

Health and development

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SUMMARY In this paper, the relationship between health and development is discussed. The impact of development on health and the importance of health to development are illustrated. The challenges to achieving health and development are outlined and the role of the World Health Organization in promoting these two objectives and their interrelationship is reviewed.

Introduction

The links between health and development have been extensively studied worldwide and have led to advocacy for comprehensive health, which should be at the centre of social and economic development. The World Health Organization (WHO) definition of health highlights the social, cultural and environmental health determinants and the Alma Ata declaration has clearly paved the way to implement such an approach [1].

Interest in the interplay between health and development has also grown since the nineties as a consequence of the important change in the development paradigm. The latter evolved after the release of the first human development report [2] and aimed to increase all human choices, not just income. As a result, human development is now based on human centrality, sustainability and empowerment.

International summits and conferences, including the United Nations Conference on Environment and Development, the International Conference on Nutrition, the International Conference for Population and

Development, the World Summit for Social Development and the recent Copenhagen plus Five conference have focused on the links between health and development. WHO has been instrumental in promoting the centrality of health in all social and economic development initiatives and programmes.

The 20/20 initiative, supported by WHO, called for better funding of social programmes (including health) from official development assistance, which should direct 20% of its resources to social sectors against the commitment of governments to allocate at least 20% of their public resources to the social sector [3]. The last Geneva summit (Copenhagen plus Five) showed that unfortunately only a few countries have been able to meet this target, partly because most donors have not honoured their commitment to increase official development assistance, while the debt burden has not been reduced enough.

International institutions such as the World Bank and International Monetary Fund have also embraced the new human development scenario and have highlighted

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the important role of investing in human capital through health and education as a prerequisite to achieve balanced and sustained development. The 1993 World Development Report [4] clearly conveyed the message that investing in health has a good return and that the cost of ill health hampers development initiatives.

Links between health and development

Several studies launched by WHO since 1978 have shown the intersectoral links between health and development as illustrated by the improvement of health status as a consequence of social and economic development [5].

The contribution of health to overall development has two aspects: the positive impact of health development and the negative social and economic consequences of ill health as a result of premature mortality, morbidity and disability.

In the 20th century, development was usually equated with economic growth without defining a clear link between economic prosperity and health, which is considered a key component of human development. A recent World Bank study showed that income improvement resulted in only about a one-fifth decline in mortality between 1960 and 1990, whereas women's education and use of new knowledge played a more important role in this respect.

It is well known that the programmes and activities aimed at protecting and promoting health, including healthy lifestyles, immunization, care and rehabilitation, have a positive impact on economic development through a healthy and productive workforce. The success achieved by WHO in a number of communicable disease con-

trol programmes has made it possible to vastly reduce the burden of ill health and to free resources for development.

The WHO-supported onchocerciasis programme has prevented hundreds of thousands of cases of blindness and has reduced the suffering of individuals and communities, which cannot be priced. Furthermore, the programme has liberated 25 million hectares of productive land in sub-Saharan Africa, to be used for housing and economic development. The total cost of the programme is estimated at US\$ 570 million for the period 1974–2000 with a rate of return of 16% to 28% and a progressive impact on income distribution [4].

In one African country, a combined health education and sanitation programme aimed at eradicating guinea worm has revitalized the farming sector, resulting in a substantial increase in production and productivity [4].

The WHO programme to eradicate smallpox, a disease which was responsible for almost 5 million deaths and 6 million disabled in the 1950s, was achieved at a cost of US\$ 300 million. The cost has been recouped several times over in both financial and human terms.

In Sri Lanka, it was found that the malaria eradication programme between 1947 and 1977 might have contributed to an increase in national revenue by a sum of US\$ 7.6 billion during this period [4]. As the cost of the eradication programme was about US\$ 52 million, the cost benefit ratio of the programme was 140. The malaria-free areas were populated and used for development purposes.

The economic burden of acquired immunodeficiency syndrome (AIDS) in some developing countries, particularly in sub-Saharan Africa, is a real source of concern as the epidemic affects mainly young and productive sectors of populations. The

World Bank has projected the economic losses in the 10 most affected countries and has shown that the annual rate of economic growth in these countries will be reduced by 0.6 points, with a range of 0.1 to 0.8 points [4].

