TWELFTH MEETING OF MINISTERS OF HEALTH OF THE COUNTRIES OF WHO SOUTH-EAST ASIA REGION
Ulaanbaatar, Mongolia, 30 August – 2 September 1994

HEALTH AND POVERTY
Introduction

As defined in WHO constitution, health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The enjoyment of the highest attainable standard of health is one of the fundamental human rights. The Thirtieth World Health Assembly in 1977 decided that the main social target of governments and WHO should be the attainment of Health For All by the Year 2000 (WHA30.43). The Alma Ata Conference in 1978 endorsing the resolution charted a new approach to health and health care based on equity and social justice to close the gap between the 'haves' and 'have-nots' and to attain a level of health for all citizens of the world to lead a socially and economically productive life. Subsequently, there has been attempts to reduce the inequities in health by formulating global strategy and different national strategies to implement this goal. Primary Health Care approach was identified as the key to attain HFA.

The four basic principles in this approach are - universal accessibility and coverage of health care, community and individual involvement and self reliance, inter sectoral collaboration, and appropriate technology and cost effectiveness in relation to available resources.

A WHO meeting 'From Alma Ata to the Year 2000 - A mid point perspective' convened in Riga in former USSR in 1988 to take stock of progress has made recommendations for further action. The problem of under-development and unchanged social and personal behaviour pattern was recognized as obstacle in operationalization of the concept of PHC approach. It was noted that in spite of substantial progress made in overall term, the benefits of health development have not been enjoyed by all sections of people. The poor and under privileged have continued to remain out of the mainstream.

Definition of Poverty

Poverty has been defined as the inability to attain a minimum standard of living or to purchase the minimum basket of goods and services required for the satisfaction of basic needs. The poor are those who fall under such a minimum level or 'poverty line. Among poor, it is possible to identify as poorest group of 'extreme poverty' or 'critical poverty' or 'indigence' or "destitution". This group even lacks the means to buy food, have a minimally adequate diet, much less to acquire other goods and services. The Expert Group Meeting on National Poverty Concepts and Measurement in the ESCAP region in 1993 conceptualized poverty, 'as a state of deprivation with reference to socially accepted norms of basic human needs'. In defining poverty, the condition and socio-cultural value should be reflected. It would therefore vary from one country to another.

Profile of the poor

It has been estimated that in the Asia and Pacific Region as a whole, the total number of absolute poor is around 800 millions. It has been observed that the incidence of poverty or indigence is much higher in rural areas in general. Average rural income, health status, education and housing are always below national average, and considerably worse than urban averages. In South East Asian Region, they seem to be usually concentrated in hill slope areas, suffering from environmental degradation or high mountainous areas with hostile environment and lack of basic infrastructure. There is scarcity of arable land in such areas and labour demand is highly seasonal. Labour productivity is extremely low. This encourages a tendency to migrate to urban area or even neighbouring countries
in a situation of economic vulnerability, physical cultural solution. In such a hostile socio-cultural environment the self esteem suffers and dignity hurts.

In regards to the health conditions, the rural poor suffer worse than the urban poor. Infant Mortality Rate is higher, there is little or no access to safe water. Life expectancy is short and levels of nutrition low. Access to health and other social services are meagre and the ratio of physicians, hospital beds and sewage disposal facility is rural areas can be very low.

In urban area, the poor often live in overcrowded shanty towns and illegal squatter settlements. They have very low education level, are afflicted with high disease burden, have larger families and earn a very low income. Unemployment, poor housing, lack of clean water, poor sanitation contribute to poor health. They have little access to social services and even if available may not use them. Usually women and children suffer most.

**Situation in the Countries**

Recent monitoring and evaluation of implementation of national HFA strategies have shown that in spite of overall improvement in health status, the progress of implementation of HFA strategies has been disappointingly slow particularly in the least developed countries. High infant child maternal mortality and high birth-rates have not shown signs of decline, particularly in areas where the poor are concentrated.

In the ultimate analysis it seems that the principle of primary health care has not yet been clearly translated in the implementation of HFA. Instead of restructuring of health system, reorienting it towards preventive and promotive health care with PHC approach, attention has mainly been given to the expansion of static health infrastructure and resources available in these countries are used without due consideration of capacity building at the community level.

