SPECIAL ARTICLE

Poverty and Health Development

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INTRODUCTION

Each year more than eight million people around the world die due to poverty. About 18.4% of the world's population or 1.2 billion people live in absolute poverty with income of less than US$1 per day. More than 800 million go hungry each day and over 100 million primary school age children cannot go to school [1]. Nearly 3 billion people or about 50% of the world population is earning less than US$2 per day. Poverty is multi dimensional and it is more than just of income. Poverty is defined as the lack of ability to fulfill the basic human needs such as not having enough food, lacking adequate clothing, not having permanent housing and lack of access to health, education and transport services. It is a denial of human right. If human beings have rights then the right to be free of poverty must be counted as most fundamental of these rights[2]. When the United Nations created the Universal Declaration of Human Rights in 1948 all member countries proclaimed that people have the right to education, work, health and well being. However, after nearly 60 years, millions of people around the world are still unable to fulfill these needs due to poverty. Millions go hungry, do not have access to healthcare and are denied the basic human rights. Poverty is complex and cannot be treated as a one-dimensional phenomenon[3]. Poverty directly influences the ability of families to meet their basic needs and provide societal minimums such as shelter, nutrition, and healthcare. Poverty can also have a negative influence on family functioning, increasing the likelihood of marital conflict, psychological distress, depression and loss of esteem.

Poverty and Health Development

Health and poverty is a vicious cycle. Poor health can reduce household savings, lower learning ability, reduce productivity and thus, create poverty. Poverty in turn can lead to malnutrition, poor health and lower access to healthcare. It is also well known that those who live in overcrowded conditions, in slums or high rise flats are clearly in a disadvantaged position than those in higher social class[4, 5]. Evidence now shows that better health translates into greater and more equitably distributed wealth by building human and social capital and increasing productivity. Ill health contributes directly to reduced productivity and loss of employment[6]. Health is a precondition for sustainable development and good health contributes to economic development and poverty reduction[7]. More then 2.6 billion people over 40% of the world's population do not have access to basic sanitation, and more than one million people still use unsafe drinking water. The global trend towards urbanisation is marginalising the rural poor and putting huge strains on the basic services of the cities. As a result of this, families living in rural villages and urban slums are being trapped in a cycle of ill health and poverty. It is a well known fact that those living in absolute poverty are five times more likely to die before reaching the age of five, and two and half times more likely to die between the ages of 15-19. Differences in maternal mortality are even more striking; the life time risk of a woman dying due to pregnancy in developing countries with absolute poverty can be as low as 1 in 12 whereas in developed countries it is 1 in 4,000. Good health and its development benefits are under threat from a relatively small group of diseases such as HIV/AIDS, malaria, tuberculosis, childhood illness, acute respiratory infections (ARI) and diarrhea which account for much of the burden of disease in developing countries. Social inequalities in health are a major problem in many countries as much of the focus has been on health differences among social groups within the countries [8].

In 1998, WHO recommitted itself to ensuring universal access to health services and resolution WHA51.7 emphasized the importance of reducing social and economic inequities by paying greater attention to those most in need or affected by poverty. The World Health Organization (WHO) would have to look at the broader context of development if improving the health of the people is seen as a means of combating poverty. Focusing on health in the context of human development will require new ways of working and changes in the way WHO uses resources. It will require collaborative effort with other partners and increase inter-sectoral collaboration. Despite efforts being made in several countries to reduce poverty to improve health of the people, several major issues in the world are now threatening to widen the gap between the rich and poor countries even greater. Health and peace are inseparable partners in the creation of a harmonious and global human community. The major wars and conflicts between countries and within countries is increasing poverty due to destruction of health infrastructure and poor allocation to health services.

International agencies' commitment to reduce poverty

Over the past decade, the international community has given top priority to reduction of poverty so as to improve health. The International Poverty and Health Network (IPHN) was

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created in 1997 following a series of conferences organised by WHO. The aim of the network is to integrate health into poverty eradication policies and strategies, promoting community partnership and intersectoral action as a means to achieve effective and sustainable results. It was formed in response to persistent and growing human suffering due to poverty[9]. The first Millennium Development Goal (MDG) is to eradicate extreme poverty and hunger. Poverty rates in all countries are expected to be reduced by half by the year 2015 if the countries implement policies that eliminate inequalities and create income earning opportunities for the poor. In this respect the UN, the World Bank the G8 countries, EU and other International agencies have all placed health high on their agendas due to the clear linkage between poverty and ill-health. World leaders at the World Summit for sustainable development in Johannesburg, South Africa in August 2002 reaffirmed goals linking poverty eradication and environmental protection to health, including reproductive health and women's empowerment[10].

