The relationship between poverty and health care

Ghasem Bahrami

Qazvin Health Insurance office, Iran Health Insurance Organization

Abstract: The Middle East and North Africa Region has made significant progress in improving the average health status of its citizens. The relation between economic condition and health is extremely robust across Communities. Many factors influence health status and a country's ability to provide quality health services for its people. Approximately 1.2 billion people in the world live in extreme poverty. Poverty creates ill-health because it forces people to live in environments that make them sick, without decent shelter, clean water or adequate sanitation. Health and poverty issues differ markedly from country to country contexts, with countries emerging from and affected by conflicts presenting a particular challenge. Many factors exogenous to income play an important role in determining health status is including a number of environmental, geographic, and evolutionary factors. Poverty also significantly reduces people's capabilities making it more difficult to avoid poverty related diseases. One of the most significant parameters effective on human capital performance is the role of individual health and its related indexes in enhancing economic level of a country so that one of the important subjects is investment in individuals' education. Education, unemployment, Poverty, work conditions, workplaces, physical environments and social support all significantly affect health.

[Ghasem Bahrami. **The relationship between poverty and health care.** *Researcher* 2014;6(3):27-32]. (ISSN: 1553-9865). http://www.sciencepub.net/researcher. 5

Key words: Health, Economic condition, Poverty, Diseases

1. Introduction

Poverty and diseases occur together. Diseases of poverty are a term sometimes used to collectively describe disabilities, diseases and health conditions that are more prevalent among the poorer than among wealthier people. Governments have undertaken to run some programs for financing health care by governmental or NGOs' resources to promote public health. One third of deaths are due to poverty-related causes: in total 270 million people, most of them women and children have died as a result of poverty since 1990. Many diseases that primarily affect the poor serve to also deepen poverty and worsen conditions (Lubotsky A. Case, D., and C. Paxson. 2002).

The causes of poor health for millions globally are rooted in political, social and economic injustices. Poverty is both a cause and a consequence of poor health. Poverty increases the chances of poor health. Poor health in turn traps communities in poverty. Infectious and neglected tropical diseases kill and weaken millions of the poorest and most vulnerable people each year. Some important unanswered questions are identified and Potential health impacts on national economic performance are explored (Acheson D. 1998). The importance of insurance coverage can be considered from two viewpoints: protect people against the costs of providing health; and providing universal coverage of health services in order that people have access to cheap and adequate health services.

Researchers have examined poverty as cause and consequence of poor health. Poverty is prejudicial to health as a result of it restricts access to medical care and healthy living conditions.

As an example, the risk of infectious disease will increase in crowded and poorly environments like prisons and the risk of infection with protozoal infection is higher in poorly made homes that are less effective at preventing the entry of vector mosquitoes. moreover, since each interference and effective treatment of adverse health events cost money, the poor don't seem to be solely seemingly to suffer from pathological state more typically, however additionally to have additional severe squeal.

Those who live in poverty have also been shown to have a far greater likelihood of having or incurring a disability within their lifetime. Poverty additionally restricts access to new tools; priority setting in molecular and clinical research and development favors the wants of wealthier populations (Kirby M. 1999). Health, however, is additionally determined by a number of things unrelated to economic well-being. A pair of studies of the influence of poverty on the ability to reason about complicated issues requiring an immediate solution found that poverty directly impedes cognitive function. Geographical, environmental and biological factors contribute to the medicine of many diseases. as an example, tropical diseases like protozoal infection are notably pernicious in sure contexts attributable to climate, topography and evolutionary history, and not merely due to poverty.

The lustiness of the correlation between health and economic indicators, therefore, suggests that health is

additionally a determinant of economic success. Therefore, the foremost valuable thanks to protect people against the high cost of health services, that are growing progressively these days more than ever, is to make an insurance partnership among government, insurance organizations and therefore the public.

Health impacts directly on household income and wealth, labor productivity, labor participation, investment rates and demographic factors, and different human capital factors. the actual fact that health impacts and is wedged by economic performance raises necessary policy issues; as an example, while some would argue that improved health is among the numerous positive results of successful economic development strategies.

Some mechanisms by that health determines economic performance Treatment with cost and labor productivity the most proximate costs of health problem to people and their households include the costs of treatment and lost period.

mistreatment data on structures and levels of infant and child mortality in historical contexts still as modern developing countries, and speculating supported anthropology data on the proportion of maternal and paternal time devoted completely to child-rearing, Reher finds that underneath conditions of high child mortality, every child who dies before the fifth birthday represents a mean loss of 1300-1800 hours of the parental period of time, depending on the particular structure of mortality patterns(Kyegombe, N. 2003).