The situation becomes worse when large proportion of available resources is allocated to sophisticated medical institutions in urban area. It is unfortunate that in many developing countries, the improvement of health is still equated with the provision of medical care provided by specialists using costly medical technologies for the benefit of the privileged few. The disadvantaged and the poor are forgotten in the process. Equity suffer. Thus, it is important that the available and additional resource is preferably invested in PHC and at the same time ensure that the population is not deprived of care at higher levels when needed. The quality of available primary care services should be good so that the level of utilization is not low. The quality of services at higher level can be gradually improved according to the availability of resources.

To ensure the efficient utilization of resources, it is important that all levels of the health system are critically reviewed for their methods, techniques, equipment and drugs so that only affordable and scientifically sound technologies are used. However, this by itself would not be enough if mass awareness about positive health is neglected and the inherent resilient strength within the community is not used to the maximum. Reorientation of medical education can further facilitate for proper appreciation of the role of primary health care amongst the medical personnel. These future medical leaders can make significant contribution by assisting the poor people to recognize their health needs and convert them into health demands.

In the process, it is important to accept the fact that only an integrated, holistic approach with intersectoral coordination can lead towards the achievement of the goal of human development and overall growth. It is important for the health services to take on the role of a support system and catalyst together with other support systems of various sectors and other governmental and NGOs with a focus on the improvement of the health status of the poor.
Economic Reality

However, global economic situation with reduced flow of aid to developing countries, increasing debt, burdened debt servicing in an unfavorable macro economic environment has forced countries to make structural adjustments. Health Sector has been worsely affected at a time when more financial resources are needed for expansion of health care delivery services. Almost all countries are concerned how to meet the growing costs of health care, which may not only be due to high population growth and expanding population coverage, but also due to misallocation of health resources, overwhelming preference for high cost curative medicine over low cost preventive care. Sources of financing have mainly been from public funds and to a lesser extent from private sources and others like user’s fees, community financing, health insurance etc. In this scenario, for involvement of the poor in health development, it is important that adequate resource allocation should be made not only in consultation with other sectors but also with community organizations as well.

Future Action

It has been observed that the government health facilities, which are expected to protect the poorest affected by high risk of diseases have yet to be improved. In the face of budgetary cut in public sector, the poorer section suffers the most. This underlines the need for political commitment to achieve a better balance between promotive/preventive and curative services and among the three levels of care with more rational allocation of resources. More resources should be considered for primary health care particularly potable water supply, sanitation, immunization, maternal and child health, family planning, healthy life style. Decentralization of health services should not be an excuse for cutting down resources in peripheral area where the poor live.

WHO has been assisting the member states in implementation of programmes which are directed to the benefit of the poor/underprivileged people. Amongst others, in 1989 the Director General of WHO launched an initiative of Intensified WHO Cooperation with countries and peoples in greatest need. The main principle is to bring about an improvement in the health of the people confronted with poverty by providing technical support to countries for health reform and development. Six countries of this region - Bangladesh, Bhutan, Maldives, Mongolia, Myanmar and Nepal are participants to this initiative. Besides, WHO has been facilitating technical cooperation amongst countries to support countries in the upliftment of the poor.

Conclusion

There have been a number of resolutions in the World Health Assembly (WHA30.43, WHA 41.34 and WHA 42.2) and the South East Asia Regional Committee (SEA/RC32/R1, SEA/RC42/R3 and SEA/RC43/R6) emphasizing inter alia the need to give preferential attention to health care to the most disadvantaged and needy section of the population. The resolutions WHA43.17 and WHA44.24 commit WHO to intensified Cooperation with countries in the greatest need to address health development in link with poverty issues.

It is heartening to note that in the Human Development Report 1994 published by UNDP, it has been suggested that donor countries change their allocation priorities in their aid budget and lift their aid allocation to human priority goals to 20%, thus making available a sum of about 12 billion dollars against the current figure of 4 billion dollars for human centered development. Simultaneously, it has been suggested that developing countries devote 20% of their budget to basic human development concerns by modifying budget priorities, reducing their military spending, privatising their loss making public enterprises and giving up low priority development projects. The assertion by the World Bank that 'no task should command a higher priority for the world's policy makers than that of reducing poverty' is relevant. If the resources are really directed to the upliftment of the poor, it will be a great step forward in the socio economic and health development in the country.