assistance.

Source: ECDKN, 2007a

PROVISION AND SCOPE OF EDUCATION : ACTION AREA 5.2

Expand the provision and scope of education to include the principles of early child development (physical, social/emotional, and language/cognitive development).

BOX 5.9: UNESCO EDUCATION FOR ALL GOALS

Expand and improve early childcare and education.

Provide free and compulsory universal primary education by 2015.

Ensure equitable access to learning and life-skills programmes.

Achieve a 50% improvement in adult literacy rates.

Eliminate gender disparities in primary and secondary education by 2005 and at all levels by 2015.

Improve all aspects of the quality of education.

Source: UNESCO, 2007a

Quality primary and secondary education

There is emerging evidence that integrating social and emotional learning in curricula in primary and secondary schools as well as attention to the children's physical and cognitive/language development improves school attendance and educational attainment (CASEL, nd), and potentially would have consequent long-term gains for health. Social and emotional learning comes under the broad umbrella of life-skills education, which is incorporated into UNICEF's definition of quality education (UNICEF, nd,b). The Education for All goals include equitable access to 'life skills' as a basic learning need for young people, to be addressed either through formal education or non-formal settings (UNESCO, 2007a). The Commission endorses increased attention to life skills-based education in all countries as a way of supporting healthy behaviours and empowering young people to take control of their lives. UNICEF has highlighted the importance of life-skills education for HIV/AIDS prevention and a comprehensive approach to quality education that responds to learners' needs and is committed to gender equity (UNICEF, nd,c).

Making schools healthy for children is the basis for the FRESH (Focusing Resources on Effective School Health) Start approach (Partnership for Child Development, nd), a joint initiative by WHO, UNICEF, UNESCO, the World Bank, and other partners to coordinate action to make schools healthy for children and improve quality and equity in education, contributing to the development of child friendly schools (Box 5.11).

Innovative, context-specific, school-based interventions can be developed to tackle health challenges faced by young people. For example, in Australia the MindMatters programme (Curriculum Corporation, nd) has been developed to promote mental health in schools, and in the United States the Action for Healthy Kids programme addresses the growing obesity epidemic (Action for Healthy Kids, 2007). These programmes demonstrate how working across sectors and involving a range of both governmental and NGOs can address health

challenges in the school setting. Out-of-school programmes in non-formal settings can also be developed to achieve similar objectives using the same approach.

Barriers to education

The Commission recommends that:

- 5.4 Governments provide quality compulsory primary and secondary education for all boys and girls, regardless of ability to pay, identify and address the barriers to girls and boys enrolling and staying in school, and abolish user fees for primary school (see Rec 6.4; 13.4).**

Barriers to education include issues of access to education and quality and acceptability of education. In many countries, but particularly low-income countries, it is children from families on low incomes and with parents with little education who are less likely to attend school and more likely to drop out of school. Poverty relief and income-generating activities (discussed in Chapters 7 and 8: *Fair Employment and Decent Work; Social Protection across the Lifecourse*) together with measures to reduce family out-of-pocket expenditure on school attendance, school books, uniforms, and other expenses are critical elements of a comprehensive strategy to make access to quality education a reality for millions of children.

Other policies aimed at encouraging parents to send their children to school vary by country but include provision of free or subsidized school meals (Bajpai et al., 2005) and providing cash incentives conditional on school attendance, removal of school fees (Glewwe, Zhao & Binder, 2006), and provision of free deworming tablets or other health interventions, for example, the Malawi School Health Initiative (Pasha et al., 2003). Context-specific analyses are needed to identify barriers to education and to develop and evaluate policies that encourage parents to enrol and keep children in school.

BOX 5.10: COUNTRY APPROACHES TO PRE-PRIMARY EDUCATION

In Chile, the expansion of pre-primary education for socially disadvantaged children began by extending provision first for ages 5-6, then ages 4-5, then ages 3-4. The programme focuses on integrating quality education, care, nutrition, and social attention for the child and his or her family care (JUNJI, nd).

Expansion of preschool education in Sweden was achieved with a government commitment that preschool education should have an emphasis on play, children's natural learning strategies, and their comprehensive development. It was a policy goal to integrate this comprehensive approach to education into the entire education system (Choi, 2002).

BOX 5.11: CHILD FRIENDLY SCHOOLS

UNICEF has developed a framework for child friendly schools that takes a rights-based approach to education. Child friendly schools create a safe, healthy, gender-sensitive learning environment, with parent and community involvement, and provide

quality education and life skills. This model or similar models are now developed or being developed in more than 90 countries, and adapted as national quality standard in 54 countries.

Source: UNICEF, nd,d

Of note, there has been rapid expansion of primary education in low-income countries over recent years, a trend attributed, in part, to the abolition of school fees in a number of countries. As the Kenyan experience highlights (Box 5.12), abolishing primary school fees needs to be complemented by hiring and training teachers, building more schools and classrooms, and providing educational materials. Increased access to primary school needs to be accompanied by attention to quality of education. In addition, expansion of primary education will require investments in secondary education to increase capacity for the new entrants, assuming they reach secondary level. The transition from primary to secondary school is a critical point for girls and for gender equity (Grown, Gupta & Pande, 2005).

A major investment is required by national governments – allocating sufficient funds to school infrastructure development, the recruitment, training, and remuneration of staff, and the provision of educational materials. Supporting low- and middle-income countries to do this requires donor countries to fulfil their aid commitments (see Chapter 11: *Fair Financing*). The annual external financing requirement to meet the ‘Education for All’ goals is estimated to be about US\$ 11 billion per annum (UNESCO, 2007a).

Educating girls

There needs to be a particular effort in securing primary and secondary education for girls, especially in low-income countries (UNESCO, 2007a, Levine et al., 2008). Abolishing user fees for primary education is a critical step. In response to continued challenges to gender equity in education, Task Force 3 on Education and Gender Equality of the UN Millennium Project identified the need to strengthen opportunities for secondary education for girls while simultaneously meeting commitments to universal primary education as key to achieving MDG 3 – promote gender equality and empower women (Grown, Gupta & Pande, 2005).

Strategies for promoting secondary education for girls include increasing access and retention. Interventions to improve both the physical and social environment (Rihani, 2006) include building functional toilets/latrines for girls and female teachers and creating a safe environment for girls (WHO, 2005a) by

introducing and enforcing codes of conduct. Measures to improve the relevance and quality of schooling (Rihani, 2006) include teacher training and curriculum reform to reduce gender biases and introducing frameworks for participation of girls in decisions about their schooling. Other interventions include targeted scholarships for girls, such as the Bangladesh’s Female Secondary School Assistance Programme (WGEKN, 2007; SEKN, 2007), and programmes that address the needs of pregnant schoolgirls, such as the Botswana Diphilana Initiative (WGEKN, 2007).

Early childhood offers huge opportunities to reduce health inequities within a generation. The importance of early child development and education for health across the lifecourse provides a strong imperative to start acting now. Inaction will have detrimental effects that can last more than a lifetime. A new approach is needed that embraces a more comprehensive understanding of early child development and includes not just physical survival but also social/emotional and language/cognitive development. This approach should be integrated into lifelong learning.

BOX 5.12: KENYA – ABOLITION OF SCHOOL FEES

When Kenya abolished school fees in 2003, there was an immediate influx of 1.3 million children into the school system, overwhelming school infrastructure and teachers. School enrolments since 2002 increased

by 28% while the total number of teachers increased by only 2.6% between 2002 and 2004; in some areas the ratio rose to one teacher for 100 pupils.

Source: Chinyama, 2006

BOX 5.13: DEMAND FOR QUALITY EDUCATION, SUB-SAHARAN AFRICA

The total fertility rate in sub-Saharan Africa is 5.5 (UNDP, 2007); Niger and Uganda have particularly high fertility rates (Niger 7.4, Uganda 6.7). Nearly 44% of the total population of sub-Saharan Africa is under 15 years old, compared with approximately 18% in

high-income OECD countries. With so many children of school age, some countries in sub-Saharan Africa face particular challenges in ensuring high-quality education for all.

CHAPTER 6

Healthy places – healthy people

“Rapid and chaotic urbanisation is being accompanied by increasing inequalities which pose enormous challenges to human security and safety”

Anna Tibaijuka, Executive Director UN-HABITAT (UN-HABITAT, 2007b)

WHY PLACE MATTERS FOR HEALTH EQUITY

Where people live affects their health and chances of leading flourishing lives. Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment are essential for health equity.

The growth of urbanization

The year 2007 saw, for the first time, the majority of human beings living in urban settings (WorldWatch Institute, 2007), and almost 1 billion people living in life-threatening conditions in urban slums³ and informal settlements. By 2010 it is expected that 3.48 billion people worldwide will live in urban areas. The growth of the ‘megacity’, massive urban agglomerations of 10 million inhabitants and upwards, is an issue of importance for global health and health equity. But a very real challenge for the future is the growth of around 500 ‘smaller’ cities of 1–10 million people – cities that are characterized by outward sprawl.

The regions of the world with the fastest growing urban populations are also the regions with the highest proportion of slum dwellers (Table 6.1). Data from around 2003 show that almost half of all urban dwellers in developing regions live in slums, and this rises to four out of five urban dwellers in the poorest countries. But slums are not only a problem of low- and middle-income countries; 6% of urban dwellers in high-income regions live in slums.

In Nairobi, where 60% of the city’s population live in slums, child mortality in the slums is 2.5 times greater than that in other areas of the city.

In Manila’s slums, up to 39% of children aged between 5 and 9 are already infected with TB – twice the national average.

The push from rural to urban living

While urban living is now the dominant form globally, the balance of rural and urban dwelling varies enormously across areas – from less than 10% urban in Burundi and Uganda to 100% or close to it in Belgium, Kuwait, Hong Kong SAR,

and Singapore. Policies and investment patterns reflecting the urban-led growth paradigm (Vlahov et al., 2007) have seen rural communities worldwide, including Indigenous Peoples (Indigenous Health Group, 2007), suffer from progressive underinvestment in infrastructure and amenities, with disproportionate levels of poverty and poor living conditions (Ooi & Phua, 2007; Eastwood & Lipton, 2000), leading ultimately to out-migration to unfamiliar urban centres. This, combined with population growth and stagnant agricultural productivity, saw sub-Saharan Africa experience one of the highest rates of urban growth internationally between the 1960s and 1990s (140%), with rural-urban migration accounting for roughly half of this (Barrios et al., 2006). These major inequities, to the disadvantage of rural conditions, contribute to the stark health inequities between urban and rural dwellers in many low-income countries (Houweling et al., 2007).

Vulnerability in urban settings

Following the current trajectory of urban growth, city populations will age and there will be more urban sprawl and greater numbers of people living in poverty, slums, and squatter settlements (Campbell & Campbell, 2007). The proportion of the older adult population residing in cities in high-income countries matches that of younger age groups and will rise at the same pace. In low- and middle-income countries, however, the share of older people in urban communities will multiply 16 times from about 56 million in 1998 to over 908 million in 2050 (WHO, 2007d). Similarly, people with disabilities are vulnerable to health threats, particularly in urban areas due to the challenges of a high population density, crowding, unsuitable living design, and lack of social support (Frumkin et al., 2004).

“A warmer world with a more intense water cycle and rising sea levels will influence many key determinants of wealth and wellbeing, including water supply, food production, human health, availability of land, and the environment” (Stern, 2006)

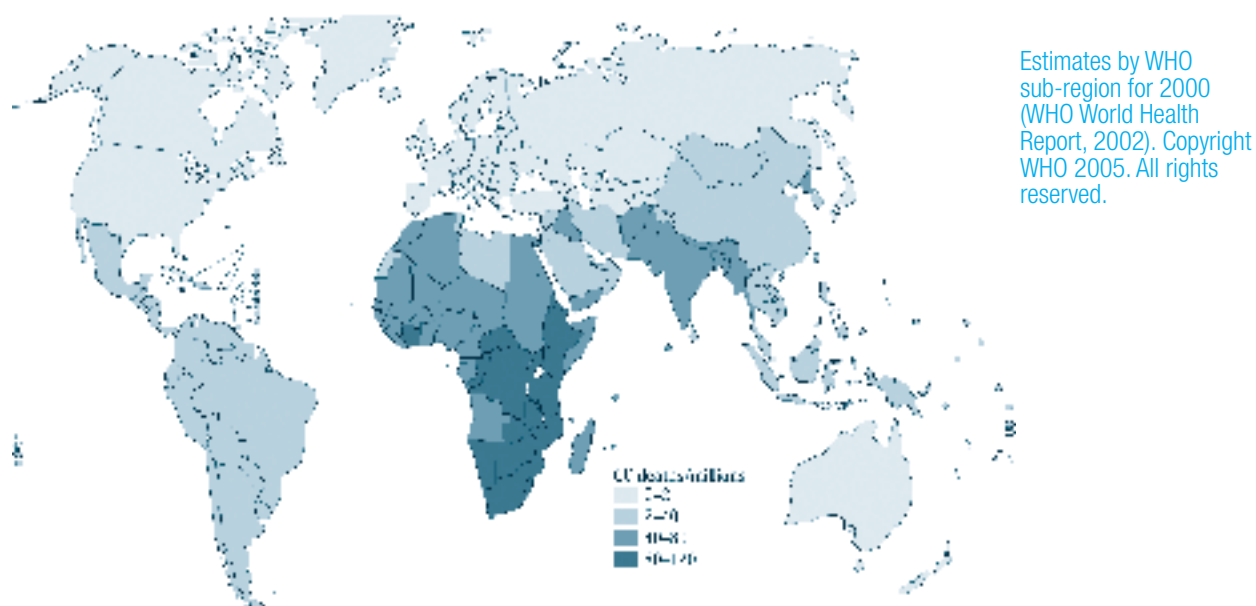
The current model of urbanization poses significant environmental challenges, particularly climate change – the impact of which is greater in low-income countries and among vulnerable subpopulations (McMichael et al., 2008; Stern, 2006) (Fig. 6.1). At present, greenhouse gas emissions are determined mainly by consumption patterns in cities of high-income countries. However, rapid development and concurrent urbanization in poorer regions means that low- and middle-income countries will be both vulnerable to health hazards from climate change and an increasing contributor to the problem (Campbell-Lendrum & Corvalan, 2007).

³ The general definition of slums used by UN-HABITAT denotes ‘a wide range of low-income settlements and/or poor human living conditions.’ These areas generally share four characteristics: buildings of poor quality; overcrowding (in, for instance, the number of persons per room); inadequate provision of infrastructure and services; and relatively low price. In many, there is a fifth characteristic – insecurity – because of some aspects of illegality (especially for squatters) or no legal protection for the inhabitants (those who rent).

Table 6.1: Urban and slum-dwelling households, circa 2003

	Total urban population (millions)	Urban populations as % of total population	Urban slum population (millions)	Slum population as % of total urban population
World	2923	47.7%	924	31.6%
Developed regions	902	75.5%	54	6.0%
Europe	534	73.6%	33	6.2%
Other	367	78.6%	21	5.7%
Developing regions	2022	40.9%	870	43.0%
Northern Africa	76	52.0%	21	28.2%
Sub-Saharan Africa	231	34.6%	166	71.9%
Latin America and the Caribbean	399	75.8%	128	31.9%
Eastern Asia	533	39.1%	194	36.4%
Eastern Asia excluding China	61	77.1%	16	25.4%
South-central Asia	452	30.0%	262	58.0%
South-East Asia	203	38.3%	57	28.0%
Western Asia	125	64.9%	41	33.1%
Oceania	2	26.7%	0	24.1%
Transition countries	259	62.9%	25	9.6%
Commonwealth of Independent States	181	64.1%	19	10.3%
Other Europe	77	60.3%	6	7.9%
Least developed countries	179	26.2%	140	78.2%

UN-HABITAT 2003 and other UN data: Reproduced from KNUS (2007).

Figure 6.1: Deaths from climate change.

Reprinted, with permission of the publisher, from WHO (2005e).

Transport and buildings contribute 21% to CO₂ emissions – a major contributor to climate change (IPCC, 2007). Rural agriculture poses a major challenge. Crop yields, which feed rural and urban dwellers alike, depend in large part on prevailing climate conditions. Worldwide, agricultural activity accounts for about one fifth of global greenhouse gas emissions (McMichael et al., 2007).

New urban health

Infectious diseases and undernutrition will continue in particular regions and groups around the world. However, urbanization itself is re-shaping population health problems, particularly among the urban poor, towards non-communicable diseases and injuries, alcohol- and substance-abuse, and impact from ecological disaster (Campbell & Campbell, 2007; Yusuf et al., 2001).

Obesity is one of the most challenging health concerns to have arisen in the past couple of decades. It is a pressing problem, particularly among socially disadvantaged groups in many cities throughout the world (Hawkes et al., 2007; Friel, Chopra & Satcher, 2007). The shift in population levels of weight towards obesity is related to the ‘nutrition transition’ – the increasing consumption of fats, sweeteners, energy-dense foods, and highly processed foods. This, together with marked reductions in energy expenditure, is believed to have contributed to the global obesity epidemic. The nutrition transition tends to begin in cities. This is due to a variety of factors including the greater availability, accessibility, and acceptability of bulk purchases, convenience foods, and ‘supersized’ portions (Dixon et al., 2007). Physical activity is strongly influenced by the design of cities through the density of residences, the mix of land uses, the degree to which streets are connected and the ability to walk from place to place, and the provision of and access to local public facilities and spaces for recreation and play. Each of these plus the increasing reliance on cars is an important

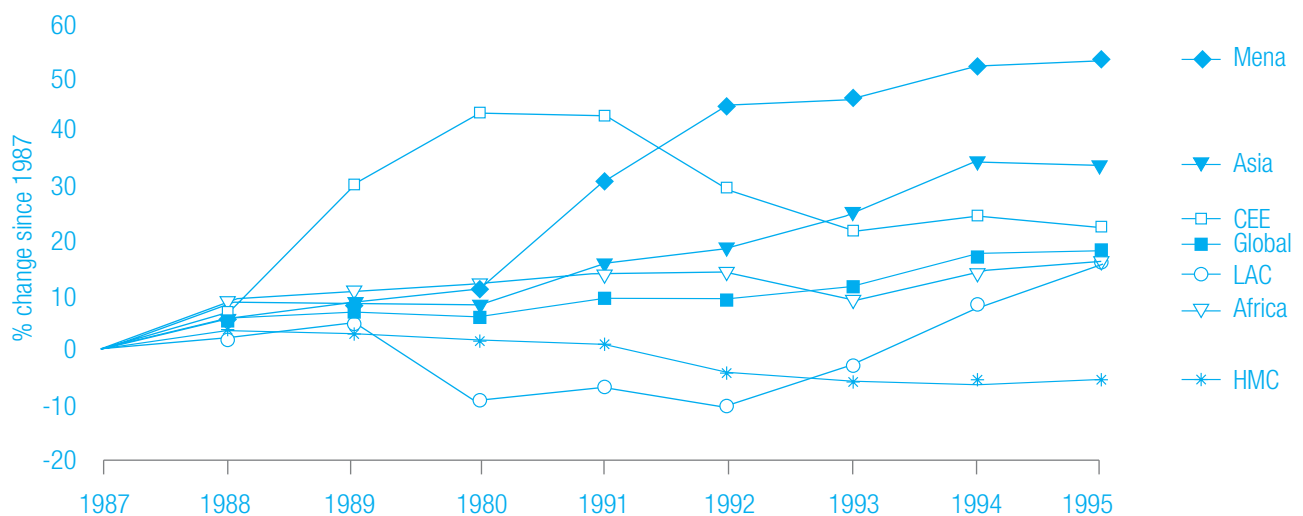
influence on shifts towards physical inactivity in high- and middle-income countries (Friel, Chopra & Satcher, 2007).

Violence and crime are major urban health challenges. Of the 1.6 million violence-related deaths worldwide (including those from conflict and suicide) that occur each year, 90% happen in low- and middle-income countries (WHO, 2002a). In the informal settlements of large cities, social exclusion and threat of violence are highly prevalent (Roberts & Meddings, 2007). In North American and European cities, and increasingly in the cities of other high-income countries, violence and crime have become concentrated problems in urban neighbourhoods, especially those with large-scale housing estates in suburbs. Alcohol is implicated in injury and violence in low-, middle-, and high-income countries – figures from WHO suggest that of the large number of deaths associated with alcohol globally, 32% are from unintentional injuries and 14% are from intentional injuries (Roberts & Meddings, 2007). The highest burden of alcohol-related disease in the world is in the region of the former Soviet Union and Central Asia, where it amounts to 13% of the total disease burden (PPHCKN, 2007b).

Urban areas are by far the most affected by road-traffic injuries and vehicle-related air pollution, with approximately 800 000 annual deaths from ambient urban air pollution and 1.2 million from road-traffic accidents (Roberts & Meddings, 2007; Prüss-Üstün & Corvalán, 2006). The decline in road-traffic deaths between 1987 and 1995 in highly motorized countries (Fig. 6.2) offers hope for other countries where motorization is on a steep upward slope – illustrating the positive effects of policy initiatives such as traffic planning, safer roads and cars, and safer driving due to, for example, compulsory and enforced seat-belt wearing and punishment for driving under the influence of alcohol.

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to depression and

Figure 6.2: Percentage changes in road-traffic deaths since 1987.



HMC = highly motorized countries: North America, Australia, New Zealand, Japan, and Western Europe; CEE = Central and Eastern Europe; LAC = Latin/Central America and the Caribbean; Mena = Middle East and North Africa.

Reprinted, with permission of the publisher, from Jacobs et al. (2000).

other common mental disorders, alcohol- and substance-use disorders, and psychoses (Prince et al., 2007). The burden of major depression is expected to rise to be the second leading cause of loss of disability-adjusted life years in 2030 and will pose a major urban health challenge.

These emerging health problems, in countries with different levels of infrastructure and health system preparedness, pose significant health equity challenges in the 21st century. Improvements over the last 50 years in mortality and morbidity in highly urbanized countries such as Japan, the Netherlands, Singapore, and Sweden, are testimony to the potential of modern cities to promote health. They also show that this is only achievable as long as there are supportive political structures, financial resources applied in an appropriate manner, and social policies that underpin the equitable provision of the conditions in which people are able to thrive (Galea & Vlahov, 2005).