UNICEF has responded by building national capacities for primary healthcare. Improving the health of the children is one responsibility among many in the fight against poverty. Healthy children become healthy adults who then create better lives for themselves, their communities and their country. UNICEF is helping children in developing countries to support good nutrition including salt iodisation, and assisting in water and sanitation improvement. It is a known fact that one in three children in the world have no access to sanitation facilities. UNICEF also creates a protective child environment and helps in advocating and raising awareness and helping effect policies for childrens' well being[9]. By following the human rights approach to eradicate poverty, a variety of human rights goals can be achieved within the same set of policies. The least developed countries have a high fertility rate and population growth and their population are expected to triple in the next 50 years. Promoting reproductive health and rights is indispensable for economic growth and poverty reduction. Lower birth rates and slower population growth over the last three decades have contributed to faster economic progress in several countries. Avoiding unwanted pregnancies, preventing HIV infection, planning and spacing families, safe births, equal opportunities for education are some of the strategies that can be used to improve health of the people, and good health in turn will reduce poverty[11].

Decline of poverty and health development in Malaysia

In Malaysia poverty is measured by the Poverty Line Index (PLI). A household is considered poor if its income falls below the poverty line. The PLI is calculated using the household expenditure survey (HES). It is based on the minimum requirements of a household for food, clothing, footwear and other non-food items such as rent, fuel and power. For the food component the minimum expenditure is based on daily requirement of 9910 calories for a family of five comprising of an adult male and adult female and three children of either sex within nine years of age. There is no separate PLI for rural and urban households. The proportion of all house holds living below this threshold is the proportion living in poverty or poverty rate. And the poverty rates are available for households only and not for individuals. The concept of hardcore poverty was first introduced by the Malaysian government in 1989 and this category includes households whose income is less than half of PLI[12].

Health status improvement in the country

About 73.19% of the populations in 1970 were rural poor and very few health facilities were provided for them. Malaysia has achieved a remarkable improvement in health status since independence. The life expectancy increased by 26% for the males and 31.7% for the females. The maternal mortality declined by 87.5% and infant mortality rate dropped 93.2% from 1957 to 2005. The poverty declined from 49.3% in 1970 to 5.1% in 2002, a reduction of 44.2% in 30 years (Table I).

The health status improvement of the population including the rural poor was partly due to the rapid development of health services. The introduction of rural health services such as the three-tier and later the two tier health system in the country made a great impact to the rural population. The healthcare network expanded throughout the country from central to grass roots level including the most remote areas enabling the people to have access to primary healthcare at different health facilities. In 1957 there were only ten general hospitals and 56 district hospitals in the country. In 2004 there were 119 Ministry of Health hospitals and 211 private hospitals[13]. There were hardly any health centres in 1957 and in 2004 there were already 859 health centres. Similarly the number of midwife clinics increased to 2017 by the year 2004. The emphasis on primary healthcare for the rural poor provided the much needed accessibility and availability of health services and this contributed tremendously to the health status of the people. Along with physical developments there has been an increase of manpower. There has been a tremendous increase in the number of doctors and other health personnel and the current doctor: population ratio is 1:1377 (2003)[14]. All these developments have lead to the decline in the incidence of infectious diseases like typhoid, tuberculosis, malaria, and increase of non-communicable diseases like diabetes, hypertension, cancers and obesity.

Government poverty eradication programme

Another reason for the improvement of the health status of the people, particularly the rural poor, was the thrust by the government towards poverty reduction. In Malaysia, poverty has been addressed from 1971 with the introduction of the New Economic Policy (NEP) by having the objective of reducing poverty and restructuring society. During this period of NEP (1971 to 1990) there was a major focus on reduction in poverty and income disparities between ethnic groups. Health and education development were central to NEP. Related investments in rural areas made these core services more accessible to the poor people with a considerable improvement on equity[15]. After the NEP, the government introduced the National Development Policy (NDP) for the hardcore poor that incorporated a package of economic, social, housing, health and provision of basic amenities. Due to these factors the incidence of poverty and hard core poverty in Malaysia has dramatically declined. The decline in poverty was also significantly contributed by high and sustained economic growth during the period which averaged 6-7 per cent annually. The poor benefited from increase in household income which improved the access of

Table I: Vital Statistics for Malaysia (1957- 2005)