So as to confirm three who survive to age five, therefore, parents would need to "waste" 800-3000 hours on children who wouldn't survive. Longer term effects chronic squeal of some illnesses include anemia, impaired psychological feature development, and different varieties of permanent incapacity (Fiscella K. 2004).

These conditions might impact economic performance, even within the absence of severe clinical illness. Health care in Iran and medical sector's market value was almost US $24 billion in 2002 and was forecast to rise to US $31 billion by 2007. With a population of 75 million (2012), Iran is one of the most populous countries in the Middle East.

According to the World Health Organization (WHO), as of 2000, Iran ranks 58 in health care and 93 in health-system performance.

The health status of Iranians has improved over the last two decades. Iran has been able to extend public health preventive services through the establishment of an extensive Primary Health Care Network.

As a result child and maternal mortality rates have fallen significantly, and life expectancy at birth has risen remarkably. Infant (IMR) and under-five (U5MR) mortality have decreased to 28.6 and 35.6 per 1,000 live births respectively in 2000, compared to an IMR of 122 per 1,000 and a U5MR of 191 per 1,000 in 1970. Immunization of children is accessible to most of the urban and rural population (Caper P.1993).

2. Demographic impacts

Iran has been very successful in training/educating the necessary human resources for its health system. There are now 488 governments funded hospitals in Iran.

Table 1: The Demographic impacts

(2011)	
Medical Schools	51
Medical Students	1 million
Professors of Medicine	20,000
Hospital Beds	120,000
Village Clinics	20,000
Doctors	100,000
Nurses	170,000

There were 0.5-1.1 physicians per 1000 population in 2004 according to various estimates Health can also have an effect on the economic performance of communities through its impacts on demographic factors.

Shorter life expectations, for instance, inhibit investment in education and alternative forms of human capital, since there's bigger risk that every individual won't survive long enough to learn from the investment additionally, a bigger proportion of the population that is dependent overwhelming additional resources than it produces incorporates a damaging result on rates of savings and capital investment, and therefore on future growth. The widespread incidence of incapacity, injury, and health problem inflate these dependency ratios. Childhood diseases like protozoal infection prevent an oversized proportion of birth cohorts from maturing to economically productive age.

AIDS may be a primary adult malady with vital demographic impacts. By decimating the urban skilled category in several African countries and Botswana were living with HIV at the end of 1998 and manufacturing lots of orphans annually, AIDS directly reduces the scale of the economically active population.

Furthermore, fertility selections could also be created partially by a necessity to make sure a given range of survivors, or in response to childhood mortality expertise. T.P. Schultz demonstrates a statistically important inflating result of child mortality on total fertility (Stockwell EG, Goza FW, Roach JL. 1995). Therefore, it's attainable that wherever childhood mortality rates are terribly high, countries could become caught in an exceedingly demographic

entice, with high fertility rates resulting in bigger demand for unit and community resources, massive proportions of that are "wasted" on children who don't survive to economically productive age.

The health house, usually the only health facility accessible to the rural population, is the most basic unit of the Iranian PHC network. Located in villages, it is designed to cover a target population of 1700 people; each health house also serves several satellite villages selected with careful attention to their cultural and social compatibility. The distance between the village in which the health house is located and the satellite villages it serves is typically no more than 30 km.

Tasks performed at the health house include record keeping and data collection; public health education and promotion of community participation; antenatal, prenatal, and postnatal care; care of small children as well as school age children; family planning services; immunization; and disease control services.

Table2: the statistic of healthcare demography

IRAN: Healthcare (Source: EIU)	2005	2006	2007	2008	2009	2010
Life expectancy, average (years)	70.0	70.3	70.6	70.9	71.1	71.4
Healthcare spending (% of GDP)	4.2	4.2	4.2	4.2	4.2	4.2
Healthcare spending ($ per head)	113	132	150	191	223	261

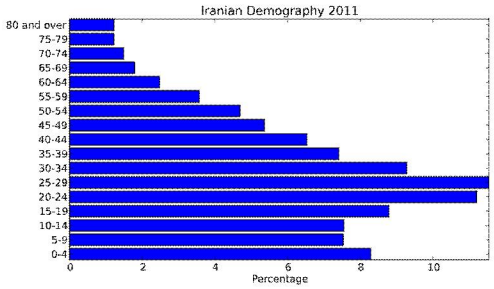

Figure1: Iranian demography

Several countries whose economies believe heavily on foreign direct investment or business enterprise, together with for instance Malaysia and Norway, are particularly energetic in dominant the unfold of infectious diseases in areas of economic importance .