ACTION TO BUILD A FLOURISHING LIVING ENVIRONMENT

If urbanization continues unabated along its current path, it will present humanity, within a generation, with social, health, and environmental challenges on a scale unprecedented in human history. There is urgent need for a new approach to urbanization and a new paradigm of urban public health, with action in three key areas:

- Within cities, new models of governance are required to plan cities that are designed in such a way that the physical, social, and natural environments prevent and ameliorate the new urban health risks, ensuring the equitable inclusion of all city dwellers in the processes by which urban policies are formed.
- Sustained investment in rural areas – making them viable places for flourishing living – must balance investment in cities in national development plans.
- Underpinning these areas of action is the development of adaptation and mitigation strategies for environmental change that take into account the social and health equity dimensions.

While the Commission did not consider rural health issues in detail, it recognizes the need for a sustainable development strategy based on balanced rural-urban growth. An overarching recommendation to this effect is made in this chapter. Similarly, climate change was outside the remit of the Commission, but there are clear opportunities for simultaneously improving health equity and cutting greenhouse gas emissions through action in the urban and rural sectors. A general recommendation in relation to climate change and health equity is made at the end of this chapter and picked up again in Part 6: *Building a Global Movement*.

Guiding urban development in a manner that places the well-being of all people and environmental sustainability at its core will require strategic participatory planning, including city,

county, and regional planning policy, embracing the dimensions of transport, housing, employment, social cohesion, and environmental protection.

The Commission recommends that:

- 6.1. Local government and civil society, backed by national government, establish local participatory governance mechanisms that enable communities and local government to partner in building healthier and safer cities (see Rec 14.3).**

Participatory urban governance

Despite the evidence of the importance of community participation in addressing urban living conditions (Box 6.1), the resources and control over decision-making processes often remain beyond the reach of people normally excluded at the local and community level.

‘Healthy Settings’ refers to places and social contexts that promote health. In particular, the Healthy Cities movement is an existing local governance model that may be adapted worldwide to promote health equity (WHO Healthy Cities, nd; Alliance for Healthy Cities, nd; PAHO, 2005). The Healthy Settings approach has been applied not only to cities but municipalities, villages, islands, marketplaces, schools, hospitals, prisons, restaurants, and public spaces. More recently, the Healthy Cities principles have been used to develop initiatives that recognize the shifting demographic towards an ageing population (The Age-Friendly Cities initiative). At its best, the Healthy Cities model provides a ‘neutral game board’ where all parties in a city can come together to negotiate healthy outcomes in relation to a diverse range of city activities including planning, housing, environmental protection, style of health services, and responses to issues such as injury prevention and drug and alcohol control. Some evaluation and assessment of Healthy Settings has been conducted at city and regional levels, but there has been no systematic review at the global level. It is important that researchers and government evaluate, where possible, the health equity impacts of Healthy Cities/Settings type programmes, formal or otherwise, in order to build evidence for relevant and effective local government actions.

Improving urban living conditions

Applying healthy urban design principles, a city would be designed for a dense, residentially mixed population with easy access to services, including designated commercial and non-commercial land use, with land also set aside for protection of natural resources and recreation. Such an urban development agenda also considers the supply of basic amenities and sufficiently developed infrastructure (Devernman, 2007). Low- and middle-income countries are not likely, in the near future, to be able to provide all the funds needed to create an entirely healthy living environment. Funding from more affluent countries will be required to support the plans made by peoples and governments in less affluent countries (Sachs, 2005).

HEALTH AND EQUITY : ACTION AREA 6.1

Place health and health equity at the heart of urban governance and planning.

Shelter/housing

One of the biggest challenges facing cities is access to adequate shelter for all. Not only is the provision of shelter essential, but the quality of the shelter and the services associated with it, such as water and sanitation, are also vital contributors to health (Shaw, 2004).

The Commission recommends that:

- 6.2. National and local government, in collaboration with civil society, manage urban development to ensure greater availability of affordable quality housing. With support from UN-HABITAT where necessary, invest in urban slum upgrading including, as a priority, provision of water and sanitation, electricity, and paved streets for all households regardless of ability to pay (see Rec 15.2).**

Many cities in rich and poor countries alike are facing a crisis in the availability of, and access to, affordable quality housing. This crisis will worsen social inequities in general, and in health in particular. In the United States, for example, inequities are being exacerbated by neighbourhoods that have adopted low-density-only zoning as a way to control growth. These have become more exclusionary, leading to fewer African American and Hispanic residents (NNC, 2001).

It is important therefore that local government regulates land development for urban regeneration, ensuring reserved urban land for low-income housing. Creating more equitable housing development means reversing the effects of exclusionary zoning through regional fair-share housing programmes, inclusionary zoning, and enforcement of fair housing laws. Taking an integrated approach, local authorities could use criteria for distribution of affordable housing tax credits to stimulate production of new affordable housing in proximity to transit, schools, and commercial areas (Box 6.2) (NNC, 2001).

There is a role for local government to monitor the health and health-equity impacts of housing, building, and infrastructure standards. Domestic energy inefficiencies and related fuel poverty⁴ have a number of effects on health and are very socially patterned (Box 6.3). It is shocking that in an economically rich country such as the Republic of Ireland, a remarkable 17% of households are fuel poor (Healy, 2004).

The situation for slum dwellers needs immediate attention. The improvement of slums is a huge investment but is nevertheless affordable in most countries (Mitlin, 2007). The central goal of UN-HABITAT, under the Economic and Social Council, is to promote socially and environmentally sustainable towns and cities with the goal of providing adequate shelter for all (UN-HABITAT, 2007a). An integrated strategic plan between UN-HABITAT and WHO would provide the mandate and

BOX 6.1: IMPROVING LIVING CONDITIONS AND SECURING TENURE IN THAILAND

Approximately 62% of Thailand's slum population lives in Bangkok and 1.6 million (20%) of Bangkok's population lives in slums. Nine communities along the Bangbua canal in north Bangkok initiated a slum upgrade project in the wake of a threatened eviction due to a proposed highway construction project. Through public hearings, it was decided that the communities wanted to negotiate legal tenure and upgrade the communities. The communities worked with a governmental agency, the Community Organization Development Institute (CODI), and an NGO, the Chumthonthai Foundation, both of which work within the national Baan Man Kong (secure tenure) housing programme, in addition to the Treasury Department, district offices, and local universities.

This project required action on two levels. The operations level was primarily led by the community. A working group was established to coordinate the project overall. This working group conducted workshops and action planning with each community to develop the housing scheme and master plan with the community. A network committee linked the nine communities and encouraged participation. Individual community committees communicated with community members and gathered information for planning and implementation. A community savings group encouraged participation in a savings scheme

that was transparent and included a community-auditing system. The policy level was primarily led by governmental agencies. CODI provided loans for urban poor housing and worked with other concerned institutions on land tenure, capacity building, housing design, and housing construction. The Treasury Department was the landlord and landowner and had provided 30-year leases to the participating communities. The local district office provided building permissions and coordinated with higher government authorities. The local university provided technical and support staff with knowledge about improving the physical and social environment.

Housing units have been built in the pilot community and construction began in January 2006 in three other communities. Several lessons have been learned from the Bangbua experience. At the institutional level, there is recognition of the need for community participation through community networks. At the community level, the network demonstrated the ability to engage the community in housing development, to build community capacity, and to assure other stakeholders of the communities' commitment to housing development, which in turn moved the process of securing land tenure forward.

Source: KNUS, 2007

⁴ Fuel poverty is defined here as the inability to heat one's home to an adequate (i.e. comfortable and safe) temperature, owing to low household income and low household energy efficiency.

technical support for many low- and middle-income countries worldwide to tackle these urban issues and, in doing so, help work towards the MDGs (see Chapter 15: *Good Global Governance*).

Based on previous estimates (Garau et al., 2005), global slum upgrading would cost less than US\$ 100 billion. A ‘Marshall plan for the world’s urban slums’ could be financed on a shared basis, for instance by international agencies and donors (45%), national and local governments (45%), and concerned households themselves (10%), in the latter case helped by micro-credit schemes.

“A slum dweller in Nairobi or Dar es Salaam, forced to rely on private water vendors, pays 5 to 7 times more for a liter of water than an average North American citizen” (Tibaijuka, 2004)

Enabling slum upgrading will require the political recognition of informal settlements, supported by regularization of tenure in slum settlements in order to allow official (public or private) utilities to extend infrastructure and services there (Box 6.5). Such action will help to empower women and improve their health by increasing access to basic resources such as water and sanitation (WGEKN, 2007).

BOX 6.2: CALIFORNIA TAX CREDIT PROGRAMME

In June 2000, the state of California reformed its tax credit programme for affordable rental housing. The new programme establishes a point system that prioritizes projects meeting sustainable development

goals (such as walking distance to transit and schools) and projects in neighbourhoods where housing is an integrated part of a comprehensive revitalization effort.

Source: NNC, 2001

BOX 6.3: SOUTH COAST OF ENGLAND: A RANDOMIZED TRIAL OF HOUSING UPGRADING AND HEALTH

Although outwardly affluent, the city of Torquay in the south of England has pockets of deprivation. Watcombe is an estate of former council-owned properties with much higher levels of deprivation than the regional average and the highest out-of-hours visiting rate by family doctors in the town – 15% above the town average. Half the estate population was receiving benefits and 45% of children under 5 years old were living in single-parent households. A randomized-to-waiting list design was agreed with residents and the Council. The intervention comprised upgrading houses (including central heating, ventilation, rewiring, insulation, and re-roofing) in two phases, a year apart.

Evaluation of the intervention was positive. The interventions succeeded in producing warmer, drier houses that were more energy efficient as measured by changes in the indoor environment and energy rating of the house. Residents appreciated the improvements and felt their health and well-being had improved as a result. Greater use of the whole house, improved relationships within families, and a greater sense of self-esteem were all mentioned as benefits. For those living in intervention houses, non-asthma-related chest problems and the combined asthma symptom score for adults diminished significantly compared with those living in control houses.

Source: Barton et al., 2007

BOX 6.4: SLUM UPGRADING IN INDIA

Slum upgrading, providing the conditions necessary for a decent quality of life for the urban poor in Ahmadabad, India, cost only US\$ 500/household. This included community contributions of US\$ 50/household. Following the investment in these

slums, there was improvement in the health of the community, with a decline in waterborne diseases, children started going to school, and women were able to take paid work, no longer having to stand in long lines to collect water.

Air quality and environmental degradation

A significant urban health issue is the pollution generated from the increased use of motorized transport. Pollution from transport contributes to total air pollution, which is estimated to be responsible for 1.4% of all deaths worldwide (WHO, 2002b). Transport accounts for 70–80% of total emissions in cities in low- and middle-income countries and this is increasing (Schirnding, 2002). There is a vicious cycle of growing car dependence, land-use change to facilitate car use, and increased inconvenience of non-motorized modes, leading to further rises in car ownership, with its knock-on effects on air quality, greenhouse gas emissions, and physical inactivity (NHE, 2007).

In order to address what is becoming a public health disaster, it is important that national and local government, with private sector collaboration, control air pollution and greenhouse gas emissions from vehicles, primarily through investment in improved technology, improved mass transport systems, and congestion charges on private transport use. For example, experiences from London (Box 6.6), Stockholm, and Singapore show that introduction of congestion charges has an immediate impact on the volume of car traffic, and subsequently on air pollution.

Urban planning and design that promotes healthy behaviours and safety

The nature of the urban environment has a major impact on health equity through its influence on behaviour and safety. Indeed, many of the risks for the urban health trajectory that is escalating towards non-communicable diseases and injuries are behaviour related. This chapter concentrates primarily on the role of urban design in relation to physical activity, diet, and violence. Clearly, the nature of different places and settings is also very influential on other behaviours such as smoking and alcohol consumption. Recommendations relating to the regulatory control of alcohol and tobacco are described in Chapter 12: Market Responsibility.

The Commission recommends that:

- 6.3. Local government and civil society plan and design urban areas to promote physical activity through investment in active transport; encourage healthy eating through retail planning to manage the availability of and access to food; and reduce violence and crime through good environmental design and regulatory controls, including control of the number of alcohol outlets (see Rec 12.3).**

BOX 6.5: CITY-WIDE UPGRADING IN THE UNITED REPUBLIC OF TANZANIA

In 1972, the United Republic of Tanzania Government recognized the importance of slums in shelter delivery and subsequently endorsed Cabinet Papers 81 and 106 on National Urban Housing Policy and Squatter Improvement Schemes, respectively. These initiatives paved the way for the World Bank-funded Sites and Services and Squatter Upgrading projects of the early 1970s.

In the United Republic of Tanzania, except for slum dwellers who live on hazardous lands, compensation is paid if permanent properties are demolished. Besides compensation, the 1995 Land Policy and the subsequent 1999 Land Act provide room for the regularization of slums. Land in the United Republic of Tanzania is owned by the government and is issued under leasehold. Recently, the Ministry of Lands and Human Settlements Development embarked on a project to formalize properties in selected slums by issuing housing/property licences for two years. In parallel to this, the Property and Business Formalization Programme is under way. The two projects are aimed at reducing urban poverty. This needs to be seen in the broad framework of the National Strategy for Growth and Reduction of Poverty, which is organized in three clusters: 1) growth and reduction of income poverty, 2) good governance and accountability, and 3) improved quality of life and social well-being.

Residents of 2 out of 17 wards of Arusha City in the north part of the United Republic of Tanzania were selected to pilot the Cities Without Slums Arusha initiative. The two wards registered 20 Community Development Committees (CDCs). Subsequently, the CDCs identified the key environmental issues affecting their areas – those that they could solve themselves with minimal assistance from the government (e.g. plot subdivision and issuance of land titles, solid waste management, social services improvement) and those that needed technical and financial assistance from the city authority such as water supply and major roads. While the CDCs were prioritizing environmental problems and identifying the resources within their reach, they also elected members (from among their leaders) to represent them in restructured City Council upgrading organs, which included two ward planning committees, the Municipal Team, and the Project Steering Committee. The CDCs and these committees were specifically incorporated into the traditional set-up of the local government administrative structure in order to broaden community participation at grassroots level and improve good governance.

The Arusha City Council has started to upgrade some of the identified major roads using its own resources, particularly the road fund. The project cost for the two wards (with a population of 60 993) is estimated to be US\$ 19 141 (approximately US\$ 32/person).

Source: Sheuya et al., 2007

Planning tools to develop the local environment for health purposes are beginning to emerge internationally and provide guiding principles that may be adapted elsewhere (Box 6.7).

Diet and physical activity

Addressing the escalating problem of obesity in rich and poor countries alike cannot be left to market forces, but requires national and local government intersectoral approaches involving agriculture, urban planning, health, and sustainable

development sectors. It is important that urban planning prioritizes cycling and walking and provides affordable and convenient mass transport and design spaces for recreation and play – in all neighbourhoods – while paying careful attention to the implications for violence and crime reduction. As highlighted in the recent United Kingdom Building Health report (NHF, 2007), a key mechanism to achieve this is through transport ministries requiring local authorities not only to adopt the policy of prioritizing pedestrians and cyclists in their

BOX 6.6: THE LONDON CONGESTION CHARGE (LCC) SCHEME

The primary objective of the LCC was to address the ever-increasing congestion problem that was hampering business and damaging London's status as a world city. A major strength of the LCC is its long-term incremental nature. The LCC area was widened and the cost level raised 2.5 years after its implementation. This is fundamental to a behaviour-change programme, as it means that the public can take decisions about their future behaviour based on a firm expectation that the balance of financial advantage will continue to move away from the car.

Key outcomes were:

Between 35 000 and 40 000 car trips/day switched to public transport, creating an average 6 minutes' additional physical activity per trip compared with private motor transport.

Between 5000 and 10 000 car trips switched to walking, cycling, motorcycle, taxi, or car share.

Cycling mileage within the zone rose by 28% in 2003 and by a further 4% in 2004.

Survey respondents reported improvement in comfort and overall quality of walking and public transport systems.

A large portion of the scheme revenues were reinvested in improvements in public transport, walking, cycling, and safe routes to schools.

Source: NHF, 2007

BOX 6.7: HEALTHY BY DESIGN, MELBOURNE, AUSTRALIA: AN INNOVATIVE PLANNING TOOL FOR THE DEVELOPMENT OF SAFE, ACCESSIBLE, AND ATTRACTIVE ENVIRONMENTS

The Heart Foundation in Victoria, Australia, developed Healthy by Design to assist local government and associated planners in the implementation of a broader set of Supportive Environments for Physical Activity guidelines.

Healthy by Design presents design considerations that facilitate 'healthy planning', resulting in healthy places for people to live, work, and visit. Healthy by Design provides planners with supporting research, a range of design considerations to promote walking, cycling, and public transport use, a practical design tool, and case studies. The 'Design Considerations' demonstrate ways planners can improve the health of communities through their planning and design. This is encouraged by providing:

well-planned networks of walking and cycling routes;

streets with direct, safe, and convenient access;

local destinations within walking distance of homes;

accessible open spaces for recreation and leisure;

conveniently located public transport stops;

local neighbourhoods fostering community spirit.

Traditionally, planners consider a range of guidelines that have an impact on health, safety, and access, often in isolation from each other. The Healthy by Design matrix has been developed as a practical tool that demonstrates the synergies between the different guidelines that influence built environment design, all of which contribute to positive health outcomes.

Source: KNUS, 2007

transport policy, supported perhaps by a motorized vehicle congestion charge (as described above), but also to produce an assessment of whether they have delivered that aspect of the policy as part of their annual plan.

There are a small number of examples of local planning policy that considers community-based and small-scale-retailer-oriented solutions to the problems of equitable access to healthy food. The city of Sam Chuk in Thailand restored its major food and small goods market with the assistance of local ISA that included architects. The markets are now designed not only to provide greater availability of foodstuffs, but also to be more welcoming and accessible to city residents. The London Development Agency plans to establish a sustainable food distribution hub to supply independent food retailers, restaurants, and city-based institutions (Dixon et al., 2007). One regulatory action that local government can effectively adopt in order to reduce access to foods high in fats and salt is the utilization, or strengthening, of planning regulations to manage the proliferation of fast food outlets in particular areas, for example, near schools and in socially disadvantaged neighbourhoods.

Undernutrition often sits alongside obesity among the urban poor. It is necessary to establish food security policies and programmes supported by national and/or local government and civil society actors (Box 6.8).

Violence and crime

Ensuring that all groups in society live in safety and are secure from crime and violence poses a major societal challenge. Reducing the prevalence of violent behaviour involves integrated strategies that target key domains for violence prevention such as nurturing and safe relationships between children and parents; reducing violence in the home; reducing access to alcohol, drugs, and lethal means (Villaveces et al., 2000); enhancing the life skills and opportunities of children and youth; and improving criminal justice and social welfare

systems (WHO, 2008c). Newer approaches to violence prevention include regulatory control – including alcohol sales designed so that harmful drinking is reduced (Voas et al., 2006) – conflict transformation, crime prevention through environmental design, and community-based approaches to social capital (WHO, 2007e; Roberts & Meddings, 2007).

The Commission points to the need for national and local government to invest in street lighting, early closing of nightclubs and bars, gun control, establishment of neighbourhood watch initiatives, and educational and recreational activities (including job training opportunities). The WHO Safe Communities programmes concerned with injury reduction (http://www.phs.ki.se/csp/index_en.htm) have been utilized with some success in various cities throughout the world. It is recommended that these be adapted in different contexts and monitored for their effectiveness for health equity.

The Brazilian example (Box 6.9) illustrates the need for integrated efforts, attentive to both national and local specificities. A continuous dialogue with civil society and authorities at different levels was a precondition for the success of this initiative. The provision of financial support by local government to local communities to develop and deliver crime-prevention and dispute-resolution services will go a long way to help rebuild trust and social capital within communities and between communities and local authorities.

Helping to counter nationally inequitable consequences of urban growth requires sustained investment in rural development. Governments, national and local, are more likely to meet these rural challenges if the challenges are integrated into the broader context of economic and social policies aimed at development and poverty reduction; these policies should be included in documents such as the PRSP.

BOX 6.8: THE NAIROBI AND ENVIRONS FOOD SECURITY, AGRICULTURE AND LIVESTOCK FORUM (NEFSALF)

Achieving food security is imperative in poor urban settings. To eradicate the problem of food insecurity, there is a need to focus on the development of policies covering enhanced productivity, increased levels of employment, and improved access to food and the market. The importance of urban and peri-urban agriculture and livestock keeping in sustaining the urban poor as well as social, economic, and recreational values is being recognized and appreciated globally. NEFSALF, initiated in January

2004, represents a mix of actors from the community, government, and market sectors whose aim is to promote urban and peri-urban agriculture. The forum provides access to an elementary training course on urban agriculture and livestock keeping. Farmers are trained in farming as a business, group dynamics, basic skills in crop and animal husbandry, and environmental management.

Source: KNUS, 2007

HEALTH AND EQUITY : ACTION AREA 6.2

Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes.

The Commission recommends that:

- 6.4. National and local government develop and implement policies and programmes that focus on: issues of rural land tenure and rights; year-round rural job opportunities; agricultural development and fairness in international trade arrangements; rural infrastructure including health, education, roads, and services; and policies that protect the health of rural-to-urban migrants (see Rec 5.4; 9.3).**

Land rights

For most of the poor in low- and middle-income countries, land is the primary means of generating a livelihood. Redistributive land reform has positive impacts on poverty reduction and employment (Quan, 1997). An important advance in favour of gender equity, in countries such as Brazil, Colombia, Costa Rica, the Dominican Republic, Guatemala,

Honduras, and Nicaragua, has been legislation that contains provisions for the mandatory joint adjudication and titling of land to couples and/or that give priority to female household heads or specific groups of women (Deere & Leon, 2003). It is critical that national and local governments, in collaboration with international agencies, enhance and enforce processes of land tenure and land rights claims for rural communities, particularly focusing on marginalized and landless groups.

