

# Helping Children Survive

## Supporting poor families to overcome barriers to maternal, newborn and child health services

“This briefing highlights the factors that contribute to the stark differences in mortality rates between poor children and those from better-off families. Where there is political will to ensure that poor people overcome these barriers, the human right to health will be progressively realised, and the health-related Millennium Development Goals will be achieved by 2015.”

Mary Robinson, former UN High Commissioner for Human Rights

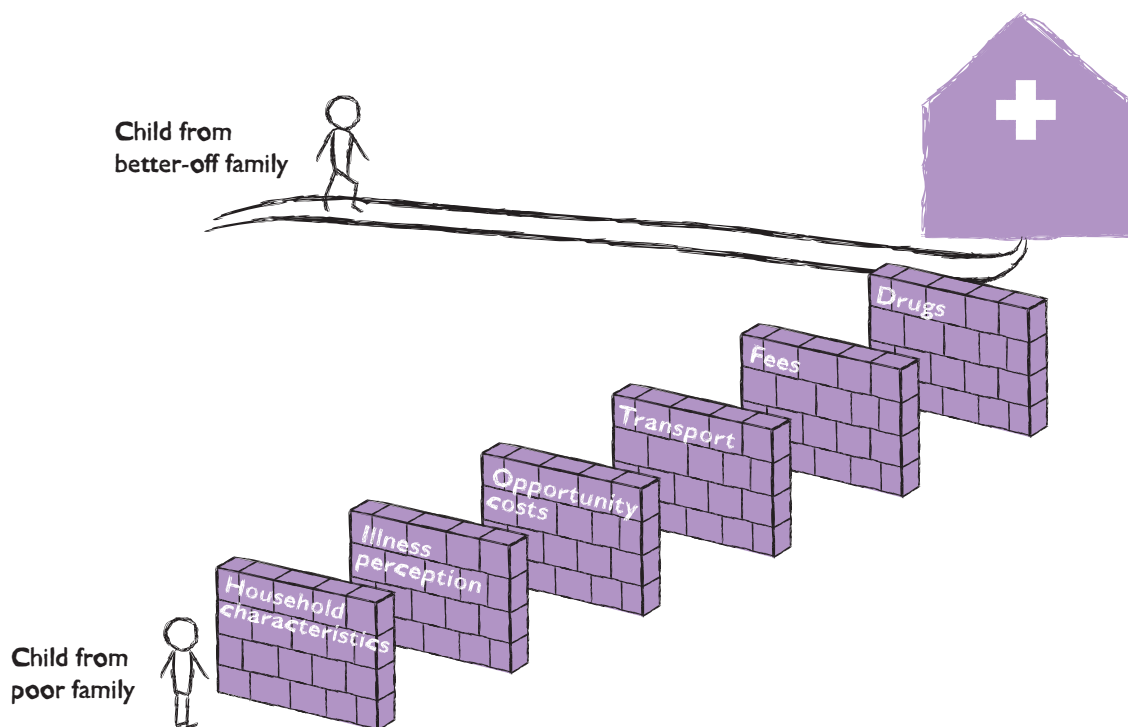


Figure I. Barriers to healthcare for poor families



## Barriers to healthcare: one woman's dilemma

It's April in a village in rural Africa. It is raining hard and the water-logged soil has made the roads virtually impassable. Only a few drivers will navigate the narrow track along the ravine connecting the village to the district hospital 8km away, and they double their prices, saying that putting the vehicle in four-wheel drive eats up diesel more quickly. The sticky volcanic mud has turned a 90-minute walk into a three-hour struggle.

The village health clinic is closed, as one health worker has just given birth and the other has returned to her village for a funeral. The mission-run dispensary ran out of medicine several months ago when the rural medical assistant sold up the drug stocks to pay his son's school fees.

The rain has meant that weeds have sprung up, choking the crops in the fields. In one family, plans have been made to weed the bean crop, the household's primary source of income. This morning, however, the youngest child, a four-year-old boy, awakes with a high fever. His mother must decide whether or not to seek care.