A major achievement of public policy in the Islamic Republic of Iran over the past 20 years has been the improvement of rural health and the near-elimination of some health disparities between urban and rural populations, the latter often comprising a much poorer group than the former(Zill N. 1988).

3. Health Expenditures

Table2: health expenditures statistic

Country	Health Expenditure (% of GDP) Public	Private	Total	Health Expenditure (US$ per capita)
Algeria	3.2	1.1	4.3	77
Arab Republic of Egypt	2.1	3.6	6.0	79
Islamic Republic of Iran	2.9	3.1	6.0	104
Jordan	4.3	5.0	9.3	165
Lebanon	3.5	8.0	11.5	568
Morocco	1.5	3.1	4.6	55
Syria	2.3	2.8	5.1	58
Tunisia	2.8	2.8	5.6	126
Republic of Yemen	1.0	2.7	3.7	23
Middle East and North Africa	2.9	3.0	5.9	89
Lower middle income countries	2.5	3.3	5.8	75

Source: World Development Indicators. CD-ROM 2004.

Some of the lower-middle-income countries in the region, including Lebanon, the Islamic Republic of Iran, and Tunisia, are well advanced in the demographic transition, with low birth rates (around two children per woman) and low mortality.

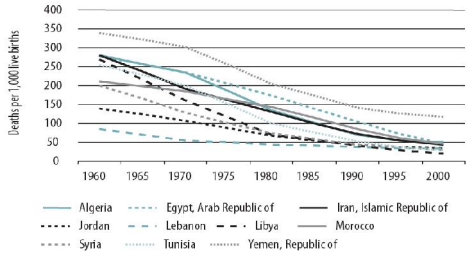

Figure2: Country-Specific Trends in Mortality among Children Less than 5 Years of Age, 1960–2000

Algeria, Egypt, Jordan, Morocco, and Syria are in mid-transition, with declining fertility and low mortality rates. In the 2002 show that, on average, Middle Eastern and North African countries spend around 5.9 percent of GDP on health, which is just above the 5.8 percent spent by other lower-middle-income countries. However, the public spending component of this is 2.9 percent in the Middle East and North Africa, compared with 2.5 percent in other lower-middle-income countries. And per capita expenditures in the region are around $89, whereas those in lower-middle-income countries are around $75.

There is a lot of variation within the region with regard to health spending, however, so the averages need to be interpreted with caution. Moreover, the variation in spending is not necessarily associated with

differences in health outcomes. The costs to trade and commerce of environmental and infectious diseases as protozoal infection stay mostly unexamined each theoretically and through empirical observation.

A growing body of medical literature has begun to think about the health impacts of accelerating commerce and investment. Magnified incidences of foot and mouth disease, HIV, malaria, and tuberculosis have all been attributed to increasing world traffic in recent decades. As these impacts are returning to be understood, they need begun to impact social behavior and government policy together with as an example trade policies. In recent cases, nations and regions that are perceived as unhealthy are expressly quarantined from international commerce (McGaughey PJ, et.al.1991).

The positive feedback of adverse health events presents pathological state typically begets future ill health by increasing the chance of apparently unrelated weakening within the future. several infectious sicknesses, together with protozoa infection need complex cell-mediated immune responses; poor overall health and nutrition reduce the effectiveness of those responses, increasing the chance that infection with these diseases are going to be a lot of severe, leading to long term incapacity or death. Empirical evidence of the future impact of health on economic performance Health and therefore the historic period the past many decades have brought unexampled enhancements in life expectancy worldwide, though these enhancements haven't been uniformly distributed.

