Editorial

Health, poverty and development

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The interplay between health, poverty and development is well known and has been studied by public health professionals, social scientists and development specialists and also by international agencies including the United Nations Development Programme (UNDP), the World Bank and the World Health Organization (WHO).

The Millennium Development Goals (MDGs), to which all countries of the world are committed, emphasize the linkages and synergies between health, poverty and development. These Goals put health at the centre of social and economic development by focusing on tackling the social determinants, including literacy, poverty reduction and environmental protection, and by scaling up public health programmes and improving access to quality health services.

As part of the studies on the social determinants of health initiated by WHO since Alma Ata [*1*] evidence has been collected on the positive impact of economic development, improved access to safe water and sanitation on health development [*2*]. Indeed, that these are important factors is clear from the fact that the decrease in general mortality and increase in life expectancy during the last century and half occurred long before the development of health systems and the important breakthroughs in medical technology.

The improvement of living conditions facilitated by economic growth and development in Europe, the United States of America (USA), Japan and other countries belonging to the Organisation for Economic Co-operation and Development (OECD) is considered the main cause of increasing life expectancy and decreasing mortality. Economic growth leads to an increase in income for individuals and communities and to improvement of housing and nutritional status, which are major determinants of health. However, ill planned and non-environmentally sensitive economic development projects may have negative impacts on health because of exposure of people to hazards resulting from the projects. Some major agricultural and industrial projects, including dams and plants, are known to have had an adverse effect on the environment where people live and hence on their health and development.

The economic growth experienced by developed economies later allowed greater investment in modern health care systems after the Second World War, which led to improved infrastructure, trained health workforce and access to biomedical technology. Furthermore, developed economies have invested in education which has a positive impact on health in terms of encouraging health protection and promotion.

Recognizing the importance of economic and social conditions, UNDP, since the 1960s, has promoted the concept of securing the basic minimum needs for development. Such an approach was also used in the field of health development and led

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to its implementation in Thailand and other Asian countries after Alma Ata. Similar approaches have been implemented in the Eastern Mediterranean Region of WHO as part of its commitment to health for all through primary health care. The concept evolved from initially simply meeting the basic needs to a more proactive and comprehensive developmental approach owned by the communities.

While economic improvement contributes to better health, health also contributes to economic growth and development by increasing the social capital in terms of: a healthy and productive workforce, reduced absenteeism, savings resulting from the prevention of occupational hazards, and increased number of disability-free years of life. Models of the contribution of health development to economic growth have been described by developmental economists worldwide and this concept was behind the focus of the 1993 *World Development Report: investing in health* [*3*]. The contribution of major public health programmes, including malaria and river blindness control in Africa and Asia, to freeing more land for housing and agricultural development, was clearly evident in economic terms.

In recent works, developmental economists, including Nobel prize-winner Amartya Sen and Nicholas Stern, have highlighted the importance of social engagement and empowerment. Without empowerment, argues Stern, economic growth will not bring improvement in health and education or relief from poverty. The active involvement of individuals, and communities, in decisions that affect their lives is crucial.

Health systems play an important role in securing access to health care provided that they are adequately financed, governed and managed at the various levels. Countries with low incomes spend less on health development which thus does not allow health systems to fund health programmes, to secure necessary health and biomedical technology and to develop a motivated personnel. As a consequence, effective coverage by health interventions and programmes is limited which results in poor health outcomes.

But funding is not the only issue; the way health systems are organized can also have a direct impact on poverty and development. Inequities in health care financing, for example the financial vulnerability caused by high levels of out-of-pocket spending on health care services, constitute a major barrier to access to health care by the poor in many low- and middle-income countries worldwide, including the Eastern Mediterranean Region. Poor patients, in the absence of social health protection mechanisms, often face catastrophic medical care expenditures when they become sick which may impoverish them and their families.

Studies implemented by WHO in 42 countries including in 2 in the Eastern Mediterranean WHO regional office have shown that 2%–3% of households face catastrophic health care expenditures and that 1%–2% are pushed into poverty when they become sick. Translating this into figures, health systems in the Eastern Mediterranean Region are producing an additional 10 million poor people every year.