### Weighing up the cost of healthcare

Will she be able to afford the transport to the district hospital, or will she have to carry the child for three hours, each way, through the sticky mud? Does she have the money to pay the hospital's fees? If not, will she be able to convince the doctor to exempt her from payment? Will the nurses ridicule her for not bringing her son in earlier, as happened the last time she visited? Will she be able to pay for both the antimalarial medication and the five-day course of antibiotics that the doctor will prescribe, as no laboratory services exist to confirm if the illness is malaria or a bacterial infection? If she cannot buy a full course of treatment and opts instead to purchase just a couple of antibiotic tablets from the drug vendor at the bus stand, will she be able to track down additional tablets from family and friends to finish the course once back in the village? Can she really afford to leave the weeding until tomorrow? Who will look after the younger children while she is away? Is the fever even serious?

In the end, her husband says that he would rather use his money to buy anti-tick medicine for the family cow, so the boy is given some herbal tea to drink by his grandmother and the family waits to see whether his condition will improve tomorrow.

## Introduction

Around 10 million children die before the age of five each year; 4 million within their first 28 days. Two-thirds of child deaths could be prevented if those children could get good-quality healthcare services.<sup>1</sup> Nearly all child deaths – 99% – occur in developing countries. Within these countries, children from the poorest families and communities are at greatest risk of early death. In most developing countries, the

poorest 20% of the population has a child mortality rate that is two to four times higher than that of the wealthiest 20%.<sup>2</sup>

In order to bring about a reduction in these shameful levels of child mortality – and achieve faster progress on the health-related Millennium Development Goals (MDGs), particularly MDGs 4 and 5 on child and maternal mortality – it is critical that poor people are able to access good-quality health services. In many

developing countries, poor people struggle to access basic healthcare because:

- services are not within easy reach
- services are understaffed and ill-equipped
- the direct and indirect costs of treatment are prohibitive.

There is a clear moral imperative to cut child mortality through improving healthcare provision and access. In addition, legal obligations to child and maternal health are enshrined in international human rights instruments, such as the UN Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights.

At the UN Millennium Summit in 2000, the eight MDGs were endorsed by assembled heads of state. Despite some progress in some areas, the world community is way off track with most of these goals, especially those relating to health. On current rates of progress, achievement of MDG4 – a two-thirds reduction in child mortality by 2015 – is out of reach. However, with a more determined and sustained effort, poor people's access to maternal, newborn and child health services could be improved substantially.

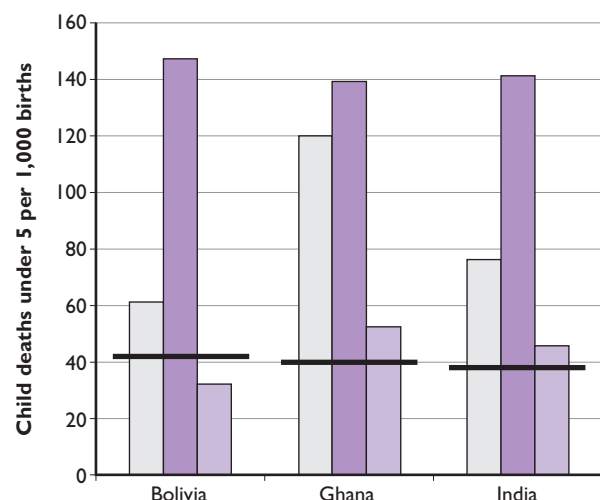
Central to achieving this is a greater focus on equity and the needs of the poorest and most marginalised. Bringing the same level of health system coverage to the poorest 20% of the population that is already available to the most affluent 20% will significantly boost any country's prospects for achieving MDGs 4 and 5. Figure 2 opposite illustrates how much closer wealthier parts of the population are to achieving MDG 4 than the rest of the population in Bolivia, Ghana and India.

Drawing on the existing literature in this area, this briefing assesses and analyses the barriers that prevent poor people from obtaining healthcare services. It suggests that the global development community has focused disproportionately on the problems posed by user fees in health. While Save the Children UK strongly opposes user fees, the research evidence shows that they generally make up only a relatively small

proportion of total costs to families when they access healthcare. Governments, international institutions and civil society need to promote a wider set of policies that address and overcome the multiple obstacles faced by poor families when they try to access healthcare services.

This briefing aims to invigorate the debate on barriers to healthcare that children are facing and to galvanise greater political will to deliver on MDGs 4 and 5. Healthcare interventions, like development interventions more generally, are likely to be much more effective when there is real leadership both from government and civil society, and where policy is tailored to the specific country or community context. There is, therefore, not a single, 'off-the shelf' model applicable to all cases. However, there are some general principles and norms that remain valid in different countries and cultural contexts. These include respect for the rights of the child and a focus on the needs of the poorest and most marginalised.

