Global Health and Local Poverty: Rich Countries' Responses to Vulnerable Populations

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ABSTRACT

Poverty is an important determinant of ill health, mortality and suffering across the globe. This commentary asks what we can learn about poverty by looking at the way rich countries respond to the needs of vulnerable populations both within their own societies and those of low-income countries. Taking advantage of recent efforts to redefine child poverty in a way that is consistent with the World Health Organization's Commission on Social Determinants of Health, three sets of data are reviewed: levels of child well-being within 23 Organization of Economic Community Development countries; the amount of official development assistance these countries disburse to poor countries; and, government social transfers targeted at families as a percentage of GDP. Analysis shows that countries in Northern Europe tend to have lower levels of child poverty, and are the most generous with social transfers and providing development assistance to poor countries; in contrast, the non-European countries like Australia, Canada, Japan, and the United States, and generally, the G7 countries, are the least generous towards the vulnerable at home and abroad and tend to have the highest levels of child poverty. The findings suggest that nations' responses tend to be ideologically based rather than evidence or needs based and that poverty is neither inevitable nor intractable.

Key words: Poverty; socioeconomic factors; child welfare; international cooperation; world health; Canada

La traduction du résumé se trouve à la fin de l'article.

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According to the World Health Organization, "the world's biggest killer and the greatest cause of ill-health and suffering across the globe" is extreme poverty, listed in the International Classification of Diseases as Z59.5.¹ Efforts to address poverty in developing countries have coalesced around the Millennium Development Goals (MDGs) – which include the goals to eradicate extreme poverty and hunger, reduce child mortality, and fight HIV, malaria and other major diseases. In high-income countries, efforts to reduce child poverty are rooted in the 1990 United Nations' Convention of the Rights of the Child (CRC) and depend on government family and other related social transfers. Yet, poverty is widely seen as inevitable and intractable. In poor countries, issues of good governance and corruption, lack of political will, limited institutional capacities, environmental extremes and political unrest are used to explain persistent poverty, while in high-income countries, personal or generational weaknesses are often cited. In both contexts, governments are provided with a rationale for inaction.

Scholars have long been interested in the relationship between welfare institutions and aid, often focusing on inequalities.^{2,3} This commentary asks what we can learn about poverty by looking at the way rich countries respond to the needs of vulnerable populations both within their own societies and those of low-income countries. Taking advantage of recent efforts by United Nations' Children's Fund (Unicef) to redefine child poverty in a way that is consistent with the World Health Organization's Commission on the Social Determinants of Health, three sets of data are reviewed. The first looks at levels of child well-being in 23 rich countries belonging to the Organization of Economic Community Development (OECD).⁴ Based on the CRC and supported by 40 outcome

indicators that take into account material well-being, health and safety, education, peer and family relationships, behaviours and risks, and children's own subjective sense of well-being, child poverty is defined as the significant lack of the basic needs required for healthy physical, mental, emotional and spiritual development. A drawback to using multiple indicators is that some OECD countries such as Mexico and Turkey are excluded because of lack of data. This study pays particular attention to Canada.

The second set of data reports the amount of official development assistance (ODA) that rich (OECD) countries disburse to poorer countries.⁵ ODA or foreign aid is disbursed either directly between governments or through multilateral agencies such as the United Nations (UN), with the aim of promoting social and economic development. In 1969, Lester B. Pearson led a UN expert commission assigned the task of recommending reasonable levels of ODA that ought to be expected from rich countries. Based on Pearson's notion that "it is only right for those who have to share with those who have not", ODA was benchmarked at 0.7% of gross national product (GNP) or, more recently, gross national income (GNI).⁶

Social transfer, according to OECD, is government support to individual households aimed at improving and protecting family security and includes family allowances, disability and sickness benefits, formal day care provision and unemployment insurance. Levels of social transfers are measured as a percentage of GDP.⁷

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Table 1. ODA as Percentage of GNI, Percent of Child Population Living in Poverty, and Family and Related Transfers as % of GDP in Selected OECD Countries

		Net ODA as % of GNI, 2006	% of Child Population Living in Poverty, 2006	Family and Related Transfers as % of GDP
Countries with ODA/GNI above 0.7%	Sweden	1.03	5.0	12.0
	Norway	.89	8.7	9.5
	Netherlands	.81	4.2	9.5
	Denmark	.80	7.2	13.5
Countries with ODA/GNI between 0.7% and 0.36%	Ireland	.53	10.2	5.6
	UK	.52	18.2	7.0
	Belgium	.50	10.7	10.5
	Austria	.48	13.8	7.0
	France	.47	13.0	9.0
	Finland	.39	7.5	11.5
	Switzerland	.39	8.3	6.5
	Germany	.36	11.2	7.0
Countries with ODA/GNI below 0.36%	Spain	.32	8.0	6.3
	Australia*	.30	14.7	7.3
	Canada	.30	11.8	6.2
	Japan*	.25	14.3	2.1
	Portugal	.21	13.7	5.5
	Italy	.20	10.0	4.0
	USA	.17	18.0	2.3
	Greece	.16	11.8	5.8
	Czech Rep.†	.11	12.5	6.5
	Poland†	.11	12.3	7.8
	Hungary†	.07	14.5	7.5

Source: references 4-6

* Until 2007, Unicef was using an income-based definition of child poverty which defines a child as poor if the income available to that child is less than half the median income available to other children growing up in that society.