Economic historians have begun to think about the importance of trends in health in determination patterns of economic process. As a result, Western Europe over this period has seen fast will increase in each proletariat participation rates and therefore the average range of calories accessible for work, increasing productivity by concerning 0.3 share points annually. Modern developing economies, even as pre industrial Europe, have low rates of proletariat productivity and reduced levels of productivity per employee because of widespread acrobatics and deficiency disease. At an equivalent time, historians have long nonplussed over the curious pattern of Southern economic growth from the until the center of the twentieth century, marked by divergence from the North till around 1910, followed by steady convergence until war II. At the top of the eighteenth century, protozoal infection incidence in the south geographical region was therefore high that solely the farmers couldn't afford to maneuver to the comparatively healthy urban environment of Charleston were left behind. During the first nineteenth century, protozoal infection outbreaks doubly forced the relocation of Alabama's capital town. Malaria and national economic performance Jeffrey Sachs and John town investigate the quantitative impact of endemicity of malaria disease on cross-country political economy growth. Dominant for tropical location, location in Africa, lifetime at birth, foreign policy, geographical accessibility to international trade, and initial financial gain, they realize that endemicity of falciparum protozoal infection correlates with considerably dampened associational GDP/capita growth rates over a twenty five year period; they observe an equivalent correlation victimization ecological zone as an instrument for protozoal infection endemicity. They discuss the historical cases of southern Europe, Taiwan, and Jamaica, all of that saw substantial acceleration of economic process when achieving sustained elimination of protozoal infection transmission. They speculate that abundant of this impact could also be through hindered integration of malarias areas into world trade networks.

Health and economic process in Asia, during a study for the Asian Development Bank, discuss the importance of the precipitous decline in mortality and fertility rates in spawning unexampled economic growth performance in East and Southeast Asia from the Sixties to the Nineteen Nineties(Getzen TE.2006). Within the late Forties, child and child mortality rates in Asia plummeted and lifetime soared. a couple of generation later, mostly in response to the new mortality regime, fertility rates also declined; the result was a population bulge with higher health prospects than any generation before. A transition that had taken centuries in pre-industrial Europe had occurred in but 3 decades. Bloom et al describes this transition as Asia's "demographic gift," and speculate that it's going to be liable for the maximum amount as 0.5-1.3% in accelerated annual growth over the amount 1965-1990, or 15-40% of the region's total growth performance.

4. Poverty eradication

Poverty occurs in both developing and developed countries. One third of deaths some 18 million people a year or 55,000 per day are due to poverty related causes: in total 280 million people, most of them children and women have died as a result of poverty since 2000. Therefore it is necessary that every step be taken to reduce poverty globally.

The UN's high ten priorities for poverty eradication:

4.1. focusing on the problem:

Eradication of poverty can only be led to by initial recognizing so working on the difficulty.

4.2. Ending discrimination against women:

Women form the majority of individuals living in poverty. They simply fall prey for poverty. Thus concentration on the essential needs of women forms a necessary a part of poverty of impoverishment.

4.3. More employment:

Productive employment plays a central role in poverty

of impoverishment. Access of land and opportunities for people cause more development each on a personal and on a large scale.

4.4. Good health:

Elimination of basic diseases that kill people round the world may be a major causative factor in reducing the quantity of deaths because of poverty. These diseases embrace diarrhea, protozoal infection, metastasis infections, AIDS/HIV and different common infectious diseases.

4.5. Adequate education:

Education plays an important role during a person's well being. It's the Government's responsibility to supply basic education to its citizens.

4.6. Sufficient supply of fresh water.

Contaminated water may be a supply several diseases and hence a provide of pure water will save many lives by simply preventing a serious problem. Poor people cannot afford to urge treatment for even common diseases. Thence prevention is that the major supply of relief for these people.

4.7. Safe environment:

A healthy and safe environment ensures a much better living for people that depend upon natural resources like forests and lands.

4.8. Social Services:

charity organizations and Social services societies everywhere the planet plays a vital role by helping folks in poverty and distress.

4.9. Adequate Nutrition:

Malnutrition may be a major killer in underdeveloped countries like Africa and thus a basic provide of food is important to stop a large range of deaths occurring in these areas due to malnutrition.

4.10. Global Alliance:

A global alliance should be formed for International community by the Governments and Civil Societies to figure along for demolition of poverty globally.

5. Discussion:

However Challenges of the future are likely to be different from those in the past because of the ongoing demographic and epidemiological transition. In the 1980s and early 1990s the Middle East and North Africa had the highest population growth rate of any region in the world. Population growth slowed in most countries in the 1990s and is now about 2 percent for the region as a whole (which is still higher than all regions except Sub-Saharan Africa).

It is estimated that by 2015 the number of adults in the region will have increased by 140 percent, representing the highest adult population growth in the world after Sub-Saharan Africa. Reciprocated questions and potential policy implications the effort to know the impact of health standing on economic performance at the national level has recently received increasing attention (Kyegombe, N. 2003).