**Figure 2. MDG 4 progress by household wealth in Bolivia, Ghana and India**



**Key**

- Average under-five mortality rate
- Under-five mortality in poorest quintile
- Under-five mortality in richest quintile
- MDG 4 target

2006 figures



## Barriers to healthcare

Figure 1 on page 1 illustrates the range of household and health systems barriers that poor families have to overcome to obtain healthcare for their children, compared with better-off families. The case study on page 2 shows what these barriers mean to poor families. This briefing primarily focuses on those barriers to healthcare like the costs of transport, fees and drugs that can be remedied by health sector policy and programmes. It also touches on barriers within the household, such as socio-economic household characteristics and perceptions of illness.

Whether households are able to access health services depends to a large extent on their wealth. However, perceptions about the quality of care available at a health clinic can also influence household decisions about whether the effort is worthwhile. A perception by families that they will get a poor-quality service is likely to deter them from making the effort to seek out healthcare. Conversely, if the services are viewed as high quality, families may go to considerable lengths and spend significant resources to access them.

## Household barriers

### Socio-economic household characteristics

Several household characteristics affect the demand for and utilisation of health services. Poverty is a fundamental determinant of ill-health: income and household assets are key to accessing healthcare, as are the available economic opportunities that shape them. Healthcare costs can take up a large proportion of a poor household's income and assets. Poverty also increases people's health needs – lack of clean water, sanitation, nutritious food and education increase exposure to infection and vulnerability to disease.

Gender is another important factor. A number of studies from South and East Asia have noted that girls are less likely to receive healthcare than boys and, when they do, parents are less likely to spend as much money on the care of girls.<sup>3</sup> In other parts of the

world, such as Africa, gender bias in healthcare access appears less pronounced, with socio-economic status, parents' education and other factors being more significant.<sup>4</sup> Mothers' education and status within the household has been shown to strongly influence child health in a positive way.<sup>5</sup>

These household characteristics are important determinants of whether families seek healthcare. However, they are not health-sector specific. A broader set of policy responses that address poverty and inequality is needed.

### Illness perception

People's perception of illness is fundamental to their ability and willingness to make use of health services. Even when they agree to their children being given insecticide-treated bednets, vaccines or de-worming medication, parents may have only a vague idea of what such technologies do and what diseases they prevent. Often, parents attribute an array of health benefits to vaccines, drugs and other health interventions, but have only limited knowledge of the actual disease the technology is meant to address.<sup>6</sup>

**In one study in Guinea, mothers believed that routine vaccines were effective against leprosy, paralysis, fever and diarrhoea.<sup>7</sup>** There was also

confusion between preventive immunisation and curative injections such as antibiotics. Parents did not know why a child, who had already been injected, needed to be injected again if he or she fell ill. Not understanding the purpose of vaccines or drugs can have negative effects on adherence to treatment regimes and immunisation schedules.

Communities may also confer their own meanings to illness, treatment and side effects, which are different from the medical purposes of certain interventions.

**In one study in Uganda, 50% of families surveyed reported having at least one child under the age of five suffering from *ebiino* or 'false teeth', and *oburo* or 'millet disease'.** *Ebiino* and *oburo* are common classifications of illness among communities around the Lake Victoria Basin in East Africa. The



symptoms of *ebiino* and *oburo* overlap with medical definitions of malaria, pneumonia and various diarrhoeal diseases. In 80% of cases of *ebiino* and *oburo*, families used traditional healers and traditional medicines – even though 60% of the population lived within 5km of a clinic and user fees had been abolished at government facilities. As a result, potentially life-saving treatment with antimalarials, antibiotics or oral rehydration therapy was delayed.<sup>8</sup>

## Health system barriers

### Transport costs

The physical accessibility of a health facility is a major factor influencing people's choices about healthcare.

**Studies from Burkina Faso,<sup>9</sup> Indonesia,<sup>10</sup> Ethiopia,<sup>11</sup> Sri Lanka<sup>12</sup> and Tanzania<sup>13</sup> have shown that transport costs account for 17% to 50% of total direct cost involved in accessing healthcare.** (Total direct costs cover all medical and non-medical costs incurred when seeking health services, including transport, fees and drug costs.)