Rural livelihoods

Wider investment in agriculture, support, and services is needed to ensure viable rural communities (Montgomery et al., 2004). Lessons from the Green Revolution highlight the need for a multifaceted approach to sustainable agriculture and livelihood support. These issues have been reflected in recent recommendations from the Indian farmers representative body (Box 6.10). A central element of a comprehensive approach to rural health equity is an increase in rural household income,

BOX 6.9: COMMUNITY MOBILIZATION AGAINST VIOLENCE IN BRAZIL

Brazil has one of the highest homicide rates in the world. Between 1980 and 2002, the national homicide rate more than doubled, from 11.4 to 28.4 per 100 000 population. In São Paulo city, the homicide rate more than tripled during the same period, from 17.5 to 53.9 per 100 000 population. Jardim Angela is a conglomerate of slums located in the southern region of São Paulo city, with about 250 000 inhabitants. In July 1996, Brazil's *Veja* magazine reported an average homicide rate of 111 per 100 000 population, ranking this region as one of the most violent in the world. Jardim Angela was experiencing what has been termed the urban penalty, which was characterized in this case by structural violence, mistrust, and lack of social cohesion.

In 1996, a community integrated effort of 200 institutions called Fórum de Defesa da Vida (Life Defense Forum) was created. Parallel to the creation of this alliance, a social protection network involving civil society was organized, capitalizing on community capacity, social movements, and formal and informal health and social services. This network engaged in a broad range of community interventions ranging from

providing assistance to recently incarcerated children to a collective initiative for rebuilding community spaces. As a result of the investment in community space, abandoned spaces such as squares, clubs, and schools were rebuilt, providing space for sports, complementary school activities, and alcohol- and drug-abuse programmes. The community and police also established a coalition aimed at securing community welfare through surveillance of violence, criminality, and drug traffic. A range of policies and services were also implemented with community input including closing times for bars, a programme for victims of domestic violence, and health promotion interventions aimed at reducing teen pregnancy.

In 2005, the homicide rate for the City and State of São Paulo was 24 per 100 000 population and 18 per 100 000 population, respectively, reflecting a 51% reduction in homicide for the State. More recently, from January to July 2006, Jardim Angela experienced a more than 50% reduction in reports of muggings, assaults, pick pocketing, and car thefts compared with previous years.

Source: KNUS, 2007

BOX 6.10: INDIA – SUSTAINABLE AGRICULTURE

The Indian National Commission on Farmers and others have outlined an agriculture renewal programme that consists of the following five integrated and reinforcing action plans: soil health enhancement; irrigation water supply augmentation and demand management; credit and insurance; technology (bridging the know-how-do-how gap); and farmer-friendly markets. Overseeing the agriculture renewal programme could be an Indian Trade

Organization to complement and challenge the World Trade Organization (WTO). An underlying principle of such an organization would be the recognition of the need to ensure support for livelihood saving and balanced support for commodities that can be considered trade distorting in the global market and damaging to health and health equity.

Source: Swaminathan, 2006

with particular focus on adequate household nutrition, through strengthened support to agricultural development and rural on- and off-farm job creation. In doing so, it is important to ensure that local agriculture is not threatened by international trade agreements and agriculture protection in rich countries (World Bank, 2008) (see Chapter 12: *Market Responsibility*).

While safe, secure, year-round work is by far the preferred option to help lift rural dwellers out of poverty, micro-credit schemes, as a short-term measure, can empower impoverished groups. The Bangladesh example (Box 6.11) highlights how an integrated approach decreased levels of poverty by 30% in three years.

Poverty and hunger in poor rural populations are inextricably linked. Addressing widespread hunger and food security in rural populations cannot be done without linking it with work security and social security. This link has been well recognized by Indian policy-makers who have designed Food-for-Work and Employment Guarantee schemes with a food security component (Dreze, 2003); in Ghana where food for education initiatives are being expanded to help develop the

local agricultural economy (SIGN, 2006); and through the Millennium Villages Project, which uses an integrated approach to tackle the social determinants of health in African villages (Millennium Villages Project, nd).

Rural infrastructure and services

The provision of infrastructure and access to quality and culturally acceptable services are major health issues for rural dwellers. Progress towards MDG 3 will be made by addressing these issues through the improvement of rural women's access to time-saving technologies, particularly access to water. Redressing the urban bias in infrastructure and services investment requires investment in the rural sector to provide: quality compulsory primary and secondary school education regardless of ability to pay (see Chapter 5: *Equity from the Start*); electricity; comprehensive primary health care (see Chapter 9: *Universal Health Care*); usable roads and accessible public transport; and access to modern electronic communication. The example from Thailand (Box 6.12) illustrates government commitment to rural health through budget allocation and regionally appropriate service development.

BOX 6.11: BANGLADESH RURAL ADVANCEMENT COMMITTEE (BRAC) AND MICRO-CREDIT

With funding from the Canadian International Development Agency (CIDA), United Kingdom Department for International Development (DFID), EU, NOVIB (the Dutch affiliate of Oxfam), and WFP, the BRAC is undertaking a multi-dimensional social and economic development project focusing on the ultra-poor – typically people who are too poor to participate in micro-finance initiatives. Launched in 2002, this project provides income-generation skills training, access to health services, a monthly stipend (US\$ 0.17/day) for subsistence, social development training to promote greater awareness of rights and social justice issues, and mobilization of local elites for programme support. Evaluation found that 55% of the 5000 poorest households from the poorest districts

in the country were able to gain sufficient resources to benefit from joining a micro-credit programme. The proportion of people in these areas living on less than US\$ 1/day decreased from 89% to 59% during the first three years of the project and chronic food deficit fell from 60% to around 15% for project households. Factors contributing to the success of this project include: work with local elite to create an enabling environment for the programme; the provision of health education and identity cards to facilitate access to local health facilities; the provision of training and refresher training for income-generating skills; and the installation of latrines and tube-wells to improve sanitation.

Source: Schurmann, 2007

BOX 6.12: THAI RURAL HEALTH SERVICES

Since 1983, the Thai government health budget allocation to rural district hospitals and health centres has been greater than that given to urban hospitals. As a result, there was extensive geographical coverage of health services to the most peripheral level. Today, a typical health centre and district hospital cover populations of 5000 and 50 000, respectively. Health centres are staffed by a team of 3-5 nurses and paramedics, while a 30-bed district hospital is staffed by 3-4 general physicians, 30 nurses, 2-3 pharmacists, a dentist, and other paramedics – acceptable numbers of qualified staff to provide health services. In addition,

there were integrations of public health programmes (prevention, disease control, and health promotion) at all levels of care. As all public health and medicine graduates are produced by publicly funded medical colleges, students are heavily subsidized by the government. In return, mandatory rural service by new graduates, notably at district hospitals, is enforced. This plays a significant role in the functioning of district hospitals. The programme started with medical graduates in 1972; it later extended to other groups including nurses, dentists, and pharmacists.

Source: HSKN, 2007

Rural-urban migration

Displacement from rural areas, either forced through war and conflict or due to continual lack of rural resources, has resulted in rural-urban migration on a massive scale. For example, more than 40 years of armed conflict has given Colombia the largest number of displaced people in the western hemisphere (UNHCR, 2007) and the second highest proportion of displaced people after Sudan (IDMC, 2007). Consequently, a massive health burden is imposed on these populations. It is important therefore that national and local governments, in collaboration with international agencies, establish supportive policies for rural-urban migrants, ensuring maintained rights of access to essential services such as education and health.

Successful policies need to place services within reach of migrant populations. For example, the use of outreach clinics can ensure the provision of health services in areas where internal migrants are found (IOM, 2006). However, for this to be effective, migrants must be aware of the services available to them. Governments should therefore promote these services to internal migrants through advertisements in migrants' languages and by adapting their practices – most notably their opening hours and providing training for staff in multicultural health-care delivery – to meet the needs of the particular ethnic communities (Ingleby et al., 2005).

The natural environment

The disruption and depletion of natural environmental systems, including the climate system, and the task of reducing health inequities around the world go hand in hand. Ecological damage is affecting the lives of everyone in society but it has the greatest impact on the most vulnerable groups, including Indigenous Peoples who are now surviving in fragile ecologies due to unsustainable deforestation and intensive exploration for minerals and other resource-based industries (Indigenous Health Group, 2007). It is critical that the erosion of natural resources through further environmental degradation is stopped. In particular, there is an urgent need to reduce greenhouse gas emissions (McMichael et al., 2008). Highly related to the areas of action in this report is the development of adaptation and mitigation strategies for environmental change that take into account the social and health equity dimensions. There is still a need for much research into the type of action most likely to affect the triangulated relationships between social factors, environmental change, and health equity.

To begin with, the Commission recommends that:

- 6.5. International agencies and national governments, building on the Intergovernmental Panel on Climate Change recommendations, consider the health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change.**

As noted earlier, the detailed consideration and analysis of specific policy options and development models to counter climate change was outside the remit of the Commission. The call, from the Stern Report (Stern, 2006) and others, has been for international funding to support improved regional information on climate change impacts. This offers a unique opportunity, led by WHO, to integrate the climate change and health equity agendas, ensuring information systems and policy development go through a health equity filter.

HEALTH AND EQUITY : ACTION AREA 6.3

Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity.

CHAPTER 7

Fair employment and decent work

“it is an absurdity to call a country civilized in which a decent and industrious man, laboriously mastering a trade which is valuable and necessary to the common weal, has no assurance that it will sustain him while he stands ready to practice it, or keep him out of the poorhouse when illness or age makes him idle”

HL Mencken (nd)

THE RELATIONSHIP BETWEEN WORK AND HEALTH INEQUITIES

Employment and working conditions have powerful effects on health and health equity. When these are good they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards – each important for health (Marmot & Wilkinson, 2006). In addition to the direct health consequences of tackling work-related inequities, the health equity impacts will be even greater due to work’s potential role in reducing gender, ethnic, racial, and other social inequities. This has major implications for the achievement of MDG 3.

Work and health inequities

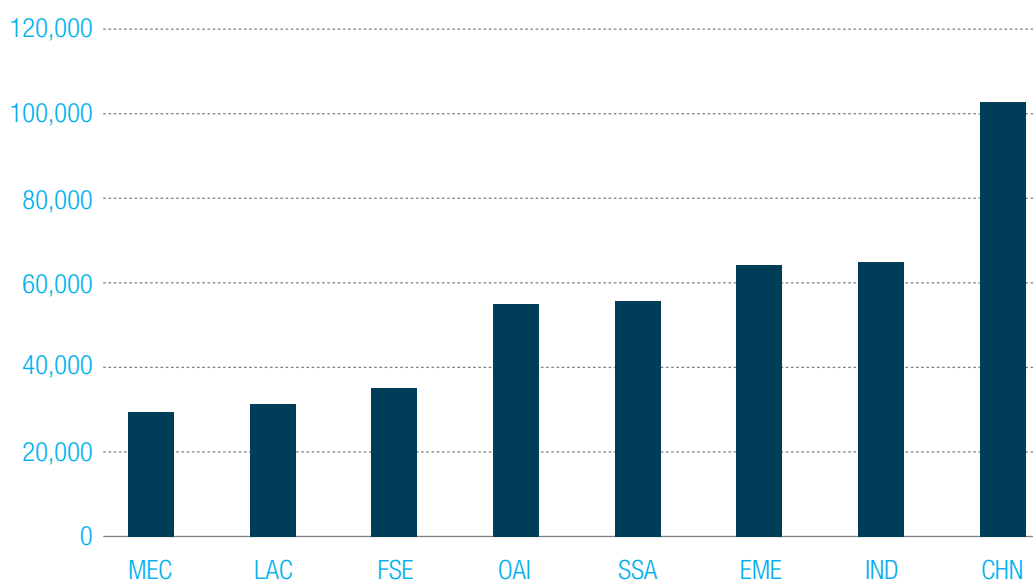
Employment conditions

A number of employment-related conditions are associated with poorer health status, including unemployment and precarious work – such as informal work, temporary work, contract work, child labour, and slavery/bonded labour. Evidence indicates that mortality is significantly higher among temporary workers compared to permanent workers (Kivimäki et al., 2003). Poor mental health outcomes are associated with precarious employment (e.g. informal work, non-fixed term temporary contracts, and part-time work) (Artazcoz et al., 2005; Kim et al., 2006). Workers who perceive work insecurity experience significant adverse effects on their physical and mental health (Ferrie et al., 2002).

Working conditions

The conditions of work also affect health and health equity. Poor work quality may affect mental health almost as much as loss of work (Bartley, 2005; Muntaner et al., 1995; Strazdins et al., 2007). Adverse conditions that expose individuals to a range of health hazards tend to cluster in lower-status occupations. Work-related fatalities through hazardous exposures remain an extremely serious problem (ILO, 2005) (Fig. 7.1). Stress at work is associated with a 50% excess risk of coronary heart disease (Marmot, 2004; Kivimäki et al., 2006), and there is consistent

Figure 7.1: Number of deaths from workplace exposure to dangerous substances in different countries and regions.



MEC = Middle East Crescent; LAC = Latin America and the Caribbean; FSE = Formerly Socialist Economies; OAI = Other Asia and Islands; SSA = sub-Saharan Africa; EME = Established Market Economies; IND = India; CHN = China. Reprinted, with permission of the author, from ILO (2005).

evidence that high job demand, low control, and effort-reward imbalance are risk factors for mental and physical health problems (Stansfeld & Candy, 2006).

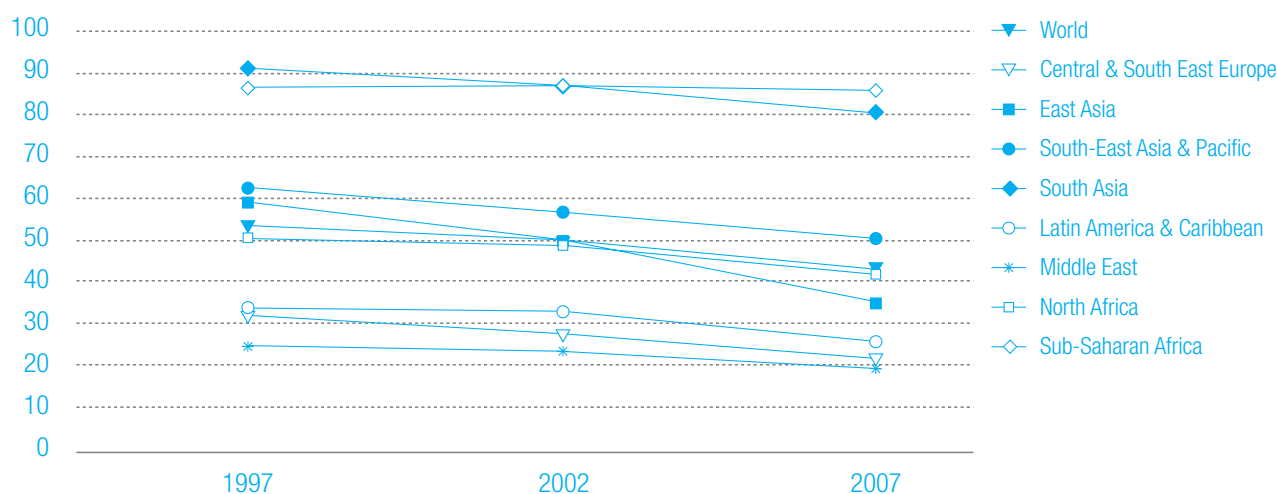
The nature of employment and working arrangements

Since the increase in global market integration began in the 1970s, there has been an emphasis on productivity and supply of products to global markets. Institutions and employers wishing to compete in this market argue the need for a flexible and ever-available global workforce. This brings with it a number of major health-related changes in employment arrangements and working conditions (Benach & Muntaner, 2007).

People's economic opportunity and financial security is primarily determined, or at least mediated, by the labour market. In 2007, there were 3 billion people aged 15 years and older in work. However, there are still 487 million workers in the world who do not earn enough to lift themselves and their families above the US\$ 1/day poverty line and 1.3 billion workers do not earn above US\$ 2/day (ILO, 2008). The regional variation in working poor is significant (Fig. 7.2).

The increasing power of large transnational corporations and international institutions to determine the labour policy agenda has led to a disempowerment of workers, unions, and those seeking work and a growth in health-damaging working arrangements and conditions (EMCONET, 2007). In high-income countries, there has been a growth in job insecurity and precarious employment arrangements (such as informal work, temporary work, part-time work, and piecework), job losses, and a weakening of regulatory protections (see Chapter 12: *Market Responsibility*). Most of the world's workforce, particularly in low- and middle-income countries, operates within the informal economy, which by its nature is precarious and characterized by a lack of statutory regulation to protect working conditions, wages, occupational health and safety (OHS), and injury insurance (EMCONET, 2007; ILO, 2008) (Fig. 7.3).

Figure 7.2: Regional variation in the percentage of people in work living on US\$ 2/day or less.



2007 figures are preliminary estimates.

Reprinted, with permission of the author, from ILO (2008).

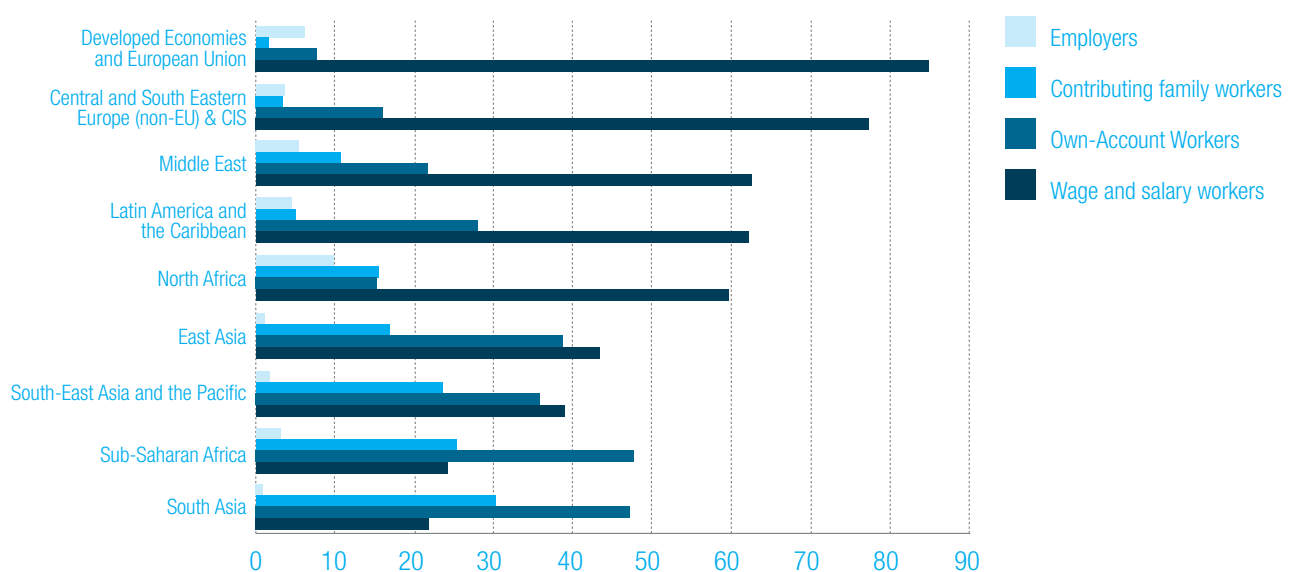
The formal economy, dominant in industrialized nations, previously tended to be characterized by progressive labour market policy-making, strong influence of unions, and often permanent full-time employment. This has undergone significant change (EMCONET, 2007). For example, Fig. 7.4 illustrates the increasing prevalence of temporary and part-time work since the early 1990s across the European Union.

Vulnerable populations

Analyses by Heymann and colleagues (2006) of nationally representative household surveys in Botswana, Brazil, Mexico, Russian Federation, South Africa, the United States, and Viet Nam found consistently that the protection and benefits provided by work are poorer for women than men (Fig. 7.5) (see also Chapter 13: *Gender Equity*).

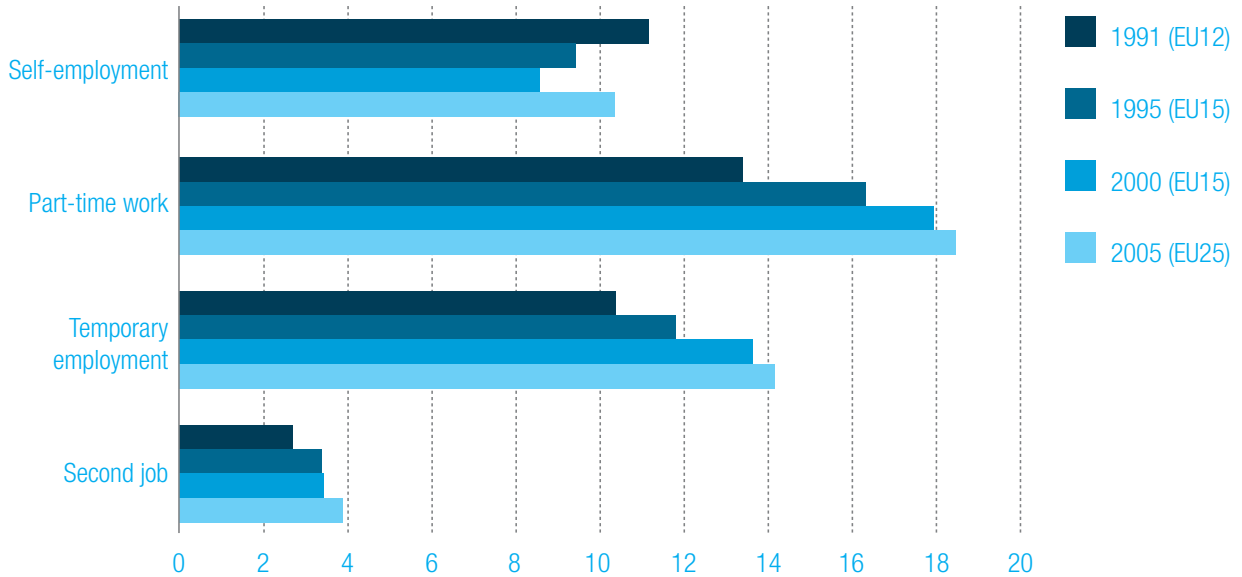
Fair employment requires freedom from coercion – including all forms of forced labour such as bonded labour, slave labour, or child labour. Globally, it is estimated that there are about 28 million victims of slavery, and 5.7 million children are in bonded labour (EMCONET, 2007). Although major progress has been made towards the elimination of the worst forms of child labour (ILO, 2007a), there are still more than 200 million children globally aged 5–17 years who are economically active (ILO, 2006a). Increasing poor households' income and ensuring essential quality schooling will help to reduce the need for children to work. It is estimated that 70% of child labourers in India would go to school if it was available and free (Grimsrud, 2002).

