Overseas Development Institute

Background Note

February 2011

# Does development give poor people what they want?

## By Claire Melamed

If you want to know what 'poverty' and 'development' mean, it is wise to start with those who know most about it – poor people. This Background Note outlines an approach in the UK's National Health Service that puts patients in the forefront of their own treatment. It asks whether such an approach is applicable to the development context and sets out potential next steps. The Overseas Development Institute will explore this promising avenue in more depth in the coming years.

Poor people have been asked again and again by governments, donors and non-governmental organisations (NGOs) what poverty means to them, most notably in the World Bank's colossal studies 'Voices of the Poor' and 'Moving out of Poverty' (Narayan, 2000), which involved tens of thousands of people in more than 60 countries.

What do these studies find? That poor people often define poverty more in terms of assets than incomes, that risk is frequently key to the way people understand poverty, that having a job is widely seen as the best route out of poverty, and that access to roads, transport and water, in particular, are often the things that poor people think will make the biggest difference to their lives. They find that a lack of respect from officials, and daily small humiliations, are the worst things about being poor for many people.

Then what happens? Development professionals continue to measure poverty mainly in terms of incomes, often ignoring such factors as ownership of assets and levels of risk. Donors and NGOs have, until recently, almost always ignored employment and jobs when looking at ways to bring 'development'. They have tended to focus instead on microcredit and other ways for poor people to set up small businesses, forgetting the fact that, like most of us, they may well prefer steady employment to the risks and uncertainties of running their own enterprises. And changing the way that officials or others treat poor people is rarely, if ever, a part of anti-poverty programmes.

Why is it that we are so bad at translating the views and priorities of poor people into development decision-making? Partly, of course, this is about politics within developing countries, and the usual problem of the poorest and most powerless being the least able to exert power over decision-making at any level. That is common to every country, and the solution is for political systems to be improved, and for the organisations of poor people to enhance their power within their countries.

But there is an additional problem in development aid, in that the people making decisions are rarely engaged in politics within developing countries – they are donors who stand outside, making decisions in consultation with local communities and governments, but not always bound by them. Donors have their own fashions, their own prejudices, and their own domestic constituencies to accommodate, all of which can drive decisions away from the priorities of poor people.

### Attempts to solve this problem

This most emphatically does not mean that all aid is wasted, or that development is not happening. People who make decisions about aid and development are, by and large, well intentioned and well informed, and often they do the right thing. But for governments, for donors, and for NGOs domestic and foreign, there is a need for more timely and useable information about what poor people want. This would, one hopes, help to improve the allocation of resources for development. Failing that, it would at least provide greater transpar-

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ency about whether the institutional priorities of different bodies accord with the views and priorities of poor people, and provide a useful tool for advocacy organisations and poor people to highlight problems and offer solutions.

There are already some methods in use for generating this information. Participatory Poverty Assessments (PPAs) seek to understand the reality of life for poor people, and to give them a voice in policy-making, using a set of well established qualitative research methods (Norton et al., 2001). They have been used widely at both a local and a national level, for example in Uganda, to elicit the views and priorities of poor people about what defines poverty and what should be done about it. Important insights, such as the fear of physical violence and the importance of vulnerability in defining poverty have emerged from these approaches, and they continue to be influential and are used regularly.

However, PPAs have not, in general, produced numerical indicators of the type that are used most frequently by, and have greatest influence on, policy-makers. Possibly as a result, the main impact of PPA approaches appears to have been on the definition and measurement of poverty, and less on decisions about resource allocations or policies.

A more quantitative approach is that of the new ‘Multidimensional Poverty Index’ (MPI) from Oxford University’s Poverty and Human Development Initiative (OPHI) (Alkire and Santos, 2010). The index includes measurement of assets, not just incomes. It also measures access to water, cooking fuel and sanitation alongside the more usual indicators of health and education outcomes. It comes much closer than any other quantitative measure of poverty to recognising the reality of poverty as experienced by poor people, and communicating it in a way that is helpful for people who are trying to decide what to do about it.