The evidence suggests that the remarkably sturdy correlation between economic and health indicators cannot merely be adduced to the actual fact that richer populations are higher able to maintain sensible health; variety of things exogenous to income additionally appear to be necessary predictors of health standing. as an example the endemicity of explicit diseases seems to play a vital role, and is commonly the results of conditions of climate, geography, topography, and evolutionary history.

Additionally, nutrition standing, that is basically a result of distinct scientific challenges to agricultural productivity, additionally seems to play a job. It looks seemingly, therefore, that the relationship between physiological condition and economic status might be alternating in nature. Improved health could create economic success, just as economic success brings concerning enhancements in health. However, variety of necessary questions remains. As an example:

1) what are the semi permanent demographic impacts of high childhood mortality? What are the economic consequences of those impacts?

2) To what extent do environmental or geographically conditioned diseases like protozoal infection impede inter- and international traffic, commerce, and trade and thus economic growth?

3) What are the future impacts of poor nutrition, in terms of longevity, productivity,
cognitive development, and different aspects of human capital?

4) However necessary are the relative effects of national economic growth and international technological enhancements in rising general human health and well-being?

5) However are dynamic patterns of technological development, changes in diversity,
global climate change, and different trends enhancing the importance of ecology, climate, and different scientific factors in conveyance concerning poor health?

6) Within the face of co-occurring effects, however will the correlation between health and economic well-being be a lot of absolutely understood?

Important empirical and analytical challenges remain in respondent these and similar questions. Additional analysis is important to understanding the nature and extent of the relationships between economic and health standing.

The results of such analysis might is necessary policy implications. For example, to
the extent that health interventions result not solely in proximate enhancements to human longevity and well-being however additionally in semi permanent enhancements to economic performance, their

cost-effectiveness could typically be underestimated. Thus an increasing share of health budget re sources is likely to be pulled toward the treatment of such cases. This may put the poor at a disadvantage if the needed resources are taken from service that addresses their needs (Partin M, Palloni A. 1995).

Distinctive and understanding these dynamics may additionally improve political in fields as various as birth control, public health, economic planning, infrastructural development, national trading policy, and many others. In recent years, governments in the region have had been investing in expensive medical technology to cope with the rising demand from urban middle-class populations.

Finding a balance between competing demands to address the demographic and epidemiologic transition and improve access to quality health services for poor people represents a major challenge for the countries in the Middle East and North Africa.

Acknowledgement:

Authors are grateful to the persons for support to carry out this work.

Correspondence to:
Ghasem Bahrami
Qazvin Health Insurance office, Iran Health Insurance Organization

References

1. Acheson D. 1998. Independent Inquiry into Inequalities in Health. London: Stationery Office.
2. Caper P.1993. The microanatomy of health care. *Health affairs*.; 12(1): 162–173
3. Fiscella K. 2004.Williams DR. Health disparities based on socioeconomic inequities: implications for urban health care. Acad Med.; 79:1139–1147.
4. Getzen TE.2006. Aggregation and the measurement of health care costs. Heal Serv Res.;41(5):1938–1954.
5. Hulme, D. 2003, 'Thinking 'small' and the understanding of poverty: Maymana and Mofizul's story', CPRC working papers no 22, CPRC, Manchester University.
6. Kyegombe, N. 2003 'Health and Chronic Poverty', Background Paper for the Chronic Poverty Report 2004-5.
7. Kyegombe, N. 2003. 'Health and Chronic Poverty', Background Paper for the Chronic Poverty Report 2004-5.
8. Lubotsky A. Case, D., and C. Paxson. 2002. "Economic Status and Health in Childhood: The Origins of the Gradient," *The American Economic Review* 25, No. 4: 1308–1334.
9. McGaughey PJ, Starfield B, Alexander C, Ensminger ME. 1991. Social environment and vulnerability of low birth weight children: a social-epidemiological perspective. *Pediatrics* 88:943–53.
10. Partin M, Palloni A. 1995. Accounting for the recent increases in low birth weight among African Americans.*FOCUS* 16:33–37.
11. Stockwell EG, Goza FW, Roach JL. 1995. The relationship between socioeconomic status and infant mortality in a metropolitan aggregate, 1989–1991. *Sociol. Forum* 10:297–308.
12. Zill N. 1988. Behavior, achievement, and health problems among children in stepfamilies: findings from a national survey of child health. In *Impact of Divorce, Single Parenting, and Step Parenting on Children*, ed. EM Hetherington, JD Arasteh. Hillsdale, NJ: Erlbaum.

3/7/2014