Healthcare for the Poor and Dispossessed
From Alma-Ata to the Millennium Development Goals

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ABSTRACT

Healthcare models which recognize the equity principle have had to confront the challenge of providing healthcare for the poor and dispossessed. Healthcare premised on "human rights" strives to remove/ reduce barriers to access by a complete waiver of all fees in the public sector or various other subsidies to make healthcare more affordable. Social welfare programmes are held hostage to the vagaries of the economy and resource scarcity. The Alma-Ata's primary healthcare is inherently a health development strategy which embraces a wholistic approach to health and wellness. This strategy, by refocussing on the Millennium Development Goals, can therefore accommodate the innovations required to overcome the challenges posed by technological, financial, cultural and geographical factors to provide a better quality of life for all, but moreso for the poor and dispossessed.

Keywords: Biopsychosocial model, healthcare, medical indigence

Atención a la Salud para los Pobres y Desposeídos: de Alma-Ata a las Metas de Desarrollo del Milenio

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RESUMEN

Los modelos de atención a la salud que reconocen el principio de la equidad han tenido que hacer frente al reto de brindar atención a la salud de los pobres y los desposeídos. La atención a la salud estipulada en los "derechos humanos" lucha por eliminar o reducir las barreras de acceso, a través de la completa exoneración de todos los pagos en el sector público y varios otros subsidios encaminados a poner los servicios de salud al alcance de todos.

Los programas de bienestar social son rehenes de los caprichos de la economía y la escasez de recursos. La atención primaria a la salud en conformidad con Alma-Ata es en esencia una estrategia de desarrollo que se adhiere a un enfoque holístico de la salud y el bienestar. Esta estrategia, que reenfoca el Objectivos Desarrollo del Milenio, puede por tanto dar espacio a las innovaciones requeridas para superar los desafíos que los factores tecnológicos, financieros, culturales y geográficos presentan a la posibilidad de ofrecer una mejor calidad de vida a todos, pero sobre todo a los pobres y los desposeídos.

Palabras claves: Modelo biopsicosocial, atención a la salud, indigencia médica

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INTRODUCTION

The overall aim of this paper is to identify and address factors which have proven to be barriers to healthcare access, especially among developing countries where adequate levels of healthcare is a function of affordability to both providers and users of these services.

Current models include *inter alia,* fee-for-service, co-payment via insurance arrangements, cost recovery and other subsidized systems for medications and ancillary investigations to facilitate management of the condition. The plight of the elderly/indigent remains an on-going challenge for policy makers and health planners as affordable healthcare for this

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vulnerable group remains an unmet need requiring creative thinking and solutions.

Healthcare comprises much more than access to a health professional for assessment/diagnosis of a health complaint. The diagnosis *per se* may well require further investigations which invariably cost the patient to have it/them done, which may or may not be affordable. In addition, the actual treatment usually involves costs of one kind or other. The cost of effective treatment for individual patient's health conditions remains a persistent challenge for healthcare planners and providers worldwide. This situation is most pronounced among the indigent, and although health programmes have been designed to meet the needs of the medically indigent, there are unmet needs along the continuum of diagnosis, further investigations and treatment. In many instances, funding for these programmes cannot meet the cost of all the required resources to deliver adequate care for this group. Reliance on charitable organizations has been a mainstay of services for the medically indigent, though these too are challenged by resource deficiencies.

In order to understand the indigent problem, the American Hospital Association (1) identified the following as key issues:

- The numbers and sociodemographic characteristics of the medically indigent, and how their characteristics differ from the rest of the population.
- What public programmes exist to provide assistance for the economically disadvantaged?
- Who provides health services to individuals who are unable to afford their own care?
- How will structional changes in the healthcare system affect indigent care?

While these are global issues, they each have local variants when examined in a specific context or location.