Critics of the MPI, however, have zoomed in on the fact that listing dimensions of poverty is one thing, but that assigning weights to each different aspect of poverty, so policy-makers have some guidance on where to put their (limited) resources, is quite another (Ravallion, 2010). As yet, the MPI does not attempt to do that, and in the vacuum donors and governments will implicitly assign weights based partly on good evidence and analysis, but partly on development fads and political imperatives.

A new approach would need to build on these and other initiatives, and solve the remaining problems, including how to attach weights to different outcomes that reflect poor people’s priorities, and how to do so in ways that provide a general and persuasive guide to decision-making and evaluating outcomes. One way to do this might be to look for lessons in other sectors.

## Measuring people’s priorities in health care

The questions with which the UK’s National Health Service has been grappling in recent years are in many ways similar to those that bedevil development. How to measure progress? Is it better to count inputs or outputs? What are the outputs the service is trying to produce? How to allocate scarce resources in ways that are both fair and provide value for money? How to make sure that the views of the people who are ultimately supposed to benefit are taken into account in answering all these questions? Those familiar with the ‘results agenda’ in the UK’s Department for International Development (DFID) and elsewhere will recognise all these dilemmas.

### Finding out what people want from health services

Until recently, the assumption in healthcare was that doctors and managers were the best judges of what patients wanted and if they were getting it. However, that focus has recently changed, with the development of ‘Patient Reported Outcome Measures’ (PROMs). As Nancy Devlin and John Appleby put it:

> *The goal of most health care is to improve patients’ health – and, arguably, it is the patients themselves who are best placed to judge how they feel. The introduction of PROMs reflects a growing recognition throughout the world that the patient’s perspective is highly relevant to efforts to improve the quality and effectiveness of health care* (Devlin and Appleby, 2010).

In order to elicit the ‘patient’s perspective’, thousands of different survey instruments have been devised to ask people about their health and quality of life. In thinking about how to translate the PROMs approach across to development, the most useful of these is probably the generic survey instrument known by the unlovely acronym of the ‘EQ-5D’ (having been developed by the EuroQol Group, and having five different dimensions of health). Each of its five sections corresponds to a different health outcome: mobility (ability to walk about normally); self-care (ability to look after oneself); usual activities (ability to perform usual activities), pain or discomfort and anxiety or depression. Each of the five asks how an individual rates their health on the day the questionnaire is completed – no problems, some problems or severe problems.

There are, therefore, 243 different possible outcomes to the questionnaire (three possible outcomes on each of five dimensions of health).

A second stage to the PROMs exercise is then to find out how people value each of the 243 different health outcomes. This is a highly complex statistical exercise but, in brief, representative samples of people are asked to imagine living with the different health outcomes represented by the 243 possible combinations of EQ-5D scores, and then to state which of the different combinations are preferable. The responses are analysed and turned into values, or weights, for each outcome.

### Quantifying health outcomes over time

In health care, both the quality and length of life are important to evaluate outcomes. For any given treatment, policy-makers need to know how much value is gained, for how long, and at what cost. The instrument for making these evaluations is the Quality Adjusted Life Year, or QALY. One QALY is equal to one year lived in full health. A year in anything less than full health is valued at less than one, depending on the social value (derived from the process described above) attached to the particular outcome. For any given treatment, the number of QALYs gained (either through improvements in quality or length of life, or both) can be compared with the total costs to produce a cost per QALY. This can then be compared with the cost for alternative uses of resources. It is the QALY that is used by the UK's National Institute of Health and Clinical Excellence (NICE) to judge the cost-effectiveness of different health interventions.