Issues over transport as a barrier include:

- proximity to health facilities
- fuel costs and shortages
- organisation of transport networks
- social attitudes towards women's independent travel
- the type of healthcare service being used.<sup>14</sup>

The proximity of communities to primary health centres determines whether caregivers can walk with their children to seek treatment or whether they need to hire transport. Numerous studies demonstrate an inverse relationship between levels of healthcare use and distance to primary health centres, despite the fact that poor people often compensate by walking great distances to access care. **A report from Mozambique, for example, showed that overall utilisation rates declined according to a household's distance from the health facility, from 81% utilisation per illness episode when services were less than 90 minutes walk away, to 35% when services were more than three**

**hours away.**<sup>15</sup> In Ethiopia, some villages are 10km to 20km from government health services. When transport is unavailable or unaffordable, this involves a two to four hour walk each way.<sup>16</sup> Rather than walk or pay for transport, households in these and many other communities make use of local healers, traditional birth assistants, private drug vendors and home-based remedies, or go without treatment altogether.<sup>17</sup>

Decisions to travel long distances to seek care are also influenced by the type of services sought, whether curative, preventive or rehabilitative. Parents see less reason to pay for transport if the service is not perceived to have immediate curative benefit. In Goa, India, parents within 30km of a clinic offering post-natal rehabilitation for high-risk babies are three times more likely to use services than parents beyond that distance. If the child was not obviously ill, parents do not spend their money and time on travel, even though the service itself is free.<sup>18</sup>

Decisions involving transport are further influenced by social and cultural restrictions on the mobility of women and children. Children are typically unable to access health services independently. Therefore, transport costs include those of the caregiver accompanying the child. Since the caregiver accompanying the child is often the mother and, in some cultures, women are not free to travel independently, costs of transport for the mother's escort have to be considered as well.<sup>19</sup>

### Fees

User fees are often cited as one of the biggest barriers to the use of health services by the poor.<sup>20</sup> **In a number of countries, user fees have been shown to be a deterrent to the use of health services, with demand for primary health services plummeting upon their implementation and increasing upon their abolition.**<sup>21</sup> While user fees, in theory, can serve a number of purposes (such as providing incentives for health workers and covering recurrent costs at facility level), they contribute only marginally to health expenditure overall and rely on costly administration systems.



Another common cost barrier to healthcare for poor families are compulsory or voluntary informal payments, or bribes. **In one review, the proportion of healthcare users who reported having made informal payments to public health providers ranged from around 25% in countries such as Ghana and India, to over 80% in Vietnam, Moldova and Sri Lanka, and to 96% in Pakistan.**<sup>22</sup>

A number of studies have shown that people in developing and transitional economies often have to pay for officially free health services.<sup>23</sup> Studies from countries in the former Soviet Union and Eastern Europe show that these payments take different forms. They may be given as bribes or gifts; compulsion may or may not be involved; and transactions may be made in cash, in kind or in favours rendered.<sup>24</sup> Whatever form they take, informal payments can make up a major proportion of the overall cost incurred by a household seeking healthcare.

Unlike former Soviet states, most countries in Africa presently have user fee policies in place. In addition, services that are free, such as childhood immunisation, are plagued by the practice of informal payment. In some instances, where healthcare staff's salaries are both very low and inconsistently paid, workers readily acknowledge charging for free services and explain such payments as vital both to meet recurrent costs and to maintain a living wage.<sup>25</sup>

In other cases, unofficial 'tipping' for informal service provision is a culturally accepted practice. For example, one study in Bangladesh, found that, although maternity services are officially free, unsolicited tips were paid in 91% of normal deliveries, and a parallel informal service involving porters and *ayahs* (women who helped care for and wash the baby and the mother after delivery) operated alongside the public sector nurses.<sup>26</sup> Even voluntary payments can act as a barrier to the use of health services.

## Drugs costs and availability

The cost of drugs is another major barrier to the use of health services. **Household expenditures**

**on medicines have been estimated at between 29% and 62% of total household healthcare expenditure per treatment episode, depending on the drug and whether the illness is chronic or acute.**<sup>27</sup> Cost is determined by a number of factors, including:

- international trade agreements
- national procurement, tariff and pricing policies
- the availability of generic or locally-produced medications
- private-sector or unofficial public-sector price mark-ups
- product availability
- storage requirements
- the type of drug required for treatment.