	1957	1970	1980	1990	2001	2005	% (+ or -)
Population	6.3 mil	10.3 mil	13.8 mil	18.0 mil	24.0 mil	26.1	+ 314 %
Growth rate	NA	2.7	2.4	2.3	2.2	2.1	- 22.0%
Life expectancy							
Male	56	64	66	69	70.3	70.6	+ 26.0%
Female	58	68	70	73	75.2	76.4	+ 31.7%
Crude birth rate	46.2	32.5	30.3	26.8	22.3	19.6	- 57.8%
Crude death rate	12.4	7.0	5.5	4.8	4.4	4.4	- 64.5%
Infant mortality rate	75.5	40.8	23.9	12.1	6.3	5.1	- 93.2%
Toddler mortality rate	10.7	4.2	2.1	0.9	0.6	0.5	- 95.3%
Maternal Mortality rate	3.2	1.5	0.6	0.2	0.3	0.4	- 87.5%
Literacy rate (10 years and above)	NA	58.0%	72.0%	85% (1991)@	NA	95.1%* (2004)	+ 37.1 (1970-2004)
Health clinics	NA	NA	373 (1985)	772 (1998)	858 (2002)	859 (2004)	+ 130 % (1980-2004)
Midwife or rural clinics (*Kelinik Desa* + MCH clinic)	NA	NA	1629 (1985)	2009 (1998)	2028 (2002)	2017 (2004)	+ 23.8% (1985-2004)
Public General Hospitals and District hospitals	66	NA	NA	111 (1996)	116 (2002)	119 (2004)	+ 80% (1957-2004)
Poverty level	NA	49.3 %**	NA	NA	5.1% (2002)	NA	- 44.2% (1970-2001)

Source: Health in Malaysia: Achievements and Challenges. Ministry of Health.2000
Health Facts 2001, 2002, 2004, 2005. Ministry of Health. IDS Unit

- *MOH Indicators for monitoring and evaluation of Strategies for All, Planning and Development Division 2005
- ** Malaysia. Economic Planning Unit Five year plans.(1970 data for Peninsular Malaysia only)
- @ ( ) specific year

healthcare. The weight of the children is a useful indicator of the level of welfare prevailing in a country. It provides a good indication of the level of health services, as well as indirectly reflecting income levels and other factors. The nutritional status of children aged less than five years is an important indicator of health status of the people. The moderate underweight dropped from 24.5% in 1990 to about 11.1% in 2002, and the severe malnutrition is about 0.9% on the children. Another strategy for poverty eradication was providing employment opportunities for those unemployed and welfare handouts for the aged and disabled who could not find employment[16].

What can the government do to eradicate poverty?

Today, Malaysia has much to be proud of with its tremendous achievements in a broad range of development indicators, the most impressive of these being Malaysia's achievement in reducing the incidence of poverty and improving the health status of the people. To further improve the health of the poor the Health Ministry should take the leadership role and work closely with other ministries, non-governmental organizations and other agencies to improve the access to basic public health services, including safe and adequate food, clean water and sanitation. The government can focus on the small number of conditions that affect the poor. Specific attention can be given to a few diseases that contribute to a high burden of disease. Cost effective measures should be introduced to overcome these specific problems. The government should ensure that the health systems serve the poor effectively and equitably. The rural and urban poor are usually marginalised and have poor accessibility to health services. It is the governments' responsibility to make sure that the poor are not marginalised but have equal access to healthcare. The goal of poverty reduction through improved health can only be effectively addressed by means of a decentralized approach that ensures community empowerment, local institution development, and promotion of good governance[7]. The decentralization will allow making decisions faster and action taken immediately. Education plays an important role in the reduction of poverty and improvement of health status. Women's level of education and literacy is a known determinant of the health of the women and also their children. A study showed that infant mortality rate among children of mothers who had primary level of schooling was 50% lower than among mothers who did not go to school[17].

Although Malaysia has done well in terms of equity and accessibility in health, the future threats of globalization, emerging and re-emerging diseases, environmental degradation, water and sewage problems may not only affect the health of future Malaysians but may pose a threat to our plan to eradicate poverty. Realising these concerns, the Prime Minister, in his recent address at the Eight Langkawi International dialogue called on the people to 'restart and re-energise' the debate on poverty with the aim of what the government could do to reduce and eradicate poverty. He proposed the creation of more income generating programmes for the poor to enable them to have better access and use of various resources, including labour, physical capital infrastructure and technology[18]. The development of medium and small scale industries is to empower youth and women to improve their economic situation and indirectly the health status.

We in the health sector need to address the future problems and help the government in its mission to eradicate poverty. Equity in health and healthcare must be placed high on the public health policy agenda and government must give priority for health[19]. More needs to be done to further improve the health of the people in terms of equitable distribution of resources and equity in healthcare. This will

include the need to improve equity in development outcomes, eradicate extreme poverty, halt the spread of HIV/AIDS, promote gender equality, especially in the economic and political spheres, and improve environmental management. There is a need to focus on the health problems of the poor and marginalised groups and we must ensure that the health system serves the poor more effectively and efficiently. Implementing healthy public policies and strategies to overcome these challenges need to be made if we are to succeed in eradicating poverty and improving the health of the poor in the country.

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