The economic burden of AIDS is also related to the high cost of treatment for diagnosed cases. In Tanzania, clinicians estimated the average number of episodes of illness before death of AIDS patients to be 17 for adults and 6.5 for children [4]. The cost of treatment for an adult patient varies from 8% to 400% of the per capita income, with a mean of 150%. Such a situation puts a real strain on already vulnerable households and communities in poor and underdeveloped countries.

The death of young and productive adults contributes also to increased poverty and marginalization, and young family members find themselves obliged to abandon education in order to support their families. The fall in children attending schools because of the mother's death was estimated at 50% in Tanzania [4].

The health sector itself also contributes to social and economic development through the production of goods and services. Spending on health worldwide is estimated to be 8% of the gross domestic product (GDP) and the health sector employs 35 million professionals, being one of the main employers in the public sector in many countries, including countries of the Eastern Mediterranean Region.

Impact of development on health

Economic and social development have both positive and negative impacts on health as illustrated by several studies carried out by WHO with other developmental

agencies. Owing to intersectoral links, health status is highly influenced by social and economic determinants, such as income, housing, nutrition, literacy and environment. Improvements in income and living conditions in industrialized countries have led to better outcomes as translated into higher life expectancy and reduced morbidity and mortality.

In developing countries, the burden of ill health comes mainly from infectious diseases which are aggravated by indoor pollution and crowding, diarrhoeal diseases caused by bad sanitation and lack of clean drinking-water, tuberculosis complicated by malnutrition and a lack of immunization coverage against preventable diseases. In many industrialized countries, welfare programmes, including health promotion and protection, are funded through taxation and play an important role in protecting health gains and improving health status, particularly of vulnerable social groups.

Economic growth in most countries has been accompanied by a progressive development of health system infrastructure including networks of facilities and human resources development aimed at bringing health services to all communities. The adoption of the Alma Ata declaration has led to the development of health systems based on primary health care and to the recognition of the importance of social health determinants and the role played by community participation and empowerment in health development.

Technological advances and innovations in health and medical care have helped to reduce morbidity, disability and mortality. The discovery of antibiotics at the beginning of the twentieth century was an important milestone in the fight against communicable diseases. Recent progress in clinical imaging and treatment, biotechnology, and medical engineering has led to im-

provements in screening, prevention and treatment of several diseases and has contributed to reducing suffering and to improving the quality of life. However, these technological developments have generated concerns as they are not equally accessible to all, are costly and have social and ethical consequences. The most striking example is the multitherapy for AIDS patients which helps improve immunity and fight against opportunistic infections. Such therapy is not accessible to patients from developing countries and the manufacturing companies have not shown enough solidarity to make such treatment affordable by poor patients from sub-Saharan Africa and Asia.

Economic development can also have a negative impact on health if health concerns are not taken into consideration when planning for development projects. The most noted links between agricultural development and health are those associated with irrigation systems. It is widely accepted that irrigation schemes carry a high risk of vector-borne and water-borne diseases, such as malaria, schistosomiasis, onchocerciasis, leishmaniasis and Japanese encephalitis. In studies carried out by WHO and the United Nations Environment Programme (UNEP), it was usually found that negative health consequences of development projects were caused because there was no assessment of health impacts in the planning and implementation processes of such projects. In addition to health hazards caused by irrigation, pesticides used in agriculture have negative impacts on rural workers and farmers [6]. In many developing countries, there is little legislation related to production, use and disposal of pesticides. Training in the safe use of pesticides is rarely carried out in development projects.

The impact of development on the environment is well documented. The destruc-

tion of the Amazon forest and of forests in Africa is a good example. Pollution, together with deforestation, contributes to climate change, ozone-layer depletion and negative health impacts, such as the spread of tropical diseases to new areas, flooding of coastal areas and the increase in skin cancers due to ultraviolet radiation.

Challenges to health and development

In many regions, including the WHO Eastern Mediterranean Region, populations lack access to safe drinking-water and adequate sanitation, particularly in rural areas and in poor suburbs of megacities. Solid waste management leaves much to be desired and as a result represents a serious health risk for the population. Political conflicts and civil strife which exist in many countries, including countries of the Eastern Mediterranean Region, have created a large number of refugees and resulted in the destruction and disruption of water supplies and other essential environmental health services, which again threatens health.