In Jamaica, for instance, the numbers and sociodemographic characteristics of the medically indigent are well-documented based on regular economic and social surveys which provide both quantitative and qualitative information to guide social welfare programmes. The prevailing political ideology of the day was an important determinant of both the social and economic responses to this challenge.

The Jamaican situation

The medically indigent population comprises individuals who lack access to care, are underinsured or impoverished and have unmet medical needs as a consequence of fragmented healthcare, and non-existent or inadequate follow-up care (2).

Life as a whole for this group is further characterized by economic and social challenges as manifested by poor housing, lack of food and clothing; all of these affect their health and well-being. Lower socio-economic status is associated with poor health, particularly in urban inner-city squatter settings.

The socially vulnerable/medically indigent segments of the population rely heavily on the State (which is charged with the responsibility of providing services for the "poor"). These agencies/programmes are usually insufficient, leaving the "poor" unprotected.

In the mid 1980s, Jamaica introduced a Food Stamp Programme in response to the impact of the global recession and to alleviate some of the suffering among the poor and dispossessed including the elderly (3).

The measure of poverty used successively in developing countries include consumer expenditure to measure absolute poverty and indigence, and income per capita [half of the national average per capita income] (4) to determine relative poverty. The line of indigence in dollars was about half the line of overall poverty. The overall poverty line was established based on the cost of a basket of goods plus additional non-food basic needs. The indigence line was fixed by the cost of a basic food basket.

Under-employment is more usual than unemployment among the urban poor who live in illegal squatter settlements, are poorly educated, have large families, little or no access to social services and often lack organized access to mechanisms of social participation.

In these settings, higher levels of depression, anxiety and hostility are usually found. In 2003, it was estimated that 14.8% of the Jamaican population was below the poverty line (5). Local reports (PIOJ) estimated that in 2007, 9.9% of the population lived below the poverty line (6).

This falling percentage of the population below the poverty line notwithstanding, the medical indigent are still faced with challenges to attain and maintain acceptable standards of health. With this in mind, governments over the years have kept the equity principle in focus through ongoing policy reviews to achieve equitable resource allocation to particularly sensitive sectors such as health and education, thus improving the distribution of health gains among all population groups. In spite of these efforts, the declining availability of staff, supplies and services reduce access to an adequate quality of healthcare, despite the safety net of social support programme like the Food Stamp Programme introduced in the 1980s to alleviate some of the worse suffering among the poor and dispossessed.

The medical indigent do receive services from private providers as well. In a survey done in the United States of America [USA] (7) to find out what were the predictors of physician care to medically indigent patients, it was revealed that sociodemographic characteristics, *viz* family lives, educational experiences and work environment combine over the life course to shape physician attitudes toward serving the medical indigent. On average, 25% of doctors' patients are medically indigent and physicians provide six hours per week of charity care. A 1969 study of physicians' attitudes towards the poor (8) revealed that entrepreneurial enthusiasm appeared to be an important factor in shaping one's attitude in relation to health as being a human right, or as a fee-for-

service item. This, however, did not influence the fact that whether a doctor's attitude towards treating the poor arose from an entrepreneurial disposition or social enlightenment/ interest, efforts to collect outstanding fees were minimal or not at all while retaining the patients. This, it was thought was in keeping with the idea of a tithe which reflects the role of charity as part of physicians' social responsibility.

The search for an acceptable solution to the problem of improved access to healthcare led to the proposed National Health Insurance Programme (NHIP) tabled in the Jamaican Parliament in 1997, which laid emphasis on hospital-based care rather than ambulatory care (reckoning that the latter was of lower cost and hence more affordable to the mass of the population than the costlier hospital-based care). This position generated much debate resulting in a withdrawal of the proposed NHIP and the advancing of some of the key elements of the NHIP, *viz* the Jamaican Drugs for the Elderly Programme (JADEP) which makes medications for chronic diseases available at subsidized cost for the elderly, and the National Health Fund (NHF), a similar programme of subsidized drugs for all age groups, were established. In the proposed NHIP, the government had committed to paying the premium on behalf of the medical indigent to guarantee that all residents would have had equitable access. Though the NHIP initiative was aborted after much debate, it is of interest to detail how the State intended to achieve the objective of universal coverage with equitable access to a package of essential services (9).