Figure 7.3: Employment status as a percentage of total employment in all regions in 2007.



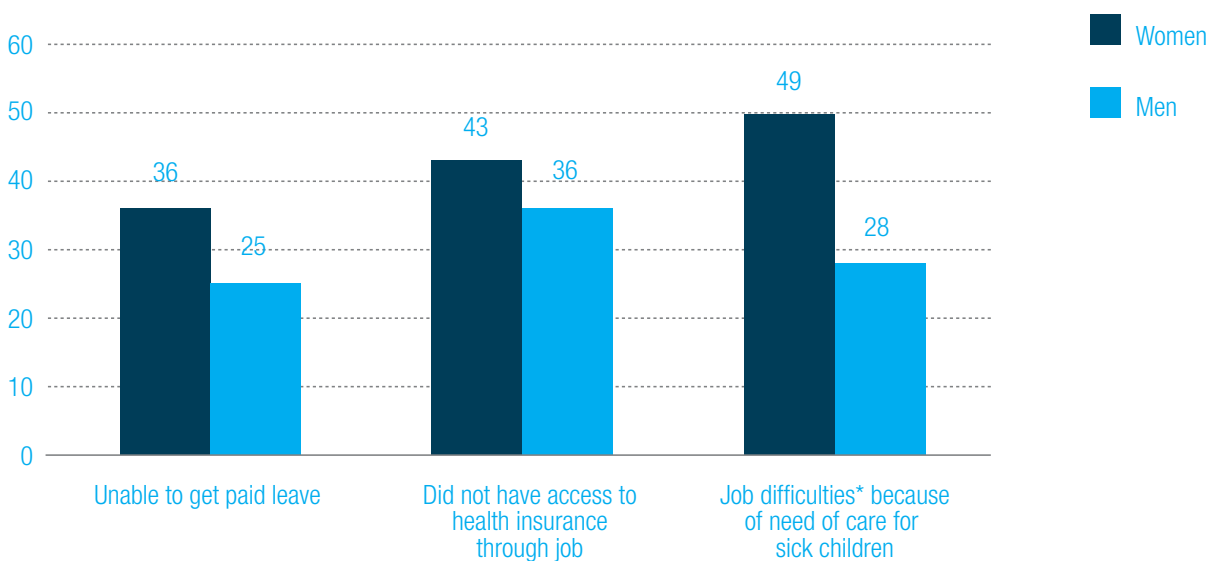
Contributing family workers and own-account workers are, by their nature, forms of precarious work. Reprinted, with permission of the author, from ILO (2008).

Figure 7.4 Non-standard employment in the European Union (percentages).



Reprinted, with permission of the author, from Parent-Thirion et al. (2007).

Figure 7.5 Gender inequities in labour conditions.



* Job difficulties: lost pay or lost job promotions or difficulty retaining jobs.
Adapted from Heymann (2006). Average percentages based on selected countries.

CREATING FAIR EMPLOYMENT⁵ AND DECENT WORK⁶

It is good for both the economy and health equity to make the promotion of fair employment and decent work a central focus in countries' policy agendas and strategies for development. The development, implementation, and enforcement of laws, policies, standards, and working conditions to promote good health must involve government, employers, workers, and those seeking work. Such action at the national level will also require efforts to create a more conducive global economic environment.

The Commission recommends that:

7.1. Full and fair employment and decent work be made a shared objective of international institutions and a central part of national policy agendas and development strategies, with strengthened representation of workers in the creation of policy, legislation, and programmes relating to employment and work (see Rec 10.2; 14.3; 15.2).

A supportive international environment

The level and terms of work are increasingly determined by economic developments at the global level, particularly in low- and middle-income countries. Therefore, implementation of the Commission's recommendations is critically dependent upon changes in the functioning of the global economy, both to promote and sustain full employment globally and to foster and support economic policies at the national level that will contribute to the generation of fair and decent work. This indicates a need for changes in the interactions of national economies with global markets, and in the activities of international institutions, for example, WTO Agreements and IMF- and World Bank-supported programmes (see Chapters 12 and 15: *Market Responsibility; Good Global Governance*). It is critical that UN bodies and other international agencies dealing with the rights of workers have the power to influence the adoption of fair employment practices among Member States. While further consideration and analysis is needed of specific policy options and development models, measures that could potentially contribute to this process might include the following:

- Direct market constraints:
 - reduced dependence on external capital through effective financial sector regulation, appropriate use of capital controls, and measures to mobilize and retain domestic capital;
- Competitive constraints:
 - an end to 'dumping' of products in low- and middle-income country markets at prices below their cost of production;
 - graduation of required labour standards and upward convergence over time;
 - an end to tariff escalation against exports from low- and middle-income countries;
 - reduced reliance on export markets through promotion of the production of goods for the domestic market;
 - promotion of intraregional trade among low- and middle-income countries, including through the establishment and strengthening of regional trade agreements;
 - encouragement of shorter working hours in high-income countries;
- International agreements:
 - greatly increased emphasis on Special and Differential Treatment for low- and middle-income countries in future WTO Agreements;
 - stronger safeguard provisions in WTO Agreements (and bilateral and trade agreements) with respect to public health;
 - increased access by (particularly smaller) low- and middle-income countries to the WTO's Dispute Settlement Mechanism.

Most of these measures require action at the international level – either discretionary changes by individual governments (in the case of increases in, or changes in the conditions attached to, donor support) or collective action mediated by international institutions.

FAIR EMPLOYMENT AND DECENT WORK : ACTION AREA 7.1

Make full and fair employment and decent work a central goal of national and international social and economic policy-making.

⁵ The term 'fair employment' complements the concept of decent work. It encompasses a public health perspective in which employment relations, as well as all the behaviours, outcomes, practices and institutions that emanate or impinge upon the employment relationship, need to be understood as a key factor in the quality of workers' health. Fair employment implies a just relationship between employers and employees.

⁶ Decent work involves opportunities for work that is productive and delivers a fair income, security in the workplace, and social protection for families; better prospects for personal development and social integration; freedom for people to express their concerns, organize, and participate in the decisions that affect their lives; and equality of opportunity and treatment for all women and men.

Fair representation of workers in developing the national policy agenda

To date, relatively few countries have integrated employment and working conditions into economic and social policies. To make this happen means redressing the power balance between private and public actors. Public sector leadership is critical, nationally and globally, and requires mechanisms that strengthen the representation of all workers and those seeking work in the creation of policy, legislation, and programmes relating to employment and work.

Historically, workers' participation has been positively associated with the development of collective labour rights, the labour movement, and the policies and labour market developed by modern welfare states (Box 7.1).

Unions are powerful vehicles through which protection for workers – nationally and internationally – can be collectively negotiated (see also Chapters 12 and 13: Market Responsibility; Gender Equity). It is important that governments take responsibility to ensure real participation of less powerful social actors through the provision of state guarantee of the right to collective action among formal and informal workers (Box 7.2).

BOX 7.1: WORK AND HEALTH AMONG THE LANDLESS AND SMALL LANDED FARMING POPULATION OF BRAZIL

In Brazil, 45% of agricultural land is held by around 1% of landowners, while around 50% of proprietors together own only roughly 2% of all arable land. About 31 million Brazilian people (18.8% of the total population) live in the countryside. These people, known as *agregados*, are extremely poor and suffer high rates of many psychosocial, educational, and health problems.

In 1984, landless families organized into the *Movimento dos Trabalhadores Rurais Sem Terra* (MST), or Movement of Rural Landless Workers. MST is probably the largest social movement in Latin America, with around 1.5 million members. Its fundamental success has been the increasing number of landless families being allocated their own piece of land, rising from a few thousand to more than 300 000 in 2000 settlements.

Research has shown that members of MST communities enjoy better health than other agricultural workers. The improved health of MST community members was attributed to a higher production of livestock, better nutrition (partly due to a greater diversity of produce), community support in case of need, and direct involvement in community decisions.

MST has limitations but, from its inception, it has acted as a catalyst for reform – not only agrarian reform, but also reform of health, with a direct impact on governmental decisions, influence on public policies, and a role in the civil society council of the Bolivarian Alternative for the Americas.

Source: EMCONET, 2007

BOX 7.2: NEPAL – CHILD LABOUR

Trade unions in Nepal have been collecting information and formulating policy, and have included the child labour issue in their workers' education programmes. One key issue in Nepal is bonded labour⁷. This affects children as well, as whole families are bonded under the *kamaiya* system. The unions, together with other civil society groups, persuaded the government that this system should be abolished and it was formally abolished in 2000. The government's decision wiped the slate clean – all debts that were the foundation for the bondage were declared illegal. In order to ensure

that former *kamaiyas* did not find themselves again in such levels of poverty and need, unions worked with the government to develop two important protective measures: the minimum wage for agricultural workers and the right for unions to organize in the informal economy, including the informal agricultural sector. These were two major steps that the unions did not feel they could have achieved without their strong position within the child labour movement.

Source: Grimsrud, 2002

⁷ *Kamaiya* is a traditional system of bonded labour in Nepal. The people affected by this system are also called *kamaiya* or *kamaiyas*. Traditionally, people without land or work could get loans from landowners allowing them to feed themselves and survive. In exchange for this, they had to live and work on the landowner's land as quasi slaves. Debts were charged exorbitantly and whole families were forced into slave labour for years and even generations. The *kamaiya* system existed in particular in western Nepal and affected especially the Tharu people and Dalits ('untouchables').

The Commission recommends that:

7.2. National governments develop and implement economic and social policies that provide secure work and a living wage that takes into account the real and current cost of living for health (see Rec 8.1; 13.5).

Towards full employment

At the 2005 world summit of the UN General Assembly, governments reaffirmed their commitment to the generation of full employment and decent work as one of the critical pathways to addressing the challenge of persistent poverty around the world. Full and productive employment and decent work for all has also been introduced as a new target under MDG 1 as a way to halve the proportion of people living in extreme poverty by 2015. However, while governments resolved to make the creation of full employment and decent work for all a central objective of national and international policies (UN, 2005), this commitment has not appeared consistently.

Reaching this goal is complex, requiring integrated economic and social policy, and will require different mechanisms in different country contexts. This could include domestic action aimed directly at employment generation, for example, through labour-intensive public works, local procurement policies, expansion of income-generation programmes, and support to small and medium enterprises. A starting point is state provision of a quantum of jobs. This has different implications for countries at different levels of development.

In low-wage settings such as India, where the infrastructure and administrative capacity often exists, state-provided work guarantees can act to lift people above the national poverty line (Box 7.3).

In many OECD countries, where most of the workforce is formal and there is relatively low unemployment, governments are trying to reach full employment by first encouraging jobseekers to become more active in their efforts to find work – through job-search support, services such as job information and matching, individualized counselling, and vocational guidance and training – and second by requiring contact with employment services as well as participation in programmes after a certain period of unemployment (OECD, 2005).

Healthy living wage

Providing a living wage that takes into account the real and current cost of living for health requires supportive economic and social policy that is regularly updated and is based on the costs of health needs including adequate nutritious food, shelter, water and sanitation, and social participation (Morris & Deeming, 2004). In low-income countries, competitive advantage is heavily dependent on low labour costs, and this may be compromised if provision of a regularly updated decent living wage becomes a statutory requirement. It is timely that:

- governments, along with public health and social policy researchers, should explore mechanisms to estimate the cost of healthy living in order to calculate the living wage level in each country (Box 7.4);
- in order to reach healthful employment equitably between countries, as a first step, governments explore mechanisms to create cross-country wage agreements, initially at regional level.

BOX 7.3: INDIAN NATIONAL RURAL EMPLOYMENT GUARANTEE PROGRAMME

The National Rural Employment Guarantee Act of 2005 obliges the Indian government to provide a social safety net for impoverished rural households, through the guarantee of 100 days of work, at minimum wage, to one family member per household.

While its implementation is relatively recent and there have been procedural difficulties, there is evidence to show that it has had a positive impact in several states where it has been implemented properly. It has provided wage security for poor rural families, aided economic empowerment of women, and created public assets. In Rajasthan, where public awareness of the programme is high, 77 days of employment per rural household were provided in 2006/07. In Uttar Pradesh, major improvements in public works are

observed as the scale of employment has increased; minimum wages are being paid and delays to payments have been reduced, and exploitation by private contractors is being pushed out.

This is not to say the programme does not have its difficulties, but transparency safeguards and the capacity to enforce procedures have been critical in making major progress. There is also a need to fairly revise the payment rates and extend the number of days and family members covered. To ensure social inclusion, worksite facilities are needed for women with children.

Source: The Hindu, 2008; Ganesh-Kumar et al., 2004

FAIR EMPLOYMENT AND DECENT WORK : ACTION AREA 7.2

Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work-life balance for all.

Training for work

A crucial part of a multifaceted policy approach to full and fair employment is ensuring that people who are not in work, or are changing work, are helped to gain the appropriate set of skills and attributes to participate in quality work. This requires the establishment of partnerships between government and NGOs to develop a comprehensive set of programmes that suit the needs of different populations such as people with a

disability or the long-term unemployed. Vocational training content and delivery must meet the needs of the community and, particularly as the workforce ages, retraining opportunities are required that suit the needs of older people. Denmark's 'flexicurity' system has been among the most successful in training its workforce to ensure employability (Box 7.5).

BOX 7.4: ESSENTIAL INCOME FOR HEALTHY LIVING

An assessment was made of the cost of living among single healthy men in the United Kingdom, aged 18-30 years, living away from their family and on their own. Based on consensual evidence, a basket of commodities considered necessary for healthy day-to-day living was priced including food and physical activity, housing, household services, household goods, transport, clothing and footwear, educational costs, personal costs, personal and medical care, savings and non-state pension contributions, and leisure goods and leisure activities, including social relationships. The total cost was considered indicative of the minimum disposable income that is now essential for health.

The minimum cost of healthy living was assessed at £131.86/week (based on April 1999 prices).

Component costs, especially those of housing (which represents around 40% of this total), depend on geographical region and on several assumptions. In today's society, the disposable income that could meet this minimal cost may be posited as a necessary precondition of health. Pay from the national minimum wage (in April 1999), £3.00 an hour at 18-21 years and £3.60 at 22 years plus, translates into disposable weekly income of £105.84 and £121.12, respectively, for a 38-hour working week after statutory tax and social security deductions. At 18-21, 51 hours, and at 22 years plus, 42.5 hours would have to be worked to earn the income needed to meet the minimum costs of healthy living.

Source: Morris et al., 2000

BOX 7.5: FLEXICURITY AND LIFELONG LEARNING IN DENMARK

The Danish labour market is as flexible as the British while offering employees the same level of security as the Swedish. Flexible rules of employment, active labour market policies with the right and duty to training and job offers, relatively high benefits, and a favourable business cycle lasting a decade have repeatedly been offered as explanations for this development. There are four elements of flexicurity in the Danish context:

flexible labour market;

generous welfare schemes;

lifelong learning;

active labour market policy.

For lifelong learning, social partners are highly involved and institutionally committed to the planning and implementation of education policies, in particular continuing vocational training (CVT) policies. A specific institutional characteristic of the Danish CVT policy is that it provides services and training for both the employed and the unemployed. Under the formal responsibility of the Ministry of Labour (now Ministry

of Education), but administered largely by the social partners, CVT for unskilled workers was established in 1960 and a similar system was established for skilled workers in 1965. From the late 1980s, collective agreements also included agreements on education, usually entitling the employees to 2 weeks leave per year to participate in job-relevant education.

The state is the main financier of the system. This financing system externalizes the costs of training and education from the firms, and indirectly serves as a government subsidy to the competitiveness of Danish industry. Partly as a result of this financing arrangement and the extensive rights of participation in CVT, Denmark has, for a number of years, ranked consistently among the top performers in Europe in relation to participation in CVT activities. Since the CVT system is predominantly financed by the public budget, CVT activities are more likely to provide general rather than firm-specific skills, which are transferable on the external labour market and improve the functional flexibility of internal labour markets.

Source: Madsen, 2006

Safe and decent work standards

The nature of employment and working conditions to which people are exposed has a major impact on health and its social distribution. Work must be fair and decent. The state plays a fundamental role in the reduction and mitigation of the negative health effects caused by inappropriate employment and working conditions.

The Commission recommends that:

7.3. Public capacity be strengthened to implement regulatory mechanisms to promote and enforce fair employment and decent work standards for all workers (see Rec 12.3).

Labour standards

The four core principles – freedom of association and the effective recognition of the right to collective bargaining; freedom from forced labour; the effective abolition of child labour; and non-discrimination in employment – behind many of the ILO standards provide the basis for fair employment and decent work. The enforcement by government agencies of internationally agreed labour standards and codes (ILOLEX, 2007) is an essential step towards health and health equity. In addition, if basic labour standards are enforced, such as equal remuneration for women and men, there is potential for significantly reducing gender inequity (see Chapter 13: *Gender Equity*).

The effects of transnational corporations on employment and working conditions and the cross-border nature of work and labour provide a strong argument for an international mechanism to support national governments to ratify and implement core labour standards (see Chapter 12: *Market Responsibility*). The development of administrative capacity, infrastructure, and financial support to undertake the recommendations must be supported in a coherent way by the ILO and WHO with donors and representation of formal and informal workers (see Chapter 15: *Good Global Governance*). The capacity of low-income countries to enforce labour standards may be relatively limited, particularly when considered in the context of the wider set of recommendations being made by the Commission. Labour standards should be graduated according to levels of economic development but with at least the four core principles being covered, and consideration should be given to the feasibility of implementation in a particular country of any international enforcement mechanism. Once the basic four are established, labour standards should be subject to a planned process of upward convergence over time, to avoid adverse effects.

A long-term goal for countries should be the progressive development and implementation of binding codes of practice in relation to labour and OHS of both domestic and international suppliers. Similarly, the establishment of domestic disclosure regulations for companies – clear identification of where products and their component parts are produced and under what working conditions (EMCONET, 2007) – as a long-term policy goal may contribute to equitable employment and working conditions globally.

While a number of multinational corporations have adopted voluntary codes of conduct and reportedly insist on the same labour practices at their companies throughout the world (http://www.jnj.com/community/policies/global_labor.htm), this represents a limited response to the huge task ahead. As a starting point, regular public sector

monitoring of private sector voluntary codes of practice in relation to labour and OHS standards can help reinforce their impact and ensure accountability (see Chapter 12: *Market Responsibility*). Consideration could also be given to changes to company law to alter the objective function of publicly quoted companies from maximization of shareholder value to a broader set of social and environmental objectives, including employment. However, such measures would need to be coordinated internationally, to avoid companies migrating away from countries making such a change, or companies based in countries that retain the shareholder value maximization principle taking over those in countries that adopt a different objective function. In the same way that, during the past two decades, the environmental movement has succeeded in increasing the responsibility of private firms for environmental degradation, a similar effort is now needed to address fair employment and decent work.

Work-life balance

It is increasingly recognized that overwork and the resulting imbalance between work and private life has negative effects on health and well-being (Felstead et al., 2002). Rebalancing work and private life requires government policy and legislative support that provides parents the right to time to look after children and the provision of childcare regardless of ability to pay, plus work provisions such as flexible working hours, paid holidays, parental leave, job share, and long-service leave (Lundberg et al., 2007). This type of policy has begun to emerge, mainly in high-income countries. Informal workers, as with other protective legislation, are excluded from any such provisions. It is timely therefore that government, with the participation of workers – both formal and informal – develop incentives to promote work-life balance policies and supportive social protection policy (see Chapter 8: *Social Protection Across the Lifecourse*), with clear mechanisms for financing and accountability.

Precarious work

The global dominance of precarious work, with its associated insecurities (Wilthagen et al., 2003), has contributed significantly to poor health and health inequities. The majority of the world's workforce is informal and is in an extremely precarious position. Given the connection between precarious jobs and poverty, women and their families will benefit from policies addressing the problems of work insecurity, low pay, and gender discrimination in informal work (see Chapter 13: *Gender Equity*). Also of note is the increasing number of migrant workers internationally. While many are in high-skilled work, large numbers of migrants, particularly illegal migrants, experience unprotected and poor conditions, often in the informal sector. Barriers are being erected to mobility between potential migrants and demand for foreign labour in host countries (see Chapter 9: *Universal Health Care*). This, plus the lack of economic opportunity within countries, has led to the smuggling and trafficking of people as a highly profitable enterprise at the expense of gross violations of basic human rights (ILO, 2006b).

The Commission recommends that:

7.4. Governments reduce insecurity among people in precarious work arrangements including informal work, temporary work, and part-time work through policy and legislation to ensure that wages are based on the real cost of living, social security, and support for parents (see Rec 8.3).

Regulation to protect precarious workers

Government policy and legislation are needed to create more security in different working arrangements, progressively working towards greater stability within the different dimensions of work. Some governments internationally are exploring ways to strengthen the regulatory controls on downsizing, subcontracting, and outsourcing (including supply chain regulation) and developing laws that limit the use of precarious work (Box 7.6).

The informal economy's contribution to health equity

The informal sector has the potential to impact health equity over and above the effects due to improvements in working conditions. Bringing informal enterprises into the tax system would provide governments with revenue that could be used for public goods and therefore health benefits (Gordon & Lei, 2005). Government-led action such as the following may help informal enterprises contribute to the development of the nation at large:

- development of legislation and regulation to protect working conditions, wages, OHS, and other benefits among informal workers;
- extension of labour standards, and their enforcement by government, employers, and workers organizations, to all informal workers;
- development by national and local government of policies targeted at the inclusion of informal businesses in the formal sector, such as special taxation gradients that would encourage small and home-based firms to register.