The worsening economic condition in the nineties in the former Soviet Union has led to a precipitous decline in life expectancy; in comparison with western Europe, the gap in life expectancy has widened from 3 years in 1970 to about 15 years in 1995 [7].

The global changes that took place during the last decades of the twentieth century in political, social, economic and technological fields have had many negative impacts on human development, particularly in low- and middle-income countries. The gap between the haves and the have-nots has widened leading to increasing poverty, which is the main determinant of ill health. Economic adjustment has caused cuts in social spending including health, which has

hampered the implementation of health-for-all strategies and programmes.

Despite the overall growth of the world economy, which doubled in the 25 years before 1998 to reach US\$ 24 trillion, around 1.3 billion people still live in absolute poverty, on less than US\$ 1 per day. Of the 4.4 billion people in developing countries, nearly three-fifths lack access to sanitation, a third do not have clean water, about a fifth have no access to health care, and a fifth have insufficient dietary energy and protein intake. Economic disparities both within and between countries have grown and in about 100 countries, incomes are lower in real terms than they were a decade ago. At the same time the world is facing a growing scarcity of renewable resources from deforestation, soil erosion, water depletion, declining fish stocks, and lost biodiversity, all of which will hit the poor populations of the world most severely.

Despite overall dramatic increases in life expectancy in the past century, health professionals are concerned about the growing and unacceptable inequalities in health and wealth. In many African countries, the debt burden is so high that it surpasses in many cases their gross national product, which thus reduces opportunities for economic recovery. Despite efforts to reduce the debt burden through various means, including agreements at the Cologne Summit, the Paris Club and the heavily indebted poor countries (HIPC) initiative, much remains to be done to help these countries escape the vicious circle of poverty and ill health.

WHO's role in health and development

Ill health and poverty are mutually reinforcing and exacerbate deterioration and hu-

man suffering. Ill health contributes directly to reduced productivity and sometimes to loss of employment, which has negative consequences on the whole family, particularly children. Poor people, who have few reserves, may be forced to sell their assets, including land and livestock, or to borrow at high interest rates to deal with the crisis caused by illness. Each option increases their social and economic vulnerability with the danger of moving down the poverty spiral [8].

In view of the importance of health determinants, WHO has taken important initiatives globally and regionally. WHO established the Commission on Health and Environment, which made a major contribution to the United Nations Conference on Environment and Development (UNCED), and WHO was given responsibility to follow up on the health aspects of Agenda 21 emanating from UNCED. The International Conference on Nutrition and the Ministerial Conference on Malaria offered a golden opportunity to highlight the link between health and development.

A WHO task force on health in development was created which included development specialists, policy-makers and health professionals. The task force held several meetings and was instrumental in the preparation of the World Summit for Social Development.

A WHO task force on health economics was established which included experts from all parts of the organization. The task force produced several papers analysing the impact on health of economic and financial reforms as well as global changes and challenges such as globalization and the creation of the World Trade Organization (WTO). Technical papers were prepared for various international meetings of WTO, which aimed at protecting health in trade. Countries were also offered help in

negotiating better terms. WHO also established a task force on macroeconomics and health economics comprised of prominent experts in these areas. This task force prepared WHO position papers highlighting the determinants of health and the added value of investing in health [10].

In its efforts to protect the poor and vulnerable populations, WHO has requested lending institutions to modify their procedures in order to guarantee access to loans for the poor and disadvantaged segments of the populations and has advocated the need to incorporate health objectives in all development projects.

In its efforts to integrate health into plans to eradicate poverty (an important determinant of ill health) and following a series of advocacy conferences, WHO helped to create the International Poverty and Health Network in 1997. The creation of the network, involving researchers from public health and development fields from government and non-governmental organizations and from business, was a response to the growing and persistent burden of human suffering due to poverty. It aims at influencing policy to protect and improve the health of the world's poor, particularly the poorest in all countries. The network calls for a balance between social development and economic growth, between human and financial dimensions of poverty, and between redistribution and market reforms.