Since the NHIP was a contributory plan, it was thought critical to identify and register those persons who would be unable to pay the premium. A study targeting health insurance subsidies to provide the government with proposals for appropriate mechanisms to target and administer a programme of health insurance subsidies to special groups was proposed – this study was to be funded by the Inter American Development Bank (9). The fact that most Jamaicans cannot pay for healthcare services challenges the State to integrate healthcare into the national economic planning to mitigate the consequences on the nation's economy.

In any event, the failure to establish the NHIP influenced greater attention to health sector reform with the objective of strengthening the primary healthcare strategy (PHC). The adoption of the PHC strategy to achieve universal coverage sought, through its key elements, promotive, preventive, curative and rehabilitative services to address health concerns in terms of social, physical, mental and spiritual well-being, and not merely by addressing disease and infirmity issues (10).

This wholistic approach to health and well-being is underpinned by administrative and legislative reform to accommodate the establishment of mechanisms to facilitate intersectoral collaboration (education, labour, social services, housing, *etc*) and community participation.

The adoption and implementation of this PHC strategy here in Jamaica has influenced a health sector reform programmme to improve the efficiency, effectiveness and equitable allocation of resources towards the attainment of the maximal social and economic potential by individuals, families and communities as a means to "health development" of the nation. Key among the challenges to achieve these aims was alternative financing mechanisms to support the PHC strategy. Decentralization of authority and responsibility was seen as one approach to achieve efficiency, effectiveness and equity with the support of intersectoral collaborative and community participation mechanisms – all of which expanded the stakeholders' base and allowed access to the central decision-making body.

One proffered form of decentralization, divestment, proposed the transfer of authority and responsibility for the health services from the public to the private sector. In this context "health services" becomes a consumer item for sale which is an egregious breach of the equity principle when compared with health as an human right which implies the removal of barriers to access. The hegemony of this philosophy among the majority of funding agencies created a moral dilemma for governments which had committed to the PHC strategy and had deemed "health" a basic human right.

Within the health sector in Jamaica, user fees were introduced in the mid 1980s; variations of this system included cost-sharing and cost-recovery – the end result being the escalation in cost of healthcare and the further financial burdening of the poor and indigent.

The PHC strategy has remained relevant to efforts directed at "health development", and despite the setbacks resulting from escalating costs to produce and deliver healthcare, new approaches were being consistently devised to address the needs of the poor and medically indigent.

In Jamaica, there was the selective removal of health user fees in 2006 and following a change in government, the removal of all user fees in the public sector was mandated in 2008.

DISCUSSION

The medically indigent as a group has been the subject of much debate and initiatives over the many years since the Moyne Commission Report (11). The 1974 proposal to Parliament for a National Health Service titled "Medicare for Jamaica" identified the various diseases prevalent at the time and reviewed factors to ensure the effective execution of the proposed healthcare programme.

This initiative was translated to the PHC strategy which spawned a health sector reform programme to put efficiency, effectiveness and equity at its centre. Financing healthcare services and the introduction of a Food Stamp Programme were aimed specifically at equitable access and social support for vulnerable groups – those living below the poverty line and the medically indigent. The worsening global recession and its impact on the Jamaica economy stymied the best effort of the State to mitigate the negative consequence of poverty and indigence.

Renewed efforts in 1997 to put in place a National Health Insurance Programme were defeated, but out of the ravages of that failed proposal, JADEP and NHF were established, both aimed at improving access to pharmacy services and keeping persons "healthy". Throughout these disappointments, there has been a revalidation of the PHC strategy which has been the constant in the thrust to provide adequate, accessible and affordable health services in an equitable manner. The total removal of user fees for health services at public facilities is yet another manifestation of commitment to this idea.