Demand for children's health services, whether public, private or traditional, is more easily affected by price fluctuations than that for adults' health services.<sup>28</sup> High drug prices in the formal sector influence parents' decisions to seek out informal providers when their children are ill, or treat children at home with traditional medicines or with drugs purchased from drug vendors.

In addition, there is growing evidence to suggest that shortages of appropriate and low-cost paediatric formulas of essential medicines are widespread. Paediatric medicines are seen as being a limited and low-return market. As a result, investment in research and development of new products is low and prices of existing products are too high for national procurement bodies to afford. Costs of procurement, packaging and storage of paediatric syrups, which usually come in large bottles, are substantially higher than for adult tablets or capsules. The World Health Organization estimates procurement of paediatric syrup to be 500% more costly than tablet-based adult formulations.<sup>29</sup>

Inappropriate treatment and prescribing also impact on drug costs at the local level. In Ghana, parents frequently paid more than necessary for chloroquine, as health centre staff failed to weigh the child first to determine dosage. Children were prescribed excessive syrup or tablets, increasing medication costs.<sup>30</sup> **A study**



**in Tanzania found that while 78% of children attended formal health clinics during an episode of malaria, only 9% received correctly dosed antimalarials.**<sup>31</sup> In Nigeria, 47% of parents purchased antibiotics for episodes of childhood diarrhoea, bypassing cheaper, potentially more appropriate oral rehydration therapy.<sup>32</sup>

Over-subscribing antibiotics and antimalarials leads to both excessive costs to households and a reduction in the effectiveness of low-cost, essential medications. **In rural China, one study found inappropriate prescription of antibiotics in 97% of all paediatric acute respiratory infections, including inappropriate dosing in 63% of children positively identified with bacterial infections.**<sup>33</sup> Inappropriate and over-prescribing of paediatric medications is pervasive throughout China,<sup>34</sup> and has also been noted in a wide range of other countries, including Peru, Nepal, Bangladesh and Tanzania.<sup>35</sup>

At the local level, the dynamics of pricing and purchasing medicine also play out in a number of other ways. In a rural area of the Democratic Republic of Congo (DRC), for example, one study found the unit cost of a drug purchased at government health clinics was much lower than the unit cost of the same medicine purchased at a private clinic or pharmacy. However, healthcare workers in government clinics refused to sell medicine by the unit, fearing inappropriate use by consumers leading to the development of drug resistance. Consumers who were unable to pay for a full course of medicines at once were, therefore, driven to private providers who would sell single tablets, albeit at a higher price.<sup>36</sup> Selling drugs in single units suits poor families' limited resources and spending patterns. However, they spend more buying daily, single dose drugs than they would if they purchased a full course at a government facility.

## Quality

Quality in healthcare refers to:

1. objective indicators of efficient, effective and equitable service provision – these include availability of drugs and supplies, communication style of staff,

waiting times, administrative efficiency, degree of leakage of fees and supplies, pricing transparency, condition of facilities, and terms of payment.

2. users' subjective perceptions of acceptability and value of health services.

**One review of six African countries (Cameroon, Gambia, Niger, Sierra Leone, Sudan and the DR Congo) described how, independent of whether services were fee-based or not, improvements in quality led to increased use of services, and poor quality led to decreased use.**<sup>37</sup> Caretakers' concerns over healthcare quality sometimes outweigh cost considerations when deciding whether healthcare for their children is worth the effort. When household resources are limited, perceived poor quality will be a particular deterrent to seeking healthcare services. Where the quality of healthcare is perceived to be good, attending a clinic is more likely to be seen as a worthwhile investment of money and time.

Drug availability, prescription practices and flexibility of payment, as outlined above, are key determinants of perceived or actual quality of service. For example, government clinics running out of drugs and vaccines is repeatedly mentioned as a major quality concern of healthcare users, regardless of whether a system is fee-based or not.<sup>38</sup> Drug shortages can be due to:

- problems in national procurement of essential medicines and vaccines
- poor forecasting of demand and supply by government stores and drug suppliers
- unavailability or high cost of transport
- wastage due to inadequate storage facilities
- poor inventory systems
- leakages of drugs and supplies due to corruption or mismanagement
- limited revenue preventing health facilities from restocking supplies.