The interest of WHO in strategies for poverty alleviation yielded positive results in the last G8 Summit where it was agreed that funds should be mobilized to fight against the diseases of poverty, such as HIV/AIDS, tuberculosis and malaria. The global efforts of WHO to promote poverty alleviation as part of health development will be translated as a growing emphasis on intersectoral links in WHO's technical cooperation with countries in the future.

Poverty has many dimensions including lack of education, inadequate housing, social exclusion, unemployment and environmental degradation. It leads to limited choices and hopes and is a real threat to the health capital of individuals, families and communities. Economic indicators focus on income-related poverty, whereas health indicators provide a measure of the multidimensional nature of poverty. For this reason, health achievement should become the pre-eminent indicator to measure and monitor the success or failure of development policies in the next century [9].

In the mid-eighties, the WHO Regional Office for the Eastern Mediterranean started to focus on the social and economic determinants of health as part of its efforts to implement health-for-all policies and strategies. Important initiatives have been launched to promote community development and empowerment as entry points to health development. The basic development needs (BDN) and quality of life (QOL) programme has gained momentum in several countries of the Region and success stories have led to its adoption and refinement throughout the Region. The pillars of such an approach are self-reliance, community empowerment and community financing. Once the needs are identified, communities, through their continuous dialogue with other partners, endeavour to secure the necessary resources. Community-based and community-run income-generating and revolving sales funds are examples of local financing programmes. Community development teams, with the active input of local health professionals supported by WHO, liaise with all concerned parties and sectors ensuring smooth intersectoral collaboration. WHO is promoting the exchange of experiences between countries implementing such approaches as a means of technical cooperation among developing

countries within the framework of the regional capacity-building policy. Tools for monitoring and evaluating BDN programmes have been developed in order to better illustrate the link between health and development. An evaluation aimed at assessing the various facets of BDN/QOL, including community empowerment, social mobilization, financial and economic sustainability and health status improvement, is to be undertaken. Such an evaluation, which will be carried out by specialists in public health and social development, will highlight the strengths and weaknesses of such an initiative in order to improve its implementation in other countries within and outside the Region. The involvement of colleagues from WHO headquarters aims at drawing necessary lessons for implementing such an approach in other social and cultural settings.

The WHO Regional Office for the Eastern Mediterranean has also developed similar initiatives aimed at incorporating the environmental determinants of health through the healthy communities and villages and healthy cities programme. Such programmes include development components, such as income-generating schemes, while highlighting the importance of sustaining the environment and maintaining social and cultural heritage. The development of such approaches has led to the creation of a new unit responsible for community-based initiatives in the new structure of the Eastern Mediterranean Regional Office.

Following the release of the World Health Report 2000 on health systems, WHO is promoting the need to secure a financial threshold that will allow health systems to perform adequately. In many developing countries, despite efforts to raise funds for health development, the financial gap is still wide. Thus, WHO is calling for international solidarity for health

development though improved and well targeted official development assistance and through reduction, if not cancellation, of debt to poor underdeveloped countries.

Conclusion

The links between health and development have been recognized for a long time, in both developing and industrialized countries. The development scenario also evolved acknowledging the centrality of health in human development. However, development strategies tended to focus on economic growth, leaving health to pursue its own strategies, which remained disease-centred and primarily oriented towards the curative approach. The political, economic and social changes that have taken place globally in the last decade have led to widening gaps between rich and poor among and within countries. The peace dividend expected as a result of the end of the Cold War did not materialize as ethnic conflict and civil strife emerged and health was thus not high on the political agenda. Increasing poverty with its negative impact on health has led to renewed interest in the fight against poverty — one of the important determinants of ill health.

WHO, striving to achieve its noble goal of health for all, is playing an important advocacy role to promote the importance of investing in health and in improving social and economic health determinants. Efforts are being made with other concerned agencies and development institutions to protect public health in development initiatives and to secure equity with respect to access to health. Such interest is reflected in WHO's programmes at various levels and the Regional Office for the Eastern Mediterranean is taking the lead in promoting a comprehensive approach to health development.

WHO's efforts to invest in community empowerment and an integrated approach to development need to be supported by the active participation of multidisciplinary groups. International solidarity to alleviate

poverty and to promote equity in access to social services, including health, is a prerequisite to comprehensive and balanced human development

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