## Making this approach work for development

Would such an approach work in development? It does seem to point towards a promising new area of enquiry for those seeking to strengthen poor people's influence in development policy making. Translating this approach across to development would need to be a cautious and iterative process, but there are a number of possible policy steps to consider:

- **First, the outcomes.** What is poverty? Developing a list of the key dimensions of poverty would have to start with asking poor people about poverty as they experience it, using methods akin to PPAs. This would almost certainly produce a very long list of characteristics of poverty, which could be reduced into a number of specific dimensions – say: level of financial security, physical security, access to local towns and villages, state of health, treatment by officials and so on. Different ways to reduce the list to a manageable number of dimensions would have to be tested repeatedly in the field. In the end, the aim would be come up with a small number of defining dimensions of poverty – analogous to the five health outcomes in the EQ-5D.
- **Second, the valuation.** There is a plethora of techniques, known in broad terms as 'stated preference methods' for finding out if people prefer option 'a' to option 'b', or 'b' to 'c', and the weights that people place on different aspects of each outcome. Again, these could be tested and refined until a sensible way of finding out preferences in different contexts can be developed. For example, although the methods used in health care tend to use complex questionnaires and tasks to find out about individuals' preferences, there are alternative and more pragmatic approaches that can be used in this context to overcome literacy and numeracy issues.

### Box 1: Using PROMs in the UK's National Health Service (NHS)

PROMs are used in two main ways in the NHS.

1. **Measuring outcomes**. Since the 1 April 2009, NHS patients treated by any hospital provider can consent to complete pre- and post-operative health status questionnaires. Currently, such PROMs cover four surgical procedures: hips, knees, hernias and varicose veins. Between April 2009 and September 2010, over 126,000 pre- and post-questionnaires were returned, to become one of the largest databases of its kind in the world. The plan is to extend coverage to as many procedures as possible, including long-term conditions such as diabetes, heart disease and asthma. The expectation is that this data will be used to inform patient choice of hospital, to aid commissioners of care to select cost effective providers, to provide a quality adjustment to current crude aggregate measures of productivity and to help providers improve the effectiveness and cost effectiveness of their services.
2. **Allocating resources.** The National Institute of Health and Clinical Excellence (NICE) was set up in 1999 to provide guidance to the NHS about the value for money of treatments. The measure of 'value' is the *effectiveness* of intervention on patients' health, based on PROMs and other outcome measures used in randomised control trials. 'Money' is the cost of achieving a unit change in effectiveness over and above comparative treatment (the incremental cost effectiveness ratio). The measure of health effect used by NICE is the quality adjusted life year (QALY), where additional years of life gained are weighted for the quality of that life using data from PROMs. Decisions to recommend interventions depend on the cost per QALY being below £30,000.

- **Third, the use.** With a list of dimensions of poverty, and a sense of how different combinations and levels of these dimensions are valued by different groups of poor people, it would be possible see how this could be used in decision-making and measuring outcomes. Is lack of access to the world beyond the village the worst thing about being poor in rural areas? If so, this would be a good reason to put a significant part of development spending into roads. Is the worst possible outcome a combination of financial insecurity, physical insecurity and lack of access to health services? Then we need to invest in employment and social protection; build police stations and support domestic violence prevention; and build clinics. How different are the values attached to these outcomes by men and women, or by rural and urban populations, different ethnic groups, different generations and so on?

This methodology could help to ensure that 'value for money' is defined according to poor people's own perceptions of 'value'. The costs and benefits of different interventions could be compared by calculating the benefits – as valued by poor people – each would bring per year, using a metric analogous to the QALY.

## Should it be done?

This would not be easy. The challenge of developing something that would have any meaningful relevance in different contexts, even in the same country, would be quite daunting. And the challenge of using such an instrument in a process as uncertain and politically charged as the social and economic change that we call 'development' would be difficult, to say the least. This type of methodology is no substitute for politics, but it can inform it and make the trade-offs involved in decision-making more transparent.

Over the next few years, ODI will be working with others to develop the methodologies described in this paper and reporting on the results. We think this could improve value for money for donors and, most importantly, help all who work in development at a national or international level to give poor people what they want.

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ISSN 1756-7610.