† Data for Czech Republic, Poland and Hungary from <http://www.oecd.org/dataoecd/52/18/37790990.pdf> (Accessed June 9, 2008)

Table 1 (column 2) shows levels of ODA for the selected countries. These levels can be divided into three groups: the first consists of the four donor countries that reach or exceed the UN target of 0.7% of GNI – Sweden (1.03%), Norway (0.89%), the Netherlands (0.81%), and Denmark (0.8%). The second group consists of the countries that achieve more than 0.36% (that is, more than half the recommended ODA contribution) but less than 0.7%. The last group shows the least generous countries, which had ODA flows at less than half the recommended level (that is, less than 0.35%). These countries were ranging from 0.07 to 0.32%; they include some of the world's richest countries, several members of the influential G7, and all of the non-European countries. Rates of ODA contributions made by the United States (0.17%) and Japan (0.24%) – the world's two largest economies – were a fraction of those made by Sweden (1.03%).

Table 1 (column 3) presents data for levels of child well-being in the selected countries. Because data were not available for Japan and Australia, income-based poverty rates were used instead. Column 3 shows that poverty rates range between 4.2% (in the Netherlands) and 18.2% (in the United Kingdom). In the Scandinavian/Nordic countries, child poverty is below 10% while in the 5 non-European countries, Australia, Canada, Japan, and the United States, and most G7 countries, one sees the highest levels of child poverty.

The relationship between levels of ODA and child poverty is shown in Figure 1. It indicates that countries in Northern Europe tend to have lower levels of child poverty and the highest levels of ODA. Non-European countries like Australia, Canada, Japan, and the United States, and generally, the G7 countries, are the least generous and have the highest levels of child poverty and lowest levels of ODA. An important exception seems to be the UK, represented in Figure 1 as an outlier: it is generous to developing countries but still has very high child poverty. None of the 4 most generous countries have child poverty above 10%; they contributed

on average 0.88% ODA/GNI and had child poverty rates at 6.8%. The average child poverty rate in the least generous countries (which contribute 0.24% ODA) was 13.2%, double that of the most generous countries.

The most obvious explanation for the relationship between levels of child poverty and ODA in the select group of countries is that governments that prioritize the needs of vulnerable populations at home tend to demonstrate concern for the needs of vulnerable populations abroad. Conversely, governments that take a more individualistic and market-based approach to economic development may be prepared to accept higher levels of inequality both domestically and in developing regions of the world. In short, the difference may be ideological, which in turn is expressed in terms of government policies, strategies and programming.

UNICEF has examined the actual influence of government policy through social transfers on inequalities.⁷ Now using the more robust, 6-dimensional definition of child poverty together with OECD "social transfer" data for the selected 23 OECD countries (Table 1, Column 4), the relationship between the two can be examined. A wide range of government efforts to address poverty become evident, with Sweden allocating 12% of GDP to social transfers and Japan 2.1%. Northern European countries tend to have much higher transfer rates than non-European countries. Figure 2 shows the correlation between levels of child poverty and "family and related transfers" in the selected countries. Direct observation shows that higher government spending on family and social benefits is associated with countries with lower child poverty rates. Countries allocating 10% or more of GDP to family-related social transfers have, on average, child poverty rates of 7.5%, whereas countries with poverty rates above 15% allocate just more than 5% on social transfers. Figure 2 indicates that variation in government policy accounts for part of the variation in child poverty between OECD countries and suggests that poverty is neither inevitable nor intractable.