**A study in Tanzania noted that people expected government health clinics to run out of stocks at the end of the month. Parents, therefore, didn't bother to attend clinics at this time.**<sup>39</sup>

When medicines are unavailable at government clinics,



some people turn to private clinics, drug vendors, traditional healers, or other community members. As explained above, this often leads to increased costs and poor quality of healthcare.

Lack of friendliness and respect from healthcare workers is seen as an important marker of poor service in many countries, even if health workers are skilled and clinics well-stocked. **An evaluation of intervention quality in the DRC noted that 94% of community members surveyed valued relational issues ('respect, patience, courtesy, friendliness and straightforwardness') over technical competence, and defined a good healthcare worker as someone who 'receives you well'.**<sup>40</sup> The power dynamics between healthcare providers and care-seekers, and the communication style of clinic staff, are important determinants of people's decisions about whether to use health services. A number of studies describe how parents are treated disrespectfully by healthcare workers, made to feel inadequate, ridiculed in front of other patients, and have their parenting skills questioned.<sup>41</sup>

## Opportunity costs

Opportunity costs here refer to the value of resources – either monetary or non-monetary – that people have to forgo in order to get healthcare for themselves or another person. When a mother seeks care for herself or her child, she may give up a wage, income earned selling produce at the market, or a period of time carrying out necessary housework. Measuring opportunity costs is more difficult than measuring other costs attributable to accessing healthcare. It typically involves assessing the time people spend seeking and obtaining care, and attaching value to that time in terms of lost wages or productivity. **A number of studies conclude that the opportunity costs involved in both illness and care-seeking are often as great, if not greater, than the combined costs of fees, drugs and transport.**<sup>42</sup>

Opportunity costs are influenced by a number of factors specific to either health systems or to households. Health systems-specific factors include:

- the proximity of health services providers
- the amount of time it takes to reach care
- waiting times.

Household-specific factors include:

- how families make their livelihood
- the value attached to work or output
- seasonal labour cycles
- the value of housework and childcare
- the household's ability to mobilise its social network to help meet expenses, make up for labour or accompany the caregiver and child to clinic.

**In Kenya, one study found the opportunity costs for managing an episode of uncomplicated childhood fever was 1.42 days. The value of time lost represented, on average, over 70% of total household costs for treating febrile illness. Taking into account that children have 10.5 episodes of fever per year, and many families have more than one young child falling ill, the burden quickly adds up.**<sup>43</sup>

In a study of a resettlement community in Delhi, residents originally from Tamil Nadu were found to be poorer than residents from other parts of India. As a result, Tamil Nadu mothers were more likely to work outside the home. **A visit to a government health clinic, which was only open during daytime hours, meant the loss of a day's wage. As a result, these mothers were more likely to substitute more expensive private care for cheaper government health services,**<sup>44</sup> further contributing to wealth and health inequality. Similar problems have been noted in South Africa, Nigeria and the Philippines.<sup>45</sup>

## Conclusions and recommendations

Most of the barriers outlined in this briefing are interrelated. For example, in deciding whether to seek treatment, parents weigh up opportunity costs, the perceived quality of service, expected drug availability, and the perceived severity and source of illness. The relative importance of different barriers varies





from one context to another. Government decision-makers and those who influence them need to consider the barriers that exist in their country, in order to develop policies and programmes that will get MDGs 4 and 5 back on track, and help children survive.

## User fees are only part of the problem

There is an emerging consensus on the elimination of out-of-pocket expenses as an important step towards universal health access. This means abolishing user fees at the point of access for a basic package of care. This has been achieved in Uganda, Zambia and, more recently, in Nepal, Niger, South Sudan and elsewhere. A number of development partners, including DFID and the World Bank, have committed to extending technical and financial support to countries who develop policies for removing user fees and request specific support.

Identifying alternative, pro-poor health financing options is key. An important consideration is risk-pooling, though the evidence on specific insurance schemes in increasing healthcare access is limited, particularly in sub-Saharan Africa. What is clear is that governments seeking to introduce health insurance mechanisms, in whatever form, must ensure adequate provisions for inclusion of the poor.