For many low- and middle-income countries, working towards each of these labour standard recommendations must be done while recognizing that, in general, the informal sector exists because even the burden of existing taxation and regulation is a serious constraint on the size of the formal sector. In the absence of effective social protection mechanisms, people need to earn incomes to survive, and are therefore driven into the informal sector. The informal sector is able to operate outside the reach of regulation and taxation because administrative capacity is often inadequate to apply them effectively to the tens or hundreds of thousands of micro-enterprises and individuals that it comprises. In many of the poorest countries, it is also likely that a large proportion of entrepreneurs in the informal sector will have minimal levels of education or literacy, severely limiting their ability to conform to regulatory requirements. Addressing the regulatory issues as described above must be part of a coherent economic and social policy approach that includes social protection, education, and public sector strengthening (see also Chapters 5, 8, 10, 11, 15, and 16: *Equity from the Start; Social Protection Across the Lifecourse; Health Equity in All Policies, Systems, and Programmes; Fair Financing; Good Global Governance; Social Determinants of Health: Monitoring, Research, and Training*).

The role of workers and civil society in achieving better employment conditions

Workers' organizations play a critical role in the protection of informal workers, and have become increasingly structured. For example, since 1998, informal workers have been

BOX 7.6: STRENGTHENING GOVERNMENT CONTROL ON SUBCONTRACTING

Production in the global economy is composed of an increasingly complex network of contractual arrangements or supply chains. Modern business practice, especially among large corporations, depends heavily on the outsourcing of production of goods and services to other firms or distant locations (including internationally). Outsourcing occurs through a variety of subcontracting arrangements, including the provision of labour-only services and partial or complete supply of services and goods. Subcontracting can be multi-tiered, involving numerous steps between the producer of a good or service and the ultimate client. Subcontractors include other firms, small businesses, and self-employed workers. International studies have overwhelmingly found that subcontracting leads to a deterioration of OHS. The OHS risks linked to subcontracting include financial/cost-cutting pressures on subcontractors, disorganization/fracturing of OHS management, and inadequate regulatory controls.

The legal framework and government and industry response to these issues varies widely and has generally been fragmented and inadequate. Governments have recently begun to explore supply chain regulation as a means of addressing the risk-shifting associated with complex subcontracting networks. The organization at the pinnacle of the

supply chain often exercises substantial control over the parties it engages to perform tasks. This control manifests itself in the financial dependence of subcontractors (for future work) and in the terms of contractual arrangements between the outsourcing firm and its suppliers to secure quantity, quality, timeliness, and price, and to allocate regulatory risks. Unlike social protection laws, this private regulatory control effectively spans international borders. Nonetheless, governmental regulation of these contractual arrangements, covering each step and focusing responsibility at the top of the supply chain, could establish the conditions, including OHS, under which work is performed. This would need to be supported internationally.

In Australia, laws integrating labour (pay, hours) and OHS standards and workers' compensation entitlements and entailing mechanisms (including mandatory codes) for transmitting legal responsibilities to the head of the supply chain have been introduced to protect home-based clothing workers and truck drivers. A statutory licensing system covering labour supply agencies (gang masters) in agriculture, horticulture, and food processing has been introduced in the United Kingdom.

Source: EMCONET, 2007

represented in Senegal by an autonomous federation, the Informal and Rural Workers' Federation. Unions in Ecuador and Panama have established departments for rural and indigenous workers. In Benin and Ghana, full-time officials are responsible for the informal economy. In Canada, unions have appointed both male and female Special Programme Union Representatives with the mandate to organize atypical workers. The example from the United States (Box 7.7) illustrates how community action can act as an important adjunct and impetus to government measures. Particularly where workers are disempowered from influencing employers or market-related issues, civil society in collaboration with unions can be powerful.

Improving working conditions

Improvements in employment arrangements need to be dovetailed with a more proactive approach to work quality (EFILWC, 2007) through the improvement of working conditions.

The Commission recommends that:

7.5. OHS policy and programmes be applied to all workers – formal and informal – and that the range be expanded to include work-related stressors and behaviours as well as exposure to material hazards (see Rec 9.1).

Protection for all

The health sector has a role and responsibility to lead occupational health policy and programme development to reach the formal and informal sectors. This could include:

- developing and strengthening occupational health legislation, policy, and services to provide basic OHS coverage to all workers;
- developing occupational training programmes targeting informal workers and relevant social movements;
- establishing workers' health as part of the primary health-care function of the health-care system.

BOX 7.7: FAIR-WEAR – WORKERS AND CIVIL SOCIETY ACTION

Over the past decade, the political antisweatshop movement has become a major political claim maker and transnational advocacy network. Large garment corporations are vulnerable targets for antisweatshop activism. Their buyer-driven character forces them to survive in highly competitive markets. To make a profit, they must compete with other sellers over increasingly fickle (non-brand loyal) consumers looking for good-quality clothing at very affordable prices. To maintain and even improve their market shares and profit margins, they outsource their manufacturing to countries where labour is inexpensive and devote considerable resources to competitive logo and image marketing. In the weakly regulated setting of outsourced garment manufacturing, worker welfare is jeopardized by the fast and flexible production needed to keep up with fashion-craving consumers.

The antisweatshop movement has used the vulnerable and competitive image situation of the buyer-driven corporate world to push to improve garment workers' rights and social justice. Wanting profits and a good image among consumers, logo garment corporations are now forced to address sweatshop problems.

Two events in 1995 were crucial formative events in North America: the establishment of the amalgamated Union of Needle, Industrial, and Technical Employees (UNITE! and now UNITE HERE!) and the police raid of

domestic sweatshops in El Monte, California. UNITE! triggered a new union activism that used consumer power to pry open space for organizing workers. The El Monte raid was a wake-up call for civil society and created a media sensation with ripple effects far into the future. Shortly afterwards, the antisweatshop movement gained momentum. Internet-based advocacy groups such as Global Exchange used its media talents to focus public and media attention on celebrity corporate leaders. Old and new civil society teamed up in the antisweatshop cause – organizations representing church groups, student groups, think tanks, policy institutes, foundations, consumer organizations, international organizations, local labour unions, labour-oriented groups, specific antisweatshop groups, no-sweat businesses, business investors, and international humanitarian and human rights organizations, networks, and groups. Noteworthy is the less common cooperation between unions and consumers, as illustrated by the UNITE! and National Consumers League's Stop Sweatshop campaign that reached out to more than 50 million consumers globally. The antisweatshop campaign has had success. For example, in Indonesia, exporting and foreign textiles and footwear producers increased wages 20-25% faster than others.

Source: Micheletti & Stolle, 2007

FAIR EMPLOYMENT AND DECENT WORK : ACTION AREA 3

Improve working conditions for all workers to reduce exposure to material hazards, work-related stress, and health-damaging behaviours.

Development work by national government, employers, international agencies, and workers is needed to include an OHS component in employment creation programmes, subcontracting and outsourcing regulation, and trade agreements. Monitoring their implementation, particularly through strengthened enforcement of occupational health legislation and inspection, would be an initial step towards ensuring that policies and employment arrangements with major global reach are conducive to health and health equity.

The breadth of occupational health and safety

Many work-related OHS policies and programmes still concentrate on traditional workplace exposures. In Canada, for example, the Canadian Environmental Protection Act, 1999, is the main piece of legislation governing chemical substances in Canada. The Chemicals Management Plan, announced in December 2006 and the policy framework now being used, aims to assess risks to human and environmental health posed by both new and existing chemical substances (see www.chemicalsubstances.gc.ca). While such OHS policies remain of critical importance, particularly in low- and middle-income countries, the evidence suggests the need to expand the remit of OHS to include work-related stress and harmful behaviours. The example from the United Kingdom (Box 7.8) illustrates how employers working with workers' unions can develop workplace standards that recognize the psychosocial environment as a legitimate component of working conditions.

Through the assurance of fair employment and decent working conditions, government, employers, and workers can help to eradicate poverty, alleviate social inequities, reduce exposure to physical and psychosocial hazards, and enhance opportunities for health and well-being. And, of course, a healthy workforce is good for productivity.

BOX 7.8: NATIONAL-LEVEL ACTION TO TACKLE WORKPLACE STRESS

The Health and Safety Commission identified work stress as one of its main priorities under the Occupational Health Strategy for Britain 2000: Revitalising Health and Safety, which set out to achieve, by 2010, a 30% reduction in the incidence of working days lost through work-related illness and injury; a 20% reduction in the incidence of people suffering from work-related ill-health; and a 10% reduction in the rate of work-related fatal and major injuries.

In 2004, the United Kingdom Health and Safety Executive (HSE) introduced management standards for work-related stress. These standards cover six work stressors: demands, control, support, relationships, role, and change. A risk assessment tool was released at the same time as the management standards; this consists of 35 items on working conditions covering the six work stressors. The HSE management standards adopted a population-based approach to tackling workplace stress aimed at moving organizational stressors to more desirable levels rather than identifying individual employees with high levels of stress. Instead of setting reference values for acceptable levels of psychosocial working

conditions that all employers should meet, the standards set aspirational targets that organizations can work towards.

The management standards are not in themselves a new law but can help employers meet their legal duty under the Management of Health and Safety at Work Regulations 1999 to assess the risk of stress-related ill-health activities arising from work.

As part of a 3-year implementation programme, in 2006/07 the HSE actively rolled out management standards to 1000 workplaces by providing support for both conducting risk assessments and making changes based on results of risk assessments. So far, evaluations in workplaces adopting the management standards approach have mostly been qualitative and good practice case studies are being made available on the HSE website (www.hse.gov.uk/stress). A national monitoring survey was conducted in 2004 before the introduction of the management standards, to provide a baseline for future monitoring of trends in psychosocial working conditions.

Source: EMCONET, 2007

CHAPTER 8

Social protection across the lifecycle

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Article 25(a) of the United Nations Universal Declaration on Human Rights (UN, 1948)

THE RELATIONSHIP BETWEEN SOCIAL PROTECTION AND HEALTH

Four out of five people worldwide lack the back up of basic social security coverage (ILO, 2003). Extending social protection to all people, within countries and globally, will be a major step towards securing health equity within a generation. Not only is this a matter of social justice; social protection can be instrumental in realizing developmental goals, rather than being dependent on their achievement (McKinnon, 2007).

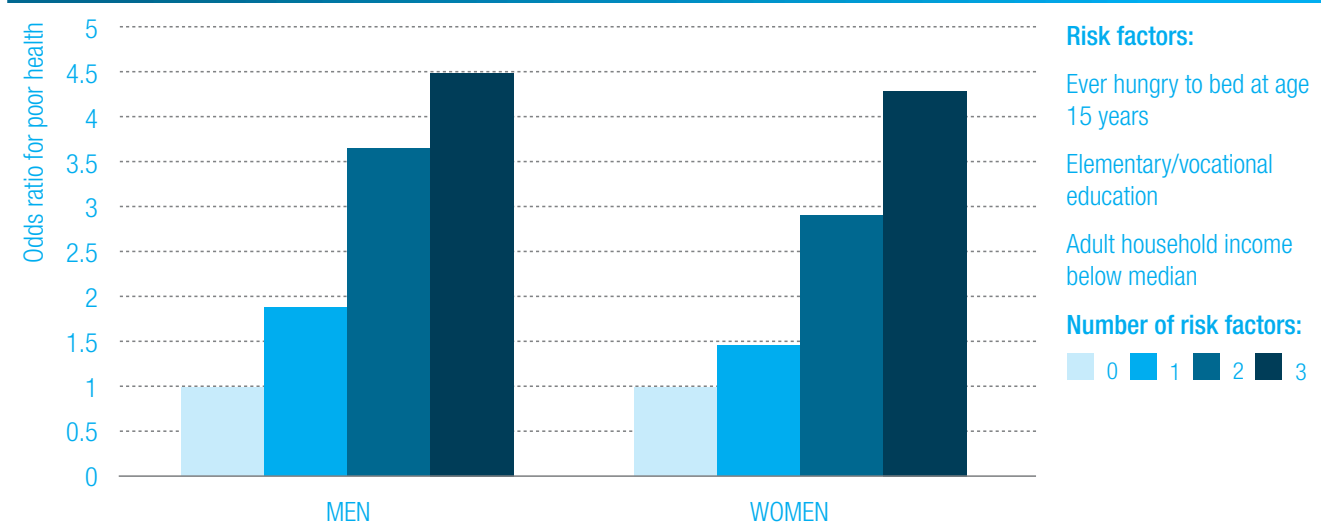
Social protection can cover a broad range of services and benefits, including basic income security, entitlements to non-income transfers such as food and other basic needs, services such as health care and education (Van Ginneken, 2003), and labour protection and benefits such as maternity leave, paid leave, and childcare. In this chapter, we concentrate on

income security. Income security typically provides protection in periods in the lifecycle in which individuals are most vulnerable (as children, when caring for children, and in old age) and in case of specific shocks (such as unemployment, sickness or disability, and loss of a main household income earner). Specific labour protection and work-related benefits are discussed in Chapter 7 (*Fair Employment and Decent Work*), while provision of and access to quality education and health care are discussed in Chapters 5 and 9 (*Equity from the Start; Universal Health Care*).

The importance of social protection across the lifecycle

Poverty and low living standards are powerful determinants of ill-health and health inequity. They have significant consequences for ECD and lifelong trajectories, among others, through crowded living conditions, lack of basic amenities, unsafe neighbourhoods, parental stress, and lack of food security. Child poverty and transmission of poverty from generation to generation are major obstacles to improving population health and reducing health inequity (see Chapter 5: *Equity from the Start*). The influence of living standards on lifelong trajectories is seen, for example, in the effect on self-rated health at age 50+ of accumulated socioeconomic risk factors across the lifecycle (Fig. 8.1).

Figure 8.1 Poor self-rated health at age 50+ and accumulation of socioeconomic risk factors over the lifecycle in Russian men and women in 2002.

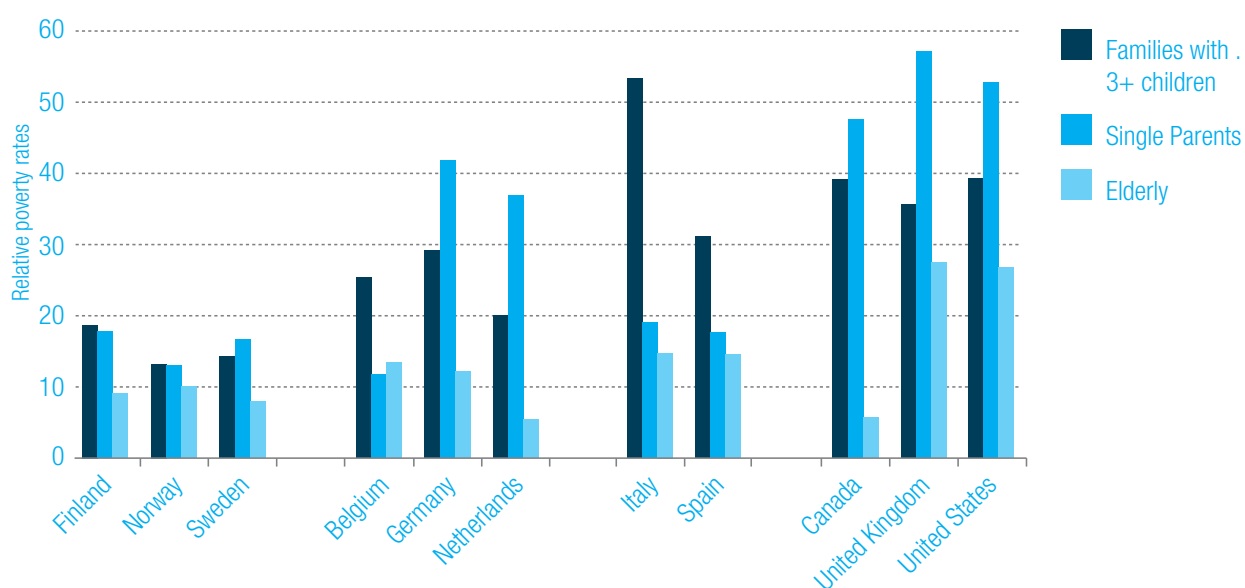


Source: Nicholson et al., 2005

Redistributive welfare systems, in combination with the extent to which people can make a healthy living through work, influence poverty levels (Lundberg et al., 2007). While evidence on the effects of these systems comes mainly from high-income countries, where data are available and policies are in place, it does show the potential effect of social protection policies more widely. In the Nordic countries, for example, poverty rates after taking into account taxes and transfers are substantially lower than in Canada, the United Kingdom, and the United States (although poverty rates are similar before taking taxes and transfers into account) (see Fig. 3.2, Chapter 3). If poverty levels among vulnerable groups are compared, variations between these countries in the prevalence of poverty become even more distinct. As Fig. 8.2 shows, the relative poverty rates among single parents, families with three or more children, and individuals aged 65+ in the Nordic countries are fairly low. It is important to highlight that this difference is not only caused by welfare state redistribution, but by a more indirect welfare state institution effect, namely, the extent to which one can make a healthy living on the labour market. Social security systems are vital; so is a minimum income that is sufficient for healthy living and labour protection (see Chapter 7: *Fair Employment and Decent Work*).

Countries with more generous social protection systems tend to have better population health outcomes, at least across high-income countries for which evidence is available (Lundberg et al., 2007). More generous family policies, for example, are associated with lower infant mortality rates (Fig. 8.3). Similarly, countries with a higher coverage and greater generosity of pensions and sickness, unemployment, and work accident insurance (taken together) have a higher LEB (Lundberg et al., 2007), and countries with more generous pension schemes tend to have lower old-age mortality (Lundberg et al., 2007). Data on the association between the magnitude of health inequities within countries and social protection policies remain scarce, however, and more investment in comparable data sources and methods is needed. The existing data from high-income countries show that while relative mortality inequities are not smaller in states with more generous, universal, social protection systems, absolute mortality levels among disadvantaged groups do appear to be lower (Lundberg et al., 2007).

Figure 8.2 Relative poverty rates for three 'social risk categories' in 11 countries, circa 2000.



Poverty threshold = 60% of median equivalent disposable income. Equivalence scale; OECD scale.

Data source: the Luxembourg Income Study (LIS).

Reprinted, with permission of the authors, from Lundberg et al. (2007).

Protection in working life

Providing a decent wage and work-related protections and benefits including disability, employment injury, and occupational disease compensation, maternity leave, and pension benefits (EMCONET, 2007) will protect significant numbers of people worldwide. Yet only a small fraction of the world’s workforce is covered by such protection schemes. For example, most workers receive no income during absences from work due to illness. Workers suffering long-term disability may also lose important skills and thus find it harder to find work in the future, or at least to continue in the work for which they have been trained. Also, the transformation of the composition of the workforce, with an increasing proportion of women working, often in precarious and informal forms of work that lack social protection, underscores the importance of universal social protection (EMCONET, 2007; WGEKN, 2007).

Vulnerability and older people

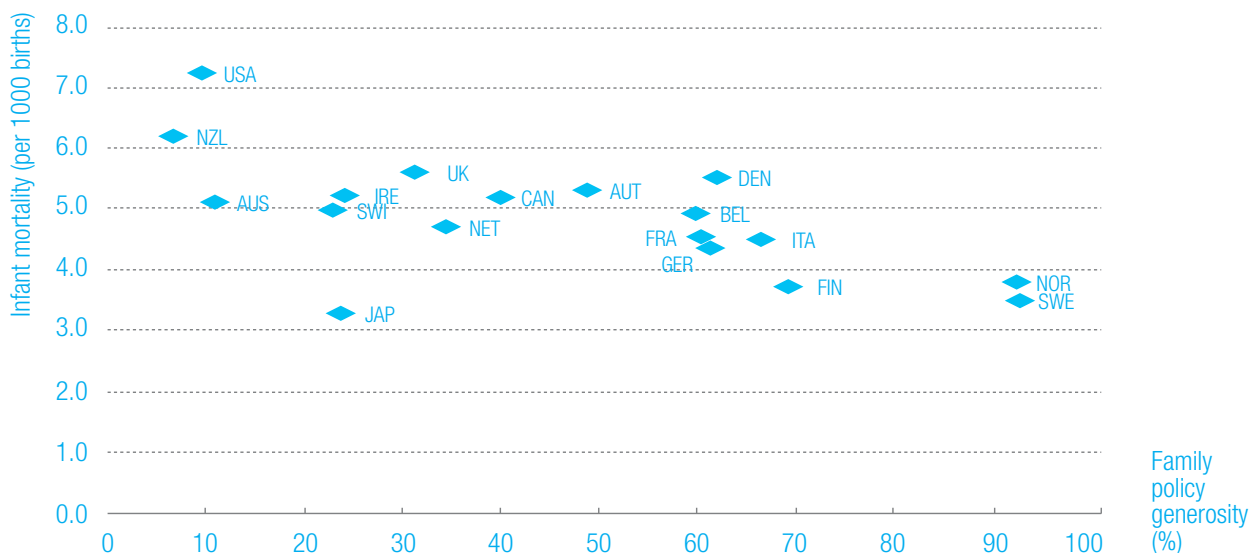
Global population ageing makes meeting social security needs an increasingly important challenge. In the next 45 years, the global population aged 60 years and over will triple. By 2050, one third of the European population will be aged 60 and over (UNDESA, Population Division, 2006). In low- and middle-income countries, the proportion of older people is growing even faster than in high-income countries. In these countries, contributory pension schemes play little role, as many people work in the informal sector. In sub-Saharan Africa and South

Asia, less than 19% of older people have a contributory pension (HelpAge International, 2006a). At the same time, in many of these countries, traditional social security arrangements are weakening (McKinnon, 2007). Families are getting smaller, and older people may have no living adult children or no children willing or able to take care of them, for example, due to rural-urban migration. Older people, particularly grandmothers, are often carrying additional burdens, for example, taking care of children orphaned due to HIV/AIDS (McKinnon, 2007). Older women are often hit particularly hard. Although there is evidence that widowers are less able to care for themselves and manage their lives than widows, the absolute number of widows tends to be greater. Widowhood is when the cumulative effect of women’s lower economic position throughout their lives is felt. Widows tend to be poorer, with higher rates of impoverishment and destitution, than widowers and many other subsets of the population (WGEKN, 2007). A number of low- and middle-income countries, including in Africa, have started to set up social pension systems.