The advent of the Millennium Development Goals is a further strategy for tackling extreme poverty in its many dimensions, *viz* income poverty, hunger, maternal and child mortality, disease, inadequate shelter, gender inequality, environmental degradation and the Global Partnership for Development – "development" being the constant from the time of the Alma-Ata Declaration to the present (12).

These goals were adopted by world leaders in 2000 and set to be achieved in 2015 – each country contextualising these goals to suit specific needs. It has been suggested that if these goals are achieved, world poverty will be cut in half, tens of millions of lives will be saved and there will be a wider cross-section of the world population which will have the opportunity to benefit from the global economy.

Pursuit of the Millennium Development Goals will help to shape the social determinants of health, but will require sincere political commitment to influence incomes, mobilization of community/social resources, improvement of nutritional states, educational levels – raising literacy rates – and all the other factors which can act as barriers to healthy behaviours (12).

Measures of quality of life will become as important as quantitative indicators of health and illness – the latter tending to give a partial picture of health in some instances, but when these quantitative measures are disaggregated they can unmask "poor health" which can be further qualified by the use of qualitative indicators.

Jamaica's progress with the MDGs

At the UN Economic and Social Council Annual Ministerial Review, "Jamaica reported significant progress in 8 of the 14 MDG targets for 2015. Among these are the targeted reductions in absolute poverty, malnutrition, hunger and universal primary enrolment, and is on-track for combating HIV/AIDS, halting and reversing the incidence of malaria and tuberculosis, access to reproductive health and provision of safe drinking water and basic sanitation" (13).

Developing a social policy for health development demands change within and among social institutions. The research efforts of behavioural scientists towards an understanding of the dynamics of such changes can be used as effective strategies in primary healthcare (14).

Practical social welfare indicators are required to highlight existing differentials in levels of living conditions, nutrition, income inequalities, educational standards and access to social services and basic amenities, *eg* clean drinking water and sanitation.

The traditional economic developmental model of planning predicated on the belief that social needs should be met through individual efforts in the marketplace – the residual model of social welfare – has created challenges for achieving equity. Though aspects of this developmental model have been reformulated as a suggested viable option, *eg* structural adjustment programmes and cut-backs in social welfare services, the inherent thinking of its advocates has not changed over time and continues to run contrary to the equity principle.

The more recent Millennium Development Goals can be regarded as an attempt to provide a range of social services while directing economic activities towards the attainment of social goals to meet basic human needs, solve specific social problems and bring about greater equity and social justice (12). The MDGs also provide the opportunity to define the problems of social planning on a country-specific based development as proposed many years ago by Sovani (15).

CONCLUSION

The development of health systems must be a dynamic process which takes into account worsening life conditions for the mass of the developing world populations – particularly those rooted in the historical antecedents of colonialism which tend to perpetuate characteristics of inherited healthcare systems (16).

The PHC strategy was meant to facilitate and reflect the economic, socio-cultural, and political characteristics of a country and its communities by providing promotive, preventive, curative and rehabilitative services. From Alma-Ata through to the Millennium Development Goals, the adaptability of the PHC strategy has given Jamaican governments the opportunity to be responsive to "worsening life conditions" as reported in their country presentation on the Millennium Development Goals at the UN Economic and Social Council, Annual Ministerial Review at Geneva in July 2009 (12). Targeting the medical indigent through the MDGs is yet another attempt to improve the quality of life for disadvantaged persons in particular, but everyone in general. The impact of the recent global recession may once again prove to be a setback by pushing more persons below the poverty line. This possibility gives greater urgency to efforts for meeting as many of the MDG targets as possible by 2015. Ultimately, Jamaica hopes to achieve all the targets by 2030, the self-imposed timeline for achieving developed world status.

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