Figure 1. Relationship between ODA and child poverty in 23 OECD countries

Sweden SWE, Norway NOR, Netherlands NET, Denmark DEN, Ireland IRE, United Kingdom UK, Belgium BEL, Austria AUT, France FRA, Finland FIN, Switzerland SWZ, Germany GER, Spain SPA, Australia AUS, Canada CAN, Japan JPN, Portugal POR, Italy ITA, United States of America USA, Greece GRE, Czech Republic CZE, Poland POL, Hungary HUN

Source: references 4, 5, 7

In low-income countries, the influence of resources on levels of poverty is less clear since what keeps poor countries impoverished is not simply inadequate inflow of ODA, but rather non-aid policies including “severe trade barriers, biased migration regimes, lopsided use of natural resources and unfair intellectual property regimes which impose a heavy burden on poor countries”.⁸ Nevertheless, the ‘10/90 gap’ alone would suggest a very strong relationship between burden of disease in developing countries (93%) and access to global health resources (less than 10%). Furthermore, a robust body of literature shows repeatedly that when the donor community has partnered with governments in well planned and financed interventions, the results can be impressive: recent examples include a 91% reduction in measles mortality in Africa (2000-2006),⁹ reduction in rural poverty in Mozambique,¹⁰ reduction of malaria mortality in Kenya,¹¹ and control of tuberculosis in Asia¹² and adult HIV in East Africa.¹³

The notion that rich countries’ responses to the needs of vulnerable populations at home and abroad may be explained in part by ideology is of course not consistent with their claim that they pursue evidence-based policy development or decision-making (EBDM). In Canada, where EBDM is supported and promoted by the relevant bureaucracies (the Department of Human Resources and Social Development, the Canadian International Development Agency and Treasury Board), child poverty has remained unchanged since 1989 and ODA stagnates at a dismal 0.30%. In fact, Unicef is quite critical of Canada which in 1989 declared it would eliminate child poverty at home. Unicef reports that “this target came and went without agreement on what the target means, or how progress towards it is to be measured, or what policies might be necessary to achieve it”.⁷ For example, with respect to early child care – one of the four key social transfers cited by Unicef as having a bearing on child well-being, and widely acknowledged as one of the most cost-effective means of reducing child poverty – the Canadian Government’s response in 2006 was to cancel the comprehensive early child-care program worked out between the provinces and the previous government. It replaced the program with a paltry monthly cash transfer of CDN\$100 – a decision that is not consistent with the

Figure 2. Relationship between child poverty (%) and social transfers (as % GDP) in OECD countries

Source: references 4, 5, 7

Government of Canada’s public support for the WHO Commission on Social Determinants of Health.¹⁴ With respect to its levels of foreign aid, the Canadian government cut ODA in its last budgetary cycle and now includes such items as the “training of the Afghanistan army and police” in these reduced allocations. Both of these actions bolster the notion that policy is excessively driven by ideology, making poverty appear as indeed “inevitable”.

Although ideology may not prevent governments from publicly supporting altruistic goals such as the MDGs, it appears to hamper their follow-up. Today, failure by rich countries to keep their promises has left the MDGs severely under-funded and off-track while child poverty is rising in 17 of 25 of these same countries – the significance of both being underscored by evidence that poverty is not intractable. The G7 countries, which ostensibly provide political and economic leadership to the rest of the world community, do not fare well in this analysis. In summary, the data show that non-G7 countries are 37% more generous towards developing countries and 53% more generous in their allocation towards child poverty at home. Child poverty is 35% higher in G7 countries, leading to questions as to what sort of leadership they are providing and for whom. In Canada, all of this provides fresh evidence that often those “who have” literally avert their gaze from the face of poverty on the streets while figuratively turning their backs on the vulnerable abroad.

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RÉSUMÉ

La pauvreté est un important déterminant de mauvaise santé, de mortalité et de souffrance à l'échelle mondiale. Ce commentaire demande ce que nous pouvons apprendre sur la pauvreté en regardant la façon dont les pays riches répondent aux besoins des populations vulnérables dans leurs propres sociétés et dans celles des pays moins

nantis. Les trois ensembles suivants de données ont été examinés en misant sur les récents efforts déployés pour redéfinir la pauvreté chez l'enfant afin qu'elle corresponde à la définition de la Commission de l'Organisation mondiale de la santé sur les déterminants sociaux de la santé : niveaux de protection de l'enfance dans les 23 pays membres de l'Organisation de coopération et développement économiques (OCDE); montant d'aide formelle de développement versé par les pays riches aux pays pauvres; et transferts sociaux gouvernementaux ciblant les familles à titre de pourcentage du PIB. L'analyse démontre des niveaux plus faibles de pauvreté chez l'enfant dans les pays du Nord de l'Europe et une plus grande générosité en termes de transferts sociaux et de prestations d'aide au développement pour les pays pauvres. D'autre part, les pays non européens comme l'Australie, le Canada, le Japon, et les États-Unis et en général les pays du G7, sont les moins généreux envers les plus vulnérables de leur propre pays et des pays étrangers. En outre, ces pays semblent démontrer les niveaux les plus élevés de pauvreté chez l'enfant. Les conclusions suggèrent que les pays réagissent en fonction d'idéologies, et non selon les données probantes ou les besoins, et que la pauvreté n'est ni inévitable ni insoluble.

Mots clés : pauvreté; facteurs socioéconomiques; protection de l'enfance; collaboration internationale; santé mondiale; Canada

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