Public health professionals throughout history have been keenly aware of the need to fight against poverty in order to achieve better health outcomes. Health professionals, dealing with poor and deprived populations, are often frustrated by the lack of response to their health and medical interventions as patients again become sick when they return to their home environment which lacks appropriate nutrition, safe water and sanitation. In dealing with patients, physicians have the obligation to

understand the root causes of the health problems and recognize that some of them are generated by the society and must be addressed. Many public health physicians thus become advocates of the idea of poverty being a preventable "disease". The history of public health includes many pioneering public health professionals, including Rudolph Virchow (1821–1902), who have contributed to the paradigm shift from the biomedical model of diseases to focus on the social, political, economic and cultural dimensions of ill health.

Research on the social determinants of health has led in some countries, including the United Kingdom and some Scandinavian countries, to a policy debate about the need to focus on comprehensive social and economic programmes aimed at reducing the social gradients in health outcomes. Studies have shown that social determinants such as illiteracy and poverty reduce access to health care services even though these may be provided without any financial barriers as part of the welfare package provided by some countries. Thus, investing more in health without addressing the major social determinants, such as literacy, female education and social health protection, may not lead to improved health outcomes. Indeed, life expectancy in the highest health spenders in the world, for example the USA, is similar to or even lower than in countries with limited income but with better access to education, sound nutritional policies and universal access to health care, such as Cuba, Costa Rica and Sri Lanka.

The Commission on Social Determinants of Health established by WHO has set up several knowledge networks to assess the magnitude of social determinants and to document working models in health systems. These networks are addressing the domain of social determinants, including gender, literacy, poverty, social exclusion, political and cultural factors and health systems.

The reports published by the networks convey important messages about the importance of social determinants in health development in both developing and developed economies. Lessons learned from these studies and research activities will be useful in reconfiguring health systems in order to achieve better health outcomes and improved performance.

The findings of these studies are also important for policy-makers who are entrusted to develop comprehensive social and economic programmes. Evidence has shown that the linkages between health, income and development can improve social development by maximizing the synergy between them. It is hoped that models found successful in some countries could be replicated in others.

In 2008 the world will be celebrating the 60th anniversary of WHO and the 30th anniversary of the Alma Ata declaration [*1*] and it is important to highlight the linkages between health and its major social and economic determinants. Investing in health system strengthening alone will remain insufficient to achieve the noble inspirational goal of health for all. The emphasis should be on the importance of social determinants and their incorporation in all endeavours aimed at improving health.

The revival of health systems based on primary health care should benefit from the new momentum characterized by the international commitment to MDGs and the renewed interest in the social determinants of health. Efforts should be made to develop accessible and pro-poor health systems and to better involve individuals and communities in their health development.

References

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Traditional medicine

Many countries use traditional medicine to help meet some of their primary health care needs: in Africa, up to 80% of the population uses traditional medicine for primary health care. In China, traditional herbal preparations account for 30%–50% of total medicinal consumption and in Germany, 90% of the population have used a natural remedy at some point in their life.

The World Health Organization (WHO) launched its first ever comprehensive traditional medicine strategy in 2002. The strategy is designed to assist countries to:

- develop national policies on the evaluation and regulation of traditional/complementary practices;
- create a stronger evidence base on the safety, efficacy and quality of the products and practices;
- ensure availability and affordability, including essential herbal medicines;
- document traditional medicines and remedies.

At present, WHO is supporting clinical studies on antimalarials in 3 African countries. Collaboration is also taking place with a number of countries, including Burkina Faso, Mali, Nigeria and Kenya in the research and evaluation of herbal treatments for HIV/AIDS, malaria, sickle cell anaemia and diabetes mellitus.

In Tanzania, WHO, in collaboration with China, is providing technical support to the government for the production of antimalarials derived from the Chinese herb *Artemisia annua*. Local production will bring the price of one dose down from US$ 6–7 to a more affordable US$ 2.