Social protection in a globalizing world

Social protection systems should be created as a social right of all citizens. Yet, increasingly, large numbers of people are not bound by a country because they are international migrants, asylum seekers, or refugees. A concerted effort by donors, national governments, and international organizations, led by UNHCR, ILO and IOM, should be made to invest in

Figure 8.3: Total family policy generosity and infant mortality across 18 countries, circa 2000.



Net benefit generosity of transfers as a percentage of an average net production-worker’s wage. Infant mortality expressed as deaths per 1000 live births.
 AUS = Australia; AUT = Austria; BEL = Belgium; CAN = Canada; DEN = Denmark; FIN = Finland; FRA = France; GER = Germany; IRE = Ireland; ITA = Italy; JAP = Japan; NET = the Netherlands; NOR = Norway; NZL = New Zealand; SWE = Sweden; SWI = Switzerland; UK = the United Kingdom; USA = the United States of America.
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developing realistic solutions that enhance health equity, to address this growing problem.

Social protection is an important instrument to mitigate some of the negative impacts of globalization (Van Ginneken, 2003) such as trade liberalization-related economic insecurity and economy-wide shocks (GKN, 2007; Blouin et al., 2007). Under conditions of market integration, poor countries in particular have been losing important forms of public revenue (GKN, 2007), which raises issues regarding the fairness in global finance of public resources in low-income countries (see Chapters 12 and 15: *Market Responsibility; Good Global Governance*). Whereas trade liberalization and tax competition can erode the ability and/or willingness of governments to strengthen universal social protection systems, this is not universally the case. Indeed, some of the East Asian countries strengthened their social protection policies when faced with economic downturn (Box 8.1). The resources available may be further reduced by trade liberalization and tax competition (GKN, 2007).

Much can be done to protect people and support them in living flourishing lives. Social protection policies, particularly income protection, can be an important, sometimes the only, source of cash income for many households in poor and rich countries alike. In poor countries, even small cash benefits provided on a regular basis can have a large positive impact on well-being and can help combat social exclusion (McKinnon, 2007). And social protection policies are cost effective. Local economies benefit from the increase in disposable incomes (McKinnon, 2007). Evidence suggests that income redistribution, via taxes and transfers – the latter of which are key to social protection – are more efficient for poverty

reduction than economic growth per se (Paes de Barros et al., 2002; de Ferranti et al., 2004; Woodward & Simms, 2006a). While limited institutional capacity remains an important barrier, it is feasible even for poor countries to start building social protection programmes, as shown by experience across the world (McKinnon, 2007).

ACTION TOWARDS UNIVERSAL SOCIAL PROTECTION

The Commission recommends that:

- 8.1 Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, build universal social protection systems and increase their generosity towards a level that is sufficient for healthy living (see Rec 7.2, 11.1).**

Universal social protection systems across the lifecourse

It is important for population health in general, and health of lower socioeconomic groups in particular, that social protection systems are designed such that they are universal in scope. Universality means that all citizens have equal rights to social protection. In other words, social protection is provided as a social right (Marshall, 1950), rather than given to just the poor out of pity (Lundberg et al., 2007). Universal approaches are important for the dignity and self-respect of those who need social protection the most. And because everybody benefits, rather than just one group that is singled out, universal social protection systems can enhance social cohesion (Townsend, 2007) and social inclusion (SEKN, 2007), and can be politically

BOX 8.1: STRENGTHENING SOCIAL PROTECTION IN CASE OF ECONOMIC CRISIS – THE CASE OF REPUBLIC OF SOUTH KOREA

Before the economic crisis, Republic of South Korea already had a social protection system that was far ahead of those of other East Asian countries. In response to rising unemployment rates due to the economic crisis, the Tripartite Commission (business-labour-government) launched legislation extending unemployment insurance to all sections of the labour force. Eligibility for this Temporary Livelihood Protection Program provided four main benefits to the newly unemployed: direct cash transfer (US\$ 70/month), tuition fee waiver and lunch subsidies for their children who were students, and a 50% reduction

in medical insurance premiums for 1 year. The success of this programme and its significance in cushioning the impact of the economic shock is evident in the Minimum Living Standards Security Act, legislated in 2000, which replaces (essentially incorporates) the earlier programme and includes provisions for food, clothing, housing, education, and health care, subsidized through cash and kind transfers for households who do not meet basic standards, with benefits linked to participation in labour programmes such as public works and job training.

Source: Blouin et al., 2007

SOCIAL PROTECTION : ACTION AREA 8.1

Establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all.

more acceptable. Including the middle classes by means of universal programmes can enhance willingness of large parts of the population to pay the taxes needed to sustain universal and generous policies (Lundberg et al., 2007). Budgets for social protection tend to be larger, and perhaps more sustainable, in countries with universal protection systems. And in these countries, there tends to be less poverty and smaller income inequity than in countries with systems that target the poor (Korpi & Palme, 1998). Universal social protection systems can be tax based, contribution based, or a combination of the two.

Children

Universal social protection systems should protect all people across the lifecycle – as children, in working life, and in old age. Women and children are often the most unprotected of the population. Women do most of the world’s work and have a reproductive role, but in most countries they work until they give birth, without access to maternity leave or benefits. Addressing child poverty clearly requires strong social protection measures, embedded within a broader set of policies that protect and promote a healthy standard of living and social inclusion of caregivers, including labour protection/rights, minimum income, childcare, and allowing flexible working hours. Box 8.2 describes the United Kingdom’s child poverty strategy, which combines some of these elements.

Working age

The Commission emphasizes that everybody should be protected against the financial consequences of inability to work and loss of work, in a way that supports people to live healthy and flourishing lives. This means that governments, with employers, set up unemployment, sickness, and disability benefit schemes. It also means attending to the needs of people with disabilities and fighting discrimination of employers against people with disabilities. Furthermore, it includes treatment of physical and mental health problems, including addiction, that hamper finding and/or keeping a job, and providing lifelong opportunities for education and training to keep people up to speed with the changing requirements of the job market (see Chapter 7: *Fair Employment and Decent Work*). Social protection measures for those out of paid work can take different forms. In the EU, for example, a significant proportion of social provisions consist of benefits that are

designed to replace or supplement earnings that individuals cannot find in the labour market for temporary or more durable reasons. Income replacement schemes usually take the form of three distinct kinds of provision: unemployment benefits (based upon previous earnings), unemployment assistance, and guaranteed minimum schemes. Some countries, such as India and South Africa, have set up employment guarantee schemes (see Chapter 7: *Fair Employment and Decent Work*).

Old age

Universal social pensions are an important element of a social protection system. They can substantially improve living standards for older people. Social pensions can raise the social status of older people within households, promote social inclusion and empowerment, and improve access to services. Moreover, they can contribute to gender equity, as women tend to live longer and often have less material resources or access to contributory pensions. Especially in low-income countries, social pension systems can also improve the well-being of other household members including children: the extra money that comes into the household can help improve, for example, school enrolment and nutrition (McKinnon, 2007). Thus, a social pension can help to break the intergenerational poverty cycle. Already several low- and middle-income countries have set up social pension schemes (Box 8.3).

BOX 8.2: NATIONAL STRATEGY TO ERADICATE CHILD POVERTY IN THE UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND

The national strategy to eradicate child poverty introduced in the United Kingdom in 1997 includes four elements: financial support for families, employment-related opportunities and support, tackling material deprivation through promoting financial inclusion and improving housing, and investing in public services. The strategy combines universal and targeted approaches. In the 18 years

before the New Labour government took power, the number of children living in relative poverty in the United Kingdom had tripled to reach 34% or 4.3 million – the third highest rate in the industrialized world. To date, the percentage reduction in child poverty resulting from the strategy appears to have been modest, although important in absolute terms.

Source: SEKN, 2007

Developing, implementing, and evaluating pilot projects

Addressing health equity through a social determinants framework is a long-term investment. Low- and middle-income countries cannot be expected to implement a fully comprehensive suite of universal social protection policies overnight. It is, however, feasible gradually to develop these systems by developing and implementing pilot projects. Many low- and middle-income countries are starting to experiment with social protection programmes. These include social pension schemes and cash transfer programmes. The latter are being set up in Latin America, in particular (Fernald, Gertler & Neufeld, 2008), but also in several African countries (Bhorat, 2003; Schubert, 2005; UNICEF, 2007b). Process and impact evaluation tends to be rare, but is critical to the success of scaling up pilot projects to the national level (McKinnon, 2007). An example of a well-evaluated (targeted) cash transfer programme is Oportunidades in Mexico, which used randomly assigned treatment and control groups (Box 8.6).

Successful pilot projects can be progressively rolled-out to the national level, for example, starting with the most deprived regions. Sustainable development and implementation of social protection schemes are best achieved through piggybacking onto existing institutional structures (McKinnon, 2007).

In Lesotho, for example, pensions are disbursed using the countrywide post office network (Save the Children UK, HelpAge International & Institute of Development Studies, 2005).

Scaling up social protection programmes to the national level of course has implications for fiscal and institutional capacity and infrastructure. The lack of capacity and infrastructure in many low-income countries severely restricts programmes aiming to extend social protection (SEKN, 2007). Donors and international organizations, including the ILO, have an important role to play in building capacity for social protection in these countries. Building up universal social protection systems will require changes in the global economy and national economic policies, allowing all countries to reach the level of development at which this is feasible and sustainable in the long term (see Chapters 11 and 15: *Fair Financing; Good Global Governance*).

Once systems are implemented, uptake is important. Civil society organizations can play an important role in helping people become aware of and access their social security entitlements (HelpAge International, 2006a) (Box 8.4). They can also play an important role in getting and keeping social security high on the policy agenda, and in monitoring progress on government commitments regarding social protection (HelpAge International, 2006a).

BOX 8.3: UNIVERSAL SOCIAL PENSION – BOLIVIA

In Bolivia, 59% of older people live on less than a US\$ 1/day. One annual payment of Bs 1800 (US\$ 217) is available to all resident Bolivian citizens over the age of 65. Recipients collect the one-off annual payments in cash from affiliated banks, which are usually in urban areas. The pension makes up 1.3% of GDP. Half of recipients said that this social pension was their only source of income. It is generally spent on household expenses, but also on basic medication. In addition, the pension provides older people with capital that they can choose to invest in income-generating activities or for younger generations. Not only does this have a financial value, but it also has a social value, increasing their status within the family.

In 2004, 77% of those eligible were claiming the entitlement. However, pension coverage is particularly low among women. Unfortunately, they are also in greatest need. One problem is that identification documents are needed to register, and 16% of older people who are eligible for the pension scheme do not have identity documents, so cannot prove their eligibility. Many older people in rural communities have never had a birth certificate. HelpAge International, an NGO, supports socio-legal centres in La Paz and El Alto that help older people obtain a birth certificate from the government registry office so that they can receive their pension.

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BOX 8.4: PROMOTING ACCOUNTABILITY TO OLDER PEOPLE AND UPTAKE OF PENSIONS – BANGLADESH

“In Bangladesh, an NGO, the Resource Integration Centre, worked with older people in 80 villages to form associations, which elected monitoring groups on older people’s entitlements – the old age allowance, widow’s allowance and access to health services. They found that significantly fewer people were receiving entitlements than were eligible – less than 1

in 10 in one area. The older people’s associations held regular meetings with local government to help people claim pension entitlements; as a result, pension uptake increased five-fold, and banks improved their procedures for serving older people.”

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The generosity of social protection systems

Health and health equity are influenced not just by the degree of universalism, but also by the degree of generosity of social protection policies (Lundberg et al., 2007). Governments are advised to build up the generosity of social protection systems towards a level that is sufficient for healthy living. At the same time, minimum wages should also be sufficient for healthy living (see Chapter 7: *Fair Employment and Decent Work*), such that social protection policies and work policies are complementary.

Methods exist for calculating the minimum cost for healthy living. One methodology, proposed by Morris et al. (2007) (Box 8.5), builds a budget standard based on a basket of commodities deemed essential for healthy living. While the amount of money required for healthy living will be context dependent, such a methodology, or similar, could be adapted in all countries and used to inform minimum-wage and social welfare-benefit levels.

Low-income countries generally have limited financial resources to fund social protection programmes, and limited capacity to raise such funds given that a large part of their economy is informal and/or based on subsistence agriculture. The resources available may be further reduced by trade liberalization and tax competition (GKN, 2007). Resource constraints will often limit the generosity of social protection systems in low-income countries. Indeed, in practice the benefit level of existing universal schemes in low- and middle-income countries is often (very) limited (see Table 8.1). While insufficient and needing progressive strengthening, even a small amount of money on a regular basis can make an important difference in terms of well-being in poor countries (McKinnon, 2007; HelpAge International, 2006a). Low- and middle-income countries can progressively increase generosity to a level sufficient for healthy living, gradually protecting against a more comprehensive set of risks, where necessary with the help of donors.

Targeting

The Commission recommends that:

- 8.2 Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, use targeting only as back up for those who slip through the net of universal systems.**

While in many countries there may be a tendency to target social protection programmes to the most deprived, there are strong arguments for setting up universal protection systems, even in poor countries. Universal approaches to social protection tend to be more efficient than approaches that target the poor. Targeting is often costly and administratively difficult (HelpAge International, 2006a; McKinnon, 2007); universal systems require less administrative and institutional capacity and infrastructure. This is critical in settings where such capacity and infrastructure are the more binding constraints (provided donors contribute to or even cover the financial costs). In most poor countries, leakage to the rich costs less than the costs of means testing (World Bank, 1997). Moreover, targeting often does not produce the desired results. For example, it may leave out those who are just above the poverty line (McKinnon, 2007). Problems also include low uptake among eligible groups and inefficiencies due to the complex administrative systems required to monitor compliance, leading to irregular/erroneous payments and increased fraud (HelpAge International, 2006a; SEKN, 2007). Moreover, historical experience suggests that the form that social protection systems take, universal or targeted, tends to depend on what a system looks like from the outset: countries that start with targeted systems tend to continue along the same line (Pierson, 2000; Pierson, 2001; Korpi, 2001). For these reasons, it is advisable to create universal protection systems from the outset.

Despite these important drawbacks, means-tested or targeted cash transfers can have a significant positive impact on poverty reduction, living standards, and health and educational outcomes. Oportunidades, the conditional cash transfer programme in Mexico, for example, uses a combination of geographic and household-level targeting, and has shown important health effects (Box 8.6). Often, selective programmes based on means testing will continue to exist as complements to universal programmes (Lundberg et al., 2007). It is advised that targeting is only used as a back up for those who slip through the net of universal systems (Lundberg et al., 2007; SEKN, 2007).

BOX 8.5: MINIMUM INCOME FOR HEALTHY LIVING

An assessment was made of the cost of living among single people aged 65+ without significant disabilities living independently in England. Based on consensual evidence, a basket of commodities considered necessary for healthy day-to-day living was priced including food and physical activity, housing, transport, medical care and hygiene, and costs relating to psychosocial relations/social inclusion (such as costs for telephone, newspapers, and small

gifts to grandchildren and others). The total cost was considered indicative of the minimum disposable income that is now essential for health. The minimum cost of healthy living for this population group was assessed at £131.00/week (England April 2007 prices). This is substantially higher than the state pension for a single person in April 2007 of £87.30, and the Pension Credit Guarantee of £119.05 (which is means tested).

Source: Morris et al., 2007

Within universal social protection systems, conditionalities are sometimes used to stimulate specific behaviours such as use of health-care or education services. Again, an example is Oportunidades. Such cash transfer schemes are being pursued in many countries, including Brazil and Colombia, and in the high-income city New York (Office of the Mayor, 2007). Similarly, unemployment, disability, and sickness benefits, for example, can be conditional on enrolling in schemes that help find work. These conditionalities depend on the availability of jobs, according to people's capabilities, that provide long-term security with an income that is at least sufficient for healthy living (see Chapter 7: *Fair Employment and Decent Work*). While such programmes can have important positive (health) effects, the evidence for the added value of conditionalities per se is inconclusive (SEKN, 2007). A cash transfer programme in Ecuador showed positive effects on the physical, social-emotional, and cognitive development of children, even without conditionalities (Paxson & Schady, 2007).

Extending social protection systems to excluded groups

The Commission recommends that:

- 8.3. Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, ensure that social protection systems extend to include those who are in precarious work, including informal work and household or care work (see Rec 7.4, 11.1, 13.3).**

For all countries, rich and poor, it is important that social protection systems also protect people normally excluded from such systems: those in precarious work, including informal work and household or care work (WGEKN, 2007). This is particularly important for women, as family responsibilities

often preclude them from accruing adequate benefits under contributory social protection schemes. Social protection systems, including pension schemes, should be set up so that they promote gender equity. A gender perspective must be incorporated into the design and reform of pension systems in order not to perpetuate gender inequities through social protection policies (WGEKN, 2007).

Including all through tax- and aid-based security systems

In many low- and middle-income countries, the majority of the population works in the informal sector and is therefore generally excluded from contributory social security schemes. In these countries, tax-based social protection programmes are of growing interest (HelpAge International, 2007; McKinnon, 2007). A number of low- and middle-income countries have, for example, set up universal or means-tested social pension systems (HelpAge International, 2006a) (see Table 8.1). It costs these countries 0.03–2% of GDP, depending on the size of the transfer and the size of the eligible population (HelpAge International, 2006a). Some are nationally financed, but for others donor support is needed (through general budget support and/or protected social protection sector programmes) (HelpAge International, 2006a). A combination of higher priority of social protection in public budgets and increased official development assistance can make rolling out social protection systems feasible in all countries (Mizunoya et al., 2006; Pal et al., 2005). Long-term and predictable funding mechanisms are needed and unpredictability of donor funding can be an important obstacle to the creation of social pension systems in many poor countries (HelpAge International, 2006a) (see Chapter 11: *Fair Financing*). Governments are advised to embed social security policies in poverty reduction strategies to ensure necessary donor funding (HelpAge International, 2006a). Existing schemes in countries such as Bolivia, Lesotho, Namibia, and Nepal show that creating a basic social protection system is administratively and practically feasible in low-

BOX 8.6: OPORTUNIDADES – CONDITIONAL CASH TRANSFER

An example of a conditional programme used to stimulate specific behaviour is Oportunidades (formerly Progressa), the conditional cash transfer programme in Mexico. The programme involves cash transfers to families provided that children aged 0–60 months are immunized and attend well-baby clinics where their nutritional status is monitored. These children are given nutritional supplements and their parents are given health education. Pregnant women receive prenatal care, lactating women receive postpartum care, other family members receive physical check-ups once per year (where they also receive health education), and adult family members participate in regular meetings where health, hygiene,

and nutritional issues are discussed. An evaluation found that the programme had important health effects. Children born during the 2-year intervention period experienced 25% less illness in the first 6 months of life than control children, and children aged 0–35 months during the intervention experienced 39.5% less illness than their counterparts in the control group. Children in the programme were also one quarter as likely to be anaemic, and grew on average 1 cm more. Finally, the effects of the programme appear to be cumulative, increasing the longer the children stayed in the programme.

Source: ECDKN, 2007b

SOCIAL PROTECTION : ACTION AREA 8.2

Extend social protection systems to those normally excluded.

and middle-income countries, despite obvious challenges (McKinnon, 2007) (Box 8.7). Setting up such systems requires long-term national, and international, commitment.

The amount that pensioners receive from such schemes varies widely between countries, from US\$ 2/month in Bangladesh and Nepal to US\$ 140/month in Brazil. Few countries provide a pension above the absolute poverty line of US\$ 1/day; all countries that do are middle- rather than low-income countries (Table 8.1). Protection systems and their generosity can be more rapidly increased with such external support (ILO, 2007b).

Including all through contributory social security systems

Tax-based financing is not the only way to set up universal social security systems in countries with a large informal sector. Box 8.8 describes an innovative initiative in India to set up a contributory social security system. The proposed system is based on contributions by employers by way of tax on their enterprise, by workers above the poverty line, and by the government.

Universal social protection systems are an important component of policies that seek to enable healthy living for all across the lifecycle – in rich and poor countries alike. Administrative and institutional capacity remains a critical barrier in many poor countries. Nevertheless, poor countries can progressively expand such systems by starting pilot projects and by gradually increasing the system’s generosity, where necessary with help from donors.

BOX 8.7: UNIVERSAL SOCIAL PENSION SYSTEM IN LESOTHO

Since 2004, Lesotho has had a universal social pension scheme for all residents aged 70+ years. It is financed out of domestic resources and costs 1.43% of GDP. The benefit level is approximately the same as the national poverty line (about US\$ 21/month). Monthly disbursement happens through the post office network that exists both in rural and urban areas

(McKinnon, 2007). The age criterion of 70+, which reduces the cost of the programme, means that only a limited number of people benefit. The Government of Lesotho plans to lower the age limit to 65+, which would allow more people to benefit from the system.

Source: Save the Children UK, HelpAge International & Institute of Development Studies, 2005

BOX 8.8: SETTING UP A CONTRIBUTORY SOCIAL SECURITY SYSTEM IN INDIA

Of the workforce in India, 93% is informal. These workers have no security of work and income, nor statutory social security. The Self-Employed Women’s Association (SEWA), a union of 1 million women workers in India, has been spearheading a national campaign for basic social security for informal workers. It developed a draft bill giving all informal workers the right to social security including, as a minimum, insurance, pension, and maternity benefits. Several national unions have joined this campaign. The national government set up a commission to develop laws and policies for informal workers. The commission developed a law that envisages

basic coverage – health insurance, life and accident insurance, maternity benefits, and pension – for the 380 million workers in the informal economy. When fully implemented, these benefits will cost less than 0.5% of Indian GDP. Contributions from the government, employers as a group (by way of a tax on their enterprises), and workers above the poverty line will finance the social security coverage suggested by the commission. Workers below the poverty line will not need to provide any contributions. At the time of writing, the bill is being reviewed and is expected to be presented to Parliament in its next session.