The evidence in this briefing clearly indicates that other cost and non-cost barriers are at least as significant as user fees in preventing poor people from accessing healthcare. Governments must do more to address these other barriers, working with development partners and civil society.

## Social protection measures can help poor households overcome barriers

The right mix of policy solutions will vary from one country to another depending on the relative importance of different barriers. What is clear from the evidence is that both conditional and non-conditional cash transfers should be part of the policy mix.

Providing a continuum of care – by extending appropriate services to community level – brings services closer to households and helps communities engage in service provision. Increasing demand for services – following the introduction of social protection mechanisms, for example – requires improvements in both the supply and quality of health service provision. Families seeking healthcare will be deterred from using services again if they do not find them to be good quality and culturally appropriate.

Child health differs from adult health, not least because caretakers mostly decide about service use on children's behalf. Caretakers' time and productivity losses, which in themselves are not health sector issues, need to be considered and addressed by the sector.

## Health systems need increased investment and strengthening

Strong health systems are possibly the most important determinant of service use and, by extension, health outcomes. The shortage of qualified and motivated health workers represents a major and urgent challenge. 'Brain drain' and other human resources issues need to be addressed jointly by governments from both developed and developing countries.

**“Investing in the health of children is not just a moral imperative. Investing in children means investing in the future health and security of a country. As part of the Every Human Has Rights campaign, The Elders are calling on the world to act to save children's lives and support Save the Children's campaign to get MDG 4 back on track.”**

Mary Robinson, member of The Elders, a group of 12 leaders from around the world convened by Nelson Mandela in 2007



If health service use is to be optimised, health systems must give sufficient attention to cultural perceptions of disease and treatment dynamics. Drug procurement and provision, especially of paediatric medicines, is another key aspect of strong health systems which, if resolved, will improve quality and increase use of health services, including by the poor.

Recent improvements in donor coordination and harmonisation, including improved collaboration mechanisms for working with developing country governments, are encouraging. Initiatives such as the International Health Partnership and related programmes (eg, IHP+) are promising. However, a great deal of work is needed to ensure these initiatives live up to expectations and add real value to developing countries, rather than simply soaking up human and financial resources.

More resources are required to strengthen health systems. National health budgets need to be increased in African countries to match Abuja commitments, and in other countries to meet agreed commitments. Improving the efficiency of health budgets and their alignment with the distribution of disease burden will also have a positive impact on the sector's finances.

Weak health systems are a symptom of competition over national political priorities. The importance of health, especially child and maternal health, as a social indicator of – and engine for – development must be recognised both politically and financially.

### **Health inequalities must be addressed head-on**

Like all of us, poor people face choices and make decisions about healthcare in a context shaped by socio-economic conditions; their perception of illness; and system-specific factors, such as distance to facilities and costs involved in accessing services. Families in better economic, social and educational positions are more likely than their poorer neighbours to obtain essential health services – to a large extent because they have the means to overcome these barriers.

There is a range of policy and programme options that can contribute to reducing the various barriers to health service use and to get MDGs 4 and 5 back on track. Poverty reduction in a wider sense is an obvious and fundamental facilitator of progress.

Reducing national child mortality averages to child mortality rates in the highest wealth quintiles would be a great short-term step forward. In some countries, such as Bolivia, Egypt, Indonesia, Vietnam and South Africa, the richest quintile already meets MDG 4<sup>46</sup> – and this is likely to be achieved in a number of others by 2015 – but national averages are lagging behind. The achievement of the MDG target among richer groups in some countries shows that this target can be reached for the whole population given political will, accompanied by policies to reach the poorest, and sufficient resources.

Strategies for achieving universal access to healthcare need to be context-specific. In Latin America it is mainly those from the poorest wealth quintile who miss out on healthcare; in countries in sub-Saharan Africa, many more people miss out. By implementing a set of locally appropriate policy and programme options to overcome barriers to healthcare, people who are economically and socially disadvantaged will gain a similar level of access as their better-off neighbours, and, at the same time advance the health of the whole population.

In 2008, the 30th anniversary of the Alma Ata Declaration – when governments agreed to work towards health for all and health equity – provides fresh impetus to efforts to achieve universal access to primary healthcare. Cutting child poverty, with a particular focus on the poorest children, is a test of whether we are really serious about inclusive development. No issue is more deserving of high-level political attention and decisive national and global action.

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