Table 8.1: Social pensions in low- and middle-income countries

Country	Age eligibility (years)	Universal (U) or means tested (M)	Amount paid monthly (US\$/local currency)	% of population 60+ years	% of people 60+ receiving a social pension	Cost as % of GDP	Low- (L) or middle-income (M) country
Argentina	70+	M	US\$ 88 273 pesos	14%	6%	0.23%	M
Bangladesh	57+	M	US\$ 2 165 taka	6%	16%*	0.03%	L
Bolivia**	65+	U	US\$ 18 150 bolivianos	7%	69%	1.3%	M
Botswana	65+	U	US\$ 27 166 pula	5%	85%	0.4%	M
Brazil (Beneficio de Prestacao Continuada)	67+	M	US\$ 140 300 reais	9%	5%	0.2%	M
Brazil (Previdencia Rural)	60+ men 55+ women	M	US\$ 140 300 reais	9%	27%***	0.7%	M
Chile	65+	M	US\$ 75 40 556 pesos	12%	51%	0.38%	M
Costa Rica	65+	M	US\$ 26 13 800 colones	8%	20%	0.18%	M
India	65+	M	US\$ 4 250 rupees	8%	13%	0.01%	L
Lesotho	70+	U****	US\$ 21 150 loti	8%	53%	1.43%	L
Mauritius	60+	U	US\$ 60 1978 rupees	10%	100%	2%	M
Moldova	62+ men 57+ women	M	US\$5 63 lei	14%	12%	0.08%	L
Namibia	60+	M	US\$ 28 200 dollars	5%	87%	0.8%	M
Nepal	75+	U	US\$ 2 150 rupees	6%	12%	unknown	L
South Africa	65+ men 58+ women	M	US\$ 109 780 rand	7%	60%	1.4%	M
Tajikistan	63+ men 58+ women	M	US\$ 4 12 somoni	5%	unknown	unknown	L
Thailand	60+	M	US\$ 8 300 baht	11%	16%	0.00582%	M
Uruguay	70+	M	US\$ 100 2499 pesos	17%	10%	0.62%	M
Viet Nam	60+	M	US\$ 6 100 000 dong	7%	2%	0.022%	L
Viet Nam	90+	U	US\$ 6 100 000 dong	7%	0.5%	0.0005%	L

*Percentage of people aged 57+ years receiving a social pension; **paid annually; ***includes women 55+; ****universal with a few exceptions, primarily people who are already receiving a substantial government pension (about 4% of those who would otherwise be eligible).

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CHAPTER 9

Universal health care

“No one should be denied access to life-saving or health-promoting interventions for unfair reasons, including those with economic or social causes”

Margaret Chan, WHO Director-General (Chan, 2008)

THE RELATIONSHIP BETWEEN HEALTH CARE AND HEALTH EQUITY

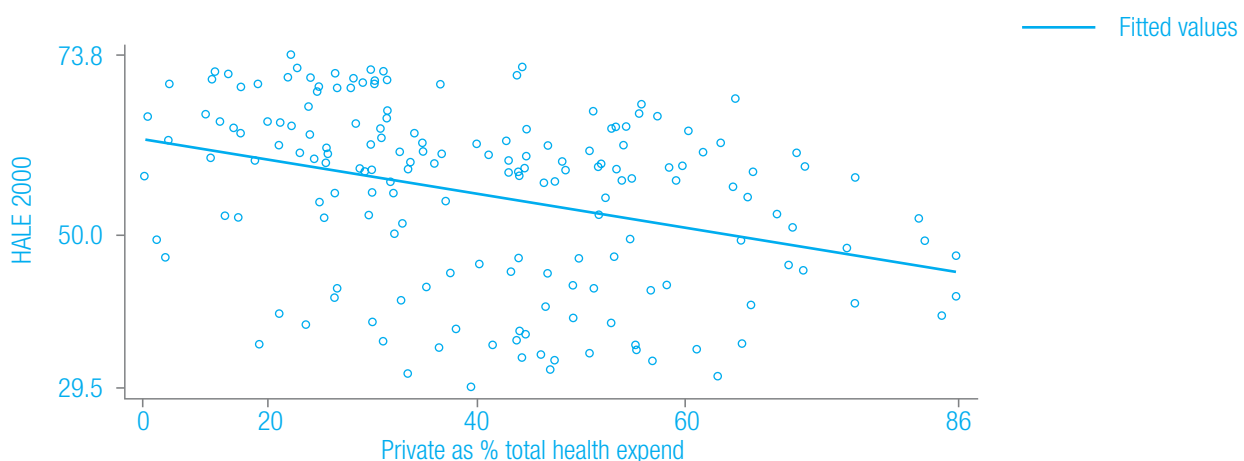
Health-care systems⁸ are a vital determinant of health. Yet, with the exception of rich industrialized countries, they are frequently chronically underresourced, and they are pervasively inequitable. Over half a million women die each year during pregnancy or delivery or shortly thereafter, virtually all in low- and middle-income countries (WHO, 2005b). Lack of access to and utilization of adequate maternity care is a key factor in this appalling statistic. In many countries, both poor and rich, costs of health care can lead to disastrous impoverishment. Every 30 seconds in the United States, someone files for bankruptcy following a serious health problem (National Coalition on Health Care, 2008). The health-care system needs to be designed and financed to ensure equitable, universal coverage, with adequate human resources. Health systems should be based on the PHC model, combining locally organized action on the social determinants of health as well as a strengthened

primary level of care, and focusing at least as much on prevention and promotion as on treatment. Under these conditions, health care can offer much more than treatment for disease when it occurs. It can provide integrated, locally relevant, high-quality programmes and services promoting equitable health and well-being for all. And it can provide a common platform of security and social cohesion across societies and communities.

Inequitable distribution of health care

Health care is inequitably distributed around the world. The pattern of inequity in utilization is pronounced in low- and middle-income countries, but inequity is prevalent in high-income settings too. In the United States, minorities are more likely to be diagnosed with late-stage breast cancer and colorectal cancer than whites. Patients in lower socioeconomic strata are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and its complications (Agency for Health Care Research and Quality, 2003). Inequities in health care are related to a host of socioeconomic and cultural factors, including income, ethnicity, gender, and rural/urban residency. As a fundamental contributor to welfare in every country, this is unacceptable.

Figure 9.1: Health-adjusted life expectancy (HALE) and private spending as a % of total health spending in 2000.



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⁸ Defined as the health system, “including preventive, curative and palliative interventions, whether directed to individuals or to populations” (WHR, 2000).

The health-care system – more than treatment of disease

Health care absorbs around 10% of global GDP, most spent in high-income countries compared with middle- and low-income countries. As employers, health-care systems provide work for around 59 million people (GKN, 2007). Health-care systems offer benefits that go beyond treating illness – especially where they are integrated with other services such as ECD programmes (ECDKN, 2007a). They can protect against sickness, generating a sense of life security, and can promote health equity through attention to the needs of socially disadvantaged and marginalized groups (HSKN, 2007). Health-care systems contribute most to improving health and health equity where the institutions and services are organized around the principle of universal coverage (extending the same scope of quality services to the whole population, according to needs and preferences, regardless of ability to pay), and where the system as a whole is organized around Primary Health Care (including both the PHC model of locally organized action across the social determinants of health, and the primary level of entry to care with upward referral).

Health-sector reform

However, broad global currents of macroeconomic policy change have strongly influenced health-sector reforms in recent decades in ways that can undermine such benefits. These reforms include encouragement of user fees, performance-related pay, separation of the provider and purchaser functions, determination of a package that privileges cost-effective medical interventions at the expense of priority interventions to address social determinants, and a stronger role for private sector agents. These have been driven strongly by a combination of international agencies, commercial actors, and medical groups whose power they enhance (Bond & Dor, 2003; Homedes & Ugalde, 2005; Lister, 2007). The result has been on the one hand an increasing commercialization of health care, and on the other, a medical and technical focus in analysis and action that have undermined the development of comprehensive primary health-care systems that could address the inequity in social determinants of health (Rifkin & Walt, 1986; Ravindran & de Pinho, 2005).

Opening the health sector to trade, reform processes have split purchasers and providers and have seen increasing segmentation and fragmentation in health-care systems. Higher private sector spending (relative to all health expenditure) is associated with worse health-adjusted life expectancy (Fig. 9.1), while higher public and social insurance spending on health (relative to GDP) is associated with better health-adjusted life expectancy (Koivusalo & Mackintosh, 2005). Moreover, public spending on health is significantly more strongly associated with lower under-5 mortality levels among the poor compared to the rich (Houweling et al., 2005). The Commission considers health care a common good, not a market commodity.

Underlying these reforms is a shift from commitment to universal coverage to an emphasis on the individual management of risk. Rather than acting protectively, health care under such reforms can actively exclude and impoverish. Upwards of 100 million people are pushed into poverty yearly through the catastrophic household health costs that result from payments for access to services (Xu et al., 2007).

Runaway commodification of health and commercialization of health care are linked to increasing medicalization of human and societal conditions, and the stark and growing divide of over- and under-consumption of health-care services between the rich and the poor worldwide. The sustainability of health-care systems is a concern for countries at all levels of socioeconomic development. Acknowledging the problem of sustainability in the context of a call for equitable health care is a vital first step in more rational policy-making, as is strengthening public participation in the design and delivery of health-care systems. The inverse care law (Tudor-Hart, 1971), in which the poor consistently gain less from health services than the better off, is visible in every country across the globe. A social determinants of health approach to health-care systems offers an alternative – one that unlocks the opportunities for greater efficiency and equity.

BOX 9.1: THAILAND – ACHIEVING UNIVERSAL HEALTH CARE

By early 2002, Thailand had achieved universal health-care coverage, incorporating a comprehensive package of curative services in outpatients, inpatients, accident and emergency, high-cost care, drugs provision reflecting the WHO Essential Drug Lists, and personal preventive and promotion services, with minimal exclusion (e.g. aesthetic surgery, renal replacement therapy for end-stage renal disease). The Universal Coverage scheme – primarily focusing on the financing side – was characterized by clear policy goals, defined participation, strong institutional capacity, and very rapid implementation (12 months). The agenda for universal coverage was set by the Prime Minister after electoral victory in 2001; policy

formulation was led by civil servants supported by policy reformers and researchers generating policy options through research-policy linkages. Based on previous experience of diverse health-care coverage schemes, the new universal coverage policy:

rejected a fee-for-service model;

adopted a capitation fee (paid to health-care provider from tax funds) as the payment method;

focused universal coverage on better use of primary care, with proper referral processes.

Source: HSKN, 2007

ACTIONS FOR UNIVERSAL HEALTH CARE

The Commission recommends that:

- 9.1 National governments, with civil society and donors, build health-care services on the principle of universal coverage of quality services, focusing on Primary Health Care (see Rec 5.2; 7.5; 8.1; 10.4; 13.6; 14.3; 15.2; 16.8).**

Universal Primary Health Care

Virtually all high-income countries organize their health-care systems around the principle of universal coverage (combining mechanisms for health financing and service provision). But commitment to universal care is not limited to high-income countries. Thailand, for example, has shown leadership and success (Box 9.1).

Primary Health Care (combining the PHC model of action on the social determinants of health and an emphasis on the primary level of care, with effective upwards referral) implies comprehensive, integrated, and appropriate care, emphasizing disease prevention and health promotion. Evidence supporting the effectiveness of PHC approaches runs across the spectrum from high- to middle- and low-income settings (Box 9.2).

In Costa Rica, strengthened primary care (with improved access and the institution of multidisciplinary health teams) resulted in a reduction in the national infant mortality rate from 60 per 1000 live births in 1970 to 19 per 1000 in 1985. For every 5 years after the reform, child mortality was reduced by 13% and adult mortality by 4%, independent of improvements in other health determinants (PAHO, 2007; Starfield, 2006; Starfield et al., 2005). Evidence of the success of primary level services is also available from Africa (Democratic Republic of the Congo formerly Zaire, Liberia, Niger), Asia (China, India (the state of Kerala), Sri Lanka), and Latin America (Brazil, Cuba) (De Maeseener et al., 2007; Doherty & Govender, 2004; Halstead et al., 1985; Macinko et al., 2006; Starfield et al., 2005; Levine, 2004).

Primary Health Care – community engagement and empowerment

The PHC model emphasizes community participation and social empowerment, even in the face of local power imbalance, resource constraints, and limited support from higher levels of the health system (Baez & Barron, 2006; Goetz & Gaventa, 2001; Lopez et al., 2007; Vega-Romero & Torres-Tovar, 2007). Social empowerment strategies can increase social awareness of health and health-care systems, strengthening

UNIVERSAL HEALTH CARE : ACTION AREA 9.1

Build health-care systems based on principles of equity, disease prevention, and health promotion.

BOX 9.2: PRIMARY HEALTH CARE, PRIMARY LEVEL CARE, AND POPULATION HEALTH

Evidence, mainly from high-income countries, shows that health-care systems that are organized around the primary care level have better health outcomes (Starfield et al., 2005).

Population health is better in geographic areas with more primary care physicians.

Individuals who receive care from primary care physicians are healthier.

There is an association between the special features of primary level care (e.g. preventive care) and improved health in the individuals who receive these services.

This last point suggests that it may not only be improved access to curative care that renders primary level care effective, but also its embodiment of the principles of disease prevention and health promotion.

Source: HSKN, 2007

BOX 9.3: EXAMPLES OF SOCIAL EMPOWERMENT STRATEGIES

Social empowerment strategies include the following:

increasing citizens' access to information and resources and raising the visibility of previously ignored health issues (the Panchayat Waves community radio programme in India; the participatory research and advocacy campaign on breast cancer in the United Kingdom; the Community Working Group on Health in Zimbabwe);

developing the consciousness, self-identity, and cohesion that underlie social action (South African study of micro-finance training and intimate partner violence for poor rural women);

involving population groups in priority-setting for planning (local theatre in the United Kingdom to identify alternative policy solutions through local Health Improvement Plans).

Source: HSKN, 2007

health literacy and mobilizing health actions (Goetz & Gaventa, 2001; Loewenson, 2003; Vega-Romero & Torres-Tovar, 2007) (Box 9.3).

Bangladesh's Urban PHC Project (Box 9.4) shows how public awareness of health needs, and partnership between local government and civil society, supports effective design and management of health care for marginalized urban groups.

Governments can take action to promote accountability of health-care systems to citizens (Murthy, 2007) (Box 9.5).

Evidence across the PHC literature supports the importance of including intended beneficiary groups in all aspects of policy and programme development, implementation, and evaluation. Advocacy – spearheaded by civil society – is required to raise attention and sustain support for services that address the health needs of poor women. Sex-specific needs in health conditions that affect both women and men must be considered, so that treatment can be accessed by both women and men without bias (WGEKN, 2007; Thorson et al., 2007; Bates et al., 2004; Huxley, 2007).

With a demographic shift in many regions towards older populations, health-care systems must focus on supporting healthy ageing. Global LEB is expected to continue to increase in both the developed and developing worlds so that the percentage of the population over age 65 years is predicted to increase from 7.4% in 2005 to between 13.7% and 19.1% in 2050 (Musgrove, 2006). Most growth is expected to occur in less-developed countries. Evidence suggests that disability,

usually due to chronic disease, is an important public health problem from age 45 years onwards. Major causes of age-related disability are neuropsychiatric disorders (the growing prevalence of conditions such as Alzheimer's disease), sight and hearing impairment, osteoporosis, arthritis, diabetes, and injury. Protective action on determinants of healthy ageing form the wider social context in which health-care services must be adapted (NAS Panel on Aging, 2006).

Prevention and promotion

Health care can do much more than treat disease when it happens. Research shows how a significant proportion of the global burden of both communicable and non-communicable disease could be reduced through improved preventive action (Lopez et al., 2006). Medical and health practitioners have powerful influence in the way society thinks about and provides health. They, alongside other advocates from across the fields of political, economic, social, and cultural action and activism, can bear witness to the ethical imperative, just as much as the efficiency value, of acting on the social causes of exposure and vulnerability to risk of poor health, and of action further upstream still (PPHCKN, 2007c; see also WHO's *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*). The PPHCKN is producing work across its departments showing how programmes can be better designed, delivered, and monitored to recognize health inequities and act on the social determinants of health. Options for action on mental health (Table 9.1) provides an example.

BOX 9.4: URBAN PRIMARY HEALTH CARE – BANGLADESH

The Urban PHC Project in Bangladesh is a partnership between municipal governments and civil society that aims to provide health services for populations living in informal settlements. City Corporations are working with 14 NGOs that set up health centres with funding from the ADB, UNDP, DFID, CIDA, and EU. The poorest women and children living in these settlements are offered subsidized good-quality

primary health-care services and constitute 75% of all beneficiaries. The ultra-poor receive services free of cost. Coverage of primary care services increased from 400 000 people in 2001 to 5 million in 2004 served by 124 primary care facilities.

Source: KNUS, 2007

BOX 9.5: GOVERNMENT ACTION FOR PUBLIC ACCOUNTABILITY IN HEALTH CARE

Government actions that increase public accountability in health care include the following:

legislation on the right to health, and on rights of citizens to information and to participate in public policy and budgeting (see Chapter 10: *Health Equity in All Policies, Systems, and Programmes*);

legislation on the right of citizens to participate in hospital management and health-service delivery, and in quality assessments of provider clinics and providers; establishment of mechanisms for self-regulation by health professionals, and for protecting patient rights;

strengthening gender equity accountability of health-care systems through ombudsmen centres on sexual and reproductive health and rights and national- and state-level committees to monitor sexual and reproductive health programmes.

Source: HSKN, 2007

Table 9.1: Mental health – determinants and interventions

Differentials	Determinant	Intervention
Differential health-care access	Lack of available services	Improving availability of mental health services through integration into general health care
	Unacceptable services	Ensuring that mental health staff are culturally and linguistically acceptable
	Economic barriers to care	Providing financially accessible services
Differential consequences	Financial consequences of impact of depression on productivity	Support to caregivers to protect households from financial consequences of depression; rehabilitation programmes
	Social consequences of depression	Antistigma campaigns; promotion of supportive family and social networks
	Financial consequences of depression treatment	Reduce cost
	Lifestyle consequences of depression	Mental health promotion, including avoidance of substance abuse
Differential vulnerability	Early developmental risks	Promote ECD programmes
	Early developmental risks, maternal mental illness, weak mother-child bonding	Mother-infant interventions, including breastfeeding
	Developmental risks for adolescence	Depression prevention programmes targeting adolescents
	Development risks for older adults	Education and stress-management programmes; peer support mechanisms
	Inaccessibility to credit and savings facilities	Improve access to credit and savings facilities for poor
Differential exposure	Violence/crime	Violence/crime prevention programmes
	Social fragmentation	Promoting programmes building family cohesion and wider social cohesion
	Natural disasters	Trauma and stress support programmes
	Injury prevention	Targeting conditions of multiple deprivation
	Inadequate housing	Housing improvement interventions
	Poor neighbourhoods	Relocation programmes
	Unemployment	Employment programmes, skills training
Socioeconomic context and position	Lack of government policy and legislation; human rights framework	Strengthening mental health policy; legislation and service infrastructure
	Substance abuse	Alcohol and drugs policies
	Stigma	Mental health promotion programmes
	Unemployment	Economic policies to promote stability and financial security, and provide adequate funding for a range of public sector services (health, social services, housing)
	Financial insecurity	Welfare policies that provide a financial safety net
	Work stress	Protective labour policies (e.g. restrictions on excessive shift work, worker rights protection, job security)
	Lack of education	Mandating basic education, incentives, financial support

Source: PPHCKN, 2007d

Using targeted⁹ health care to build universal coverage

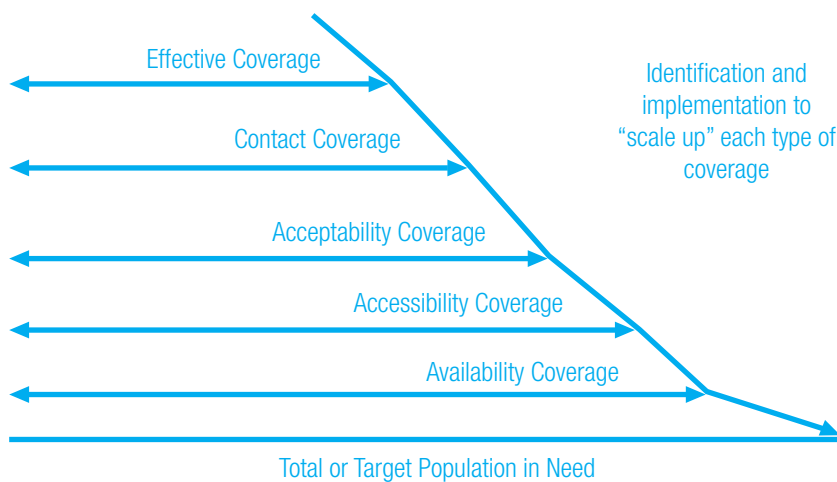
Coverage is not simply a matter of availability of drugs and services. It implies adequate, quality services reaching, and being utilized by, all those who need them. The Tanahashi model (Fig. 9.2) demonstrates five levels or steps that individuals, groups, or populations in need must pass through to obtain effective services or interventions, and how the proportion of people able to access care diminishes at each stage. Traditional disease programmes focus on effective and contact coverage. The PPHCKN is identifying entry points to overcome barriers, improving national programmes at each step (see Chapter 15: *Good Global Governance*).

In low-income countries, where public funding is limited and public spending commonly pro-rich, some argue that universal coverage is unlikely to be achieved in the short term and, as a policy goal, distracts attention from the critical need to experiment with other ways of extending health-care coverage to poorer groups (Gwatkin et al., 2004). While

it is important that all countries build a universal health-care system, ensuring that services preferentially benefit disadvantaged groups and regions can be an important strategy in the short term. Geographical or group-specific targeting and universal access are not contradictory policy approaches. Brazil and the Bolivarian Republic of Venezuela (Box 9.6) provide examples of the way large-scale national targeted health-care programmes can work towards universalism – establishing and enlarging right of access, promoting utilization, and channelling benefits, initially, towards the most disadvantaged groups in the population.

Yet care should be taken with targeting. Experience shows that it is difficult to expand small-scale projects designed preferentially to benefit the poor into national-scale action to address inequity (Ranson et al., 2003; Simmons & Shiffman, 2006).

Figure 9.2: Effective services for universal coverage.



Reprinted, with permission of the publisher, from Tanahashi (1978).

⁹ 'Targeted' refers to the range of social – including health-care – policy options whose central objective is to channel scarce health-care resources – in the immediate or medium term – preferentially towards poor and disadvantaged groups and regions.

The Commission recommends that:

9.2 National governments ensure public sector leadership in health-care systems financing, focusing on tax-/insurance-based funding, ensuring universal coverage of health care regardless of ability to pay, and minimizing out-of-pocket health spending (see Rec 10.4; 11.1; 11.2).

Health-care financing – tax and insurance

Universal coverage requires that everyone within a country can use the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency, and that people are empowered to use these services. It extends the same scope of benefits to the whole population (though the range of benefits varies between contexts), and it incorporates policy objectives of equity in payments, financial protection (Box 9.7), and equity of access to acceptable services.

There are a number of different models of health-care system financing, from general taxation, through mandatory universal insurance, to voluntary and community-based insurance schemes, and direct, out-of-pocket payment. Of these, the Commission advocates pre-payment methods of financing through general taxation (Box 9.8) and/or mandatory universal insurance for health equity (HSKN, 2007).

In Asia, public spending on health was redistributive in 10 of 11 countries, while four others achieved a pro-poor, or even, distribution of health benefits (O'Donnell et al., 2007; O'Donnell et al., 2005). In five of seven Latin American countries, public spending on health was either proportionally distributed across rich and poor groups or weighted to the poor (PAHO, 2001). Even in Africa, where concern has been expressed about inequity of public health-care expenditure, spending was found to be redistributive in all of the 30 countries studied (Chu et al., 2004). Health-care spending reached those in the lowest income categories (Kida & Mackintosh, 2005).

BOX 9.6: BRAZIL – THE FAMILY HEALTH PROGRAMME (PSF)

Established in the 1990s, PSF involves the provision of free universal access to primary care as the gateway to a publicly funded unified health-care system. Under the system, Family Health Teams (ESF) were set up covering a population of between 3000 and 4000 people each, and consisting of a general practitioner, a nurse, a nurse assistant, and a 'community agent' selected from the local population. Some ESFs also had Oral Health Teams. Initially, PSF focused on poor areas, but from 1998 onwards, the approach was adopted by the Federal Government as a strategy for transforming the existing national model of health assistance, and financial incentives were given to municipalities to encourage them to adopt the programme.

By 2006, 82 million people (46% of the population) were covered; coverage significantly increased in poor regions in the north and northeast; coverage was higher in cities with poorer populations.

Between 1988 and 2006, the programme created 330 000 new jobs.

Between 1998 and 2003, among cities with low Human Development Index, those with high PSF coverage saw the infant mortality rate decrease by 19%, while those with low PSF coverage saw it rise.

BOLIVARIAN REPUBLIC OF VENEZUELA - 'BARRIO ADENTRO

Barrio Adentro aims to transform the health-care system and has been a catalyst for initiatives aimed at wider social, political, cultural, and economic development. The programme began with the establishment of free primary care centres in informal settlements in Caracas but expanded into a national initiative providing primary health care to more than 70% of the population by 2006. In the early period of development, Barrio Adentro staff identified illiteracy and malnutrition as key priorities for public health and in response the government announced additional 'social missions' to enhance rights to land, education, housing, and cultural resources, and to promote recognition for indigenous people.

By 2006, 19.6 million people (73% of the population) were covered.

Between 2003 and 2005, there was an accelerated decline in the infant mortality rate and prevalent childhood diseases, with increased identification and follow-up of chronic illnesses.

Source: SEKN, 2007

UNIVERSAL HEALTH CARE : ACTION AREA 9.2

Ensure that health-care system financing is equitable.

The potential for redistributive health-care systems to offer health equity gains is further suggested by evidence from low- and middle-income countries that public health-care spending has a greater impact on mortality among the poor than the non-poor (Bidani & Ravallion, 1997; Gupta, Verhoeven & Tiongson, 2003; Wagstaff, 2003). So even where the poor receive less of the public spending subsidy than the rich, they may still secure relatively greater health gains than richer groups (O'Donnell et al., 2005; Wagstaff et al., 1999). This might be partly explained by the finding that health-care use among the poor is significantly more strongly related to public spending on health than health-care use among the rich (Houweling, 2005). Clearly, the emphasis on progressive tax-based health care depends on capacity to achieve adequate levels of domestic revenue (and/or adequate international aid) (see Chapter 11: *Fair Financing*).

Where taxation capacity and/or available sources of tax are weak, an alternative form of pre-payment is a national,

mandatory health insurance scheme. However, especially in low-income settings, such financing can be heavily reliant on external funding, in the initial instance at least, and this raises questions about long-term sustainability. The Ghana example (Box 9.9) has shown signs of dependence, but also shows how bold moves towards universal pre-payment are possible.

Smaller-scale insurance schemes may be useful as a way of increasing health services among very poor communities and households, but the small size of the risk pool, and the potential for fragmentation among multiple schemes, can have a negative impact on health equity. Strengthened risk sharing is associated with better average LEB and more equitable child survival rates (HSKN, 2007). The Thai case study (Box 9.10, Fig. 9.3) shows how financial coverage was extended to lower-income groups through the tax-funded Universal Coverage scheme, initially complementing other health insurance schemes, but building through the national insurance agency the potential to pool funds across schemes.

BOX 9.7: EQUITY AND PROTECTION

The essence of financing arrangements for universal coverage is to ensure protection against the financial costs of ill-health for everyone. In the context of low- and middle-income countries, financing universal coverage essentially means substantially reducing the often very high amounts paid out of pocket for health care, and substantially increasing the share of health financing that comes from tax funding and/or contributory health insurance. The implications of

such changes for who pays and who benefits will depend on the financing source(s), the scope of risk pooling arrangements, the approach to purchasing, and the determinants of use of services, including the influence of any mechanisms designed to target benefits to specific groups.

Source: HSKN, 2007

BOX 9.8: PROGRESSIVE HEALTH-CARE FUNDING – EVIDENCE FROM MIDDLE-INCOME AREAS

Areas where general tax funding makes up a greater share (e.g. Hong Kong SAR, Sri Lanka, Thailand) appear to have a more progressive pattern of health

financing than those dependent more on mandatory social health insurance financing (e.g. Korea).

Source: HSKN, 2007

BOX 9.9: MANDATORY HEALTH INSURANCE IN GHANA

While a growing number of African countries are considering or are in the early phases of introducing mandatory health insurance, the Ghanaian government has made the boldest moves in this direction of any African country to date. The government has made an explicit commitment to achieving universal coverage under the National Health Insurance (NHI), but recognizes that coverage will have to be gradually extended and the aim is to achieve enrolment levels of about 60% of residents in Ghana within 10 years of starting mandatory health

insurance. Ghana's NHI explicitly includes both those in the formal and informal sectors from the outset, building on a long Ghanaian tradition of community-based health insurance schemes. Secondly, although there are different sources of funding for the formal and informal sectors, they will belong to one unified scheme. It should be noted that there are signs of severe financial stress in the Ghana health insurance programme, deriving from its reliance on external funding support.

Source: HSKN, 2007

Despite recent interest in social health insurance (Box 9.11), progressive tax-based funding offers particular advantages (Mills, 2007; Wagstaff, 2007). Examples of tax-based systems include Canada, Sweden, and the United Kingdom. In some situations, such as falling employment, it may be difficult to extend mandatory insurance; and even within insurance systems, tax funding must be used fully or partially to subsidize the costs of care provided to groups who are hard to reach through insurance, such as the informally employed or self-employed.

Community-based insurance schemes played an important role in the evolution of universal coverage in Europe and Japan (Ogawa et al., 2003), as well as in Thailand, and are currently important in China and some African (Carrin et al., 2005) and transitional countries (Balabanova, 2007). Although such schemes may offer financial protection benefits to some among

the poor, cross-national evidence suggests that limited coverage, frequent exclusion of the very poorest, and weak capacity can limit the impact they have on equity and undermine their sustainability (Lagarde & Palmer, 2006; Mills, 2007). There is evidence that micro-insurance schemes for health suffer from similar problems and that, while they may offer immediate opportunities to extend coverage to those normally unable to achieve more formal insurance cover, they should be carefully regulated and monitored (Siegel et al., 2001). Separate insurance programmes may also face difficulties in achieving high coverage of the target population (Mills, 2007). Community-based and micro health insurance arrangements should only be implemented with caution, therefore, and efforts must be made to safeguard access for socially disadvantaged groups.

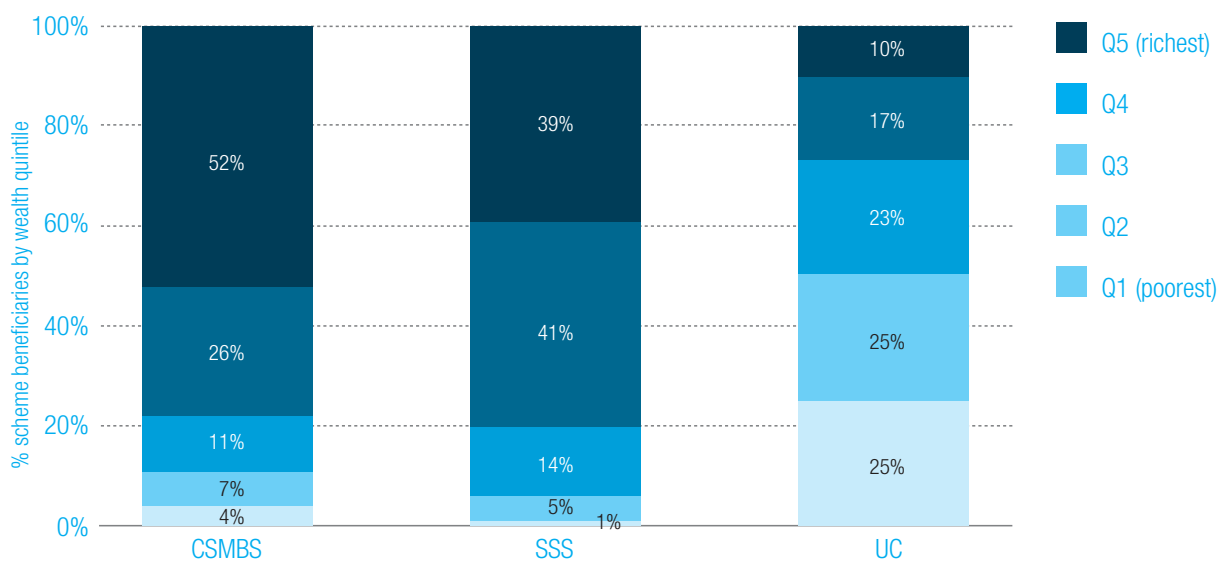
BOX 9.10: THAILAND – TAX-FINANCED UNIVERSAL HEALTH CARE

In the process of health-care system reforms in Thailand, a universal coverage model was built out of pre-existing health insurance schemes, including the Civil Service Medical Benefits Scheme (CSMBS) and the Social Security Scheme (SSS). Direct taxation was chosen as the funding mechanism for pragmatic reasons – the desire for speedy implementation. It has since been assessed as an equitable funding model in comparison with social insurance or other contributory schemes. Evidence from the Health and Welfare Survey conducted by the National Statistical

Office indicates that, compared with the CSMBS and SSS, the Universal Coverage scheme extended benefits much more towards the poor. Where 52% of beneficiaries under the CSMBS belonged to the richest quintile, 50% of the Universal Coverage scheme beneficiaries belong to the poorest two quintiles. The scheme has resulted in a reduced incidence of catastrophic health expenditure from 5.4% to 2.8-3.3%.

Source: HSKN, 2007

Figure 9.3 Extension of benefits to the poor through the Universal Coverage scheme.



CSMBS = Civil Service Medical Benefits Scheme; SSS = Social Security Scheme; UC = Universal Coverage Scheme; Q = wealth quintile. Source: HSKN, 2007

There are circumstances, in rich and poor country contexts, in which health-care users pay fees directly for services. In instances where such direct fee paying does not exacerbate inequity, it can be a component of health-care financing. However, where user fees adversely impact social inequity, or equity of health-care access, utilization, and/or benefit, they should be removed. Systematic reviews of available evidence clearly show that introduction of user fees in low- and middle-income countries has led to falling utilization levels (Lagarde & Palmer, 2006; Palmer et al., 2004) (Box 9.12). Out-of-pocket payments generate utilization inequities and impoverish women and lower-income and socially marginalized groups (Box 9.13).

The Commission recommends that:

9.3 National governments and donors increase investment in medical and health personnel, balancing health-worker density in rural and urban areas (see Rec 6.4; 16.5).

There is often geographical imbalance in the distribution of health workers within countries, which affects health-care service equity. More equitable distribution of the health workforce is likely to require national measures to improve overall human resource availability, as well as differential implementation between geographical areas to address the particular needs of underserved areas.

BOX 9.11: SOCIAL HEALTH INSURANCE

The concept of social health insurance is deeply ingrained in the fabric of health-care systems in Western Europe. It provides the organizing principle and a preponderance of the funding in seven countries – Austria, Belgium, France, Germany, Luxembourg, the Netherlands, and Switzerland. Since 1995, it has also become the legal basis for organizing health services in Israel. Previously, social health insurance models played an important role in a number of other countries that subsequently changed to predominantly tax-funded arrangements in the second half of the twentieth century – Denmark (1973), Italy (1978), Portugal (1979), Greece (1983), and Spain (1986).

Moreover, there are segments of social health insurance-based health-care funding arrangements still operating in predominantly tax-funded countries such as Finland, Sweden, and the United Kingdom, as well as in Greece and Portugal. In addition, a substantial number of central and eastern European countries have introduced adapted social health insurance models – among them, Hungary (1989), Lithuania (1991), the Czech Republic (1992), Estonia (1992), Latvia (1994), Slovakia (1994), and Poland (1999).

Amended, with permission of the publisher, from Saltman et al. (2004).

BOX 9.12: UGANDA – USER FEES IMPOSITION AND ABOLITION

Uganda introduced user fees on a universal basis in 1993. Although revenue generation was relatively low (generally less than 5% of expenditure), it was an important source of funds for supplementing health worker salaries, maintaining facilities, and purchasing additional drugs. However, there was a dramatic decline in the utilization of health-care services and there were growing concerns about the impact on the poor. User fees at public sector facilities were abolished in March 2001, with the exception of private wards. Utilization of health services increased immediately and dramatically. The poor particularly benefited from the removal of fees. Utilization of

health services (percentage who when sick sought professional care) increased from 58% to 70% in the case of the poorest quintile and from 80% to 85% for those in the richest quintile. National immunization coverage increased from 41% in 1999/2000 to 84% in 2002/03. This could not have been achieved without significant government financial support. Moreover, attention is required to other expenses such as drugs and transport costs, and the elimination of unofficial payments (Balabanova, 2007; O'Donnell et al., 2007).

Source: HSKN, 2007

The 2006 World Health Report (WHO, 2006) concludes that the actions with the most potential to improve personnel availability relate to salaries and payment mechanisms, combined with availability of materials and equipment needed and flexibility and autonomy to manage work. Experience in eastern and southern Africa also suggests that non-financial incentives (e.g. training, welfare provision, career paths, support, and supervision) may play a significant role in motivating health workers' choice of whether to work and stay at particular levels of service, and may have a more sustained effect in situations of high inflation and economic instability (Caffery & Frelick, 2006; Dambisya et al., 2005) (Box 9.14).

Human resources, both formal and informal, are an integral part of health-care systems. A majority of the health workforce is female, and the contributions of women to formal and informal health-care systems are significant but undervalued and unrecognized. This is partly due to the unavailability of sex disaggregated data on the care economy (WGEKN, 2007).

Women providing informal or auxiliary health services should be strongly supported in the health-care system, and closely tied in with higher levels of care service.

Across the health-care system, health-care workers offer a powerful lobby to lead the way in better integrating health care and the social determinants of health. Community health workers, while by no means the 'magic bullet' for health-care systems, offer a number of potential benefits in sustaining and developing health human resources. In most cases, community health workers are associated with lower costs in terms of training finance and time; they provide significant value to local health services provision, with minimal risk of brain-drain out-migration; depending on recruitment, they are often more willing to be posted in (or indeed are recruited from) rural areas; and they are often more conversant with the norms, traditions, and health needs of the communities they serve (Canadian Health Services Research Foundation, 2007).

BOX 9.13: OUT-OF-POCKET SPENDING AND HEALTH EQUITY

Out-of-pocket payment by patients at the point of service delivery negatively influences access to care.

In Asia, health-care payments pushed 2.7% of the total population of 11 low- to middle-income countries below the very low poverty threshold of US\$ 1/day.

A cross-country study in sub-Saharan Africa found that, "the poorer the quintile, the higher the rate of use of private facilities for [acute respiratory infection (ARI)], the lower the rate of treatment for ARI, the higher the percentage of children that lack immunization entirely, and the worse the child mortality rate."

In the United States, the average employee contribution to company-provided health insurance has increased more than 143% since 2000. Average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose 115% during the same period.

The average out-of-pocket medical debt for those who filed for bankruptcy in the United States was US\$ 12 000; 68% of those who filed for bankruptcy had health insurance, and 50% of all bankruptcy filings were partly the result of medical expenses (<http://www.nchc.org/facts/cost.shtml>).

Source: HSKN, 2007

BOX 9.14: REVERSING THE INTERNAL BRAIN DRAIN IN THAILAND

The internal brain drain in Thailand was reversed by providing:

combined financial and non-financial incentives for working in rural areas that included: changing physicians' status from civil servants to contracted public employees; housing; and recognition;

support through a wider programme of sustained rural development.

The differential availability of doctors between the rural northeast and Bangkok fell from 21 in 1979 to 8.6 in 1986.

Source: HSKN, 2007

UNIVERSAL HEALTH CARE : ACTION AREA 9.3

Build and strengthen the health workforce, and expand capabilities to act on the social determinants of health.

Aid for the health workforce

Increases in aid and debt relief should contribute to the strengthening of health-care systems, including contributing to recurrent costs such as human resource recruitment and training. This is not, however, always the case. Countries applying for debt relief under the Highly Indebted Poor Countries (HIPC) initiative must complete a PRSP – a national development plan – as part of the qualifying process. Each PRSP (acting as a gateway more broadly for the flow of aid to a given recipient) is moderated by means of a shorter timeframe plan for controlling expenditure – the Medium-Term Expenditure Framework (MTEF). Although not explicitly placing a cap on recurrent costs such as recruitment and salaries for much-needed health-care staff, the MTEF has been found to discourage such expenditure, leading to underinvestment in the human capacity critical for health-care systems (Box 9.15).

Global health initiatives (GHI) – such as the Global Fund for AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunisation, Stop TB, Roll Back Malaria, and the Multi-Country AIDS Programme – have brought significant new resources to international development and health. There is, however, a danger that large new funding

lines, running parallel to national budgeting, distort national priorities for allocation of expenditure and action (Box 9.16). At the same time, GHI – often offering higher salaries than those available in the public sector – may cream off health human resources from the national health system, exacerbating personnel scarcity.

The Commission recommends that:

9.4 International agencies, donors and national governments address the health human resources brain-drain, focusing on investment in increased health human resources and training, and bilateral agreements to regulate gains and losses.

Adequate numbers of appropriately skilled health workers at the local level are fundamental to extending coverage, improving the quality of care, and developing successful partnerships with the community and other sectors (Kurowski et al., 2007). In many parts of the world, however, low wages coupled with lack of infrastructure and poor working conditions lead to emigration of valuable and experienced human resources (GKN, 2007). Some high-income countries actively recruit doctors and nurses in Africa and Asia. International action can help to redress this (Box 9.17).

BOX 9.15: DEBT RELIEF, POVERTY REDUCTION, AND PAYING FOR HEALTH WORKERS

Part of the approval process for many PRSPs (conditional in the agreement and provision of debt relief under the HIPC programme) is the completion of an MTEF. MTEFs are set in negotiations between ministries of finance and the IMF, which prioritize very low inflation and avoiding fiscal deficits rather than addressing poverty or health needs. This process limits the size of the total budget and, within the budget, non-discretionary expenditures such as debt repayments tend to be prioritized, limiting sectoral

budgets. One study of four African countries found that health ministries had difficulty influencing this budget-setting process. Although the IMF stipulates that ceilings are not placed on recurrent costs such as the health sector wage bill, there is evidence that in practice the MTEF process has had a suppressant effect on adequate budget allocations to investment in the health workforce.

Source: GKN, 2007

BOX 9.16: GLOBAL HEALTH INITIATIVES

While GHIs have brought enormous new levels of funding to health-care systems within low- and middle-income countries (US\$ 8.9 billion in 2006 for HIV/AIDS alone), there is a concern that their vertically managed programmes have potential to undermine the population health orientation of health-care systems and exacerbate health inequity. As the GHIs

provide an estimated 90% of total development assistance for health (DAH) services, they have become major actors in global health policy. All GHIs need to plan for, finance, and address the impact on health systems, in particular addressing any potential drain on local and national health human resources.

Source: HSKN, 2007

Health-care systems are an important social determinant of health. Strengthened focus on the primary level of care, and wider action to build a broader Primary Health Care orientation within the health-care system, including community engagement in the assessment of needs, is vital. Within countries, increased financial allocations to health care are needed in almost every conceivable setting – most pressing in low-income countries. More than this, though, equitable modes of financing, removing any costs at the point of service that deter use or degrade equity of access and benefit, are key. This means public sector, pre-payment methods, with smaller-scale schemes used only as subsidiary strategies. An adequate supply of health workers requires not only investment in recruitment and training – including improved training in the social determinants of health as a core part of medical and health curricula – but also action to stop the haemorrhage of health workers migrating out of low- and some middle-income countries.

BOX 9.17: POLICY OPTIONS TO STOP THE HEALTH HUMAN RESOURCES BRAIN DRAIN

A number of policy options exist to address – and stop – the brain drain of health human resources from poorer countries. These include:

return of migrant programmes (costly and largely unsuccessful);

restricted emigration (weak, resulting often only in delaying migration) or immigration (modestly successful, although criticized for singling out health workers over other migrants);

bi/multilateral agreements to manage flow between source and destination countries (somewhat successful);

strengthening domestic health human resources in source countries (strongly supported in the literature, but questionable from the perspective of source countries in the context of global markets);

restitution (including two-way health human resources flows, and increased contribution from high-income receiving countries to health and health-training systems in low-income source countries).

Preference tends towards bilateral agreements and restitution as promising policy areas.

Source: GKN, 2007