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HEALTH

A PRECIOUS ASSET

Accelerating follow-up to the
World Summit for Social Development

Proposals by the
World Health Organization

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Contents

HEALTH: A PRECIOUS ASSET

Five years after the Copenhagen Summit

World Health Organization's Proposals for Action

Foreword

The world has committed to halving the number of people living in extreme poverty by 2015, and a set of concrete targets has been set. Many of them focus on health – on child and maternal health and access to primary and reproductive health care. To me it is clear that we must strengthen our focus on the pathway that leads from health to poverty reduction and sustainable development.

Until recently, many development professionals have argued that the health sector, itself, is only a minor player in efforts to improve the overall health of populations. And the overwhelming majority of finance officials and economists have believed that health is relatively unimportant as a development goal or as an instrument for poverty reduction. Health was seen as a consumption rather than an investment cost.

But this is changing. We are standing on the threshold of a major shift in thinking. Health is increasingly being seen as a crucially important asset of poor people. From this perspective protecting and improving health are central to the entire process of poverty eradication and human development. It is the purpose of this report to share WHO's views on health in development.

I believe that the Special Session of the UN General Assembly in Geneva in June 2000 offers a timely opportunity for international endorsement of a more robust, multidimensional approach to human development and its social components, particularly health.

Gro Harlem Brundtland
Director General
World Health Organization

Health as an asset

"The wealth of poor people is their capabilities and their "assets". Of these, health is the most precious and important. Health allows poor people the opportunity to participate in the labour market or in the production of goods. It is a key to productivity. Having a fit, strong body is an asset to anyone: a sick, weak and disabled body is a liability, both to the persons affected and to those who must support them. When breadwinners die or experience episodes of ill-health or long-term disability, the results can be disastrous for the entire household. The family faces not only a loss of income and care but also needs to find the money to cover medical care costs as well. Health calamities are a common cause of impoverishment.

If health is an asset and ill-health a liability for poor people, protecting and promoting health are central to the entire process of poverty eradication and human development. As such they should be goals of development policy shared by all sectors - economic, environmental and social."

Introduction

"We commit ourselves to the goal of eradicating extreme poverty in the world, through decisive national actions and international cooperation, as an ethical, social, political and economic imperative of humankind."
Copenhagen Declaration, World Summit for Social Development, 1995

Five years after the commitments were made at the World Summit for Social Development (WSSD) in Copenhagen, progress in achieving the targets has failed to match expectations. Whereas the Summit aimed for substantial reductions in the number of people living in extreme poverty, the number has actually grown. Nor has much progress been made in the objective of achieving universal health care. In some countries access has deteriorated, particularly for the poorest populations.

Nevertheless, the international consensus on what constitutes the essential elements of human development has progressed. Belief in economic liberalization has given way to a global social concern. There is a greater understanding that effective human development policy must allow a better integration of economic, social and environmental concerns.

The centrality of health has been recognized. Health is seen as both a critical input to development and as an outcome of development, as well as a fundamental human right with a value in and of itself. Herein lies the opportunity which must be seized in "Copenhagen Plus Five", the five-year follow-up meeting. It takes place in Geneva, 26-30 June 2000, as the Special Session of the United Nations General Assembly on the Implementation of the Outcome of the World Summit for Social Development and Further Initiatives.

Health as an asset

The wealth of poor people is their capabilities and their "assets". Of these, health is the most precious and important. Health allows poor people the opportunity to participate in the labour market or the production of goods. It is a key to productivity. Having a fit, strong body is an asset to anyone: a sick, weak and disabled body is a liability, both to the persons affected and to those who must support them. When breadwinners die or experience episodes of ill-health or long-term disability, the results can be disastrous for the entire household. The family faces not only a loss of income and care but also needs to find the money to cover medical care costs as well. Health calamities are a common cause of impoverishment.

If health is an asset and ill-health a liability for poor people, protecting and promoting health are central to the entire process of poverty eradication and human development. As such they should be goals of development policy shared by all sectors – economic, environmental and social.

Health improvements are disproportionately beneficial to the poor because they are wholly dependent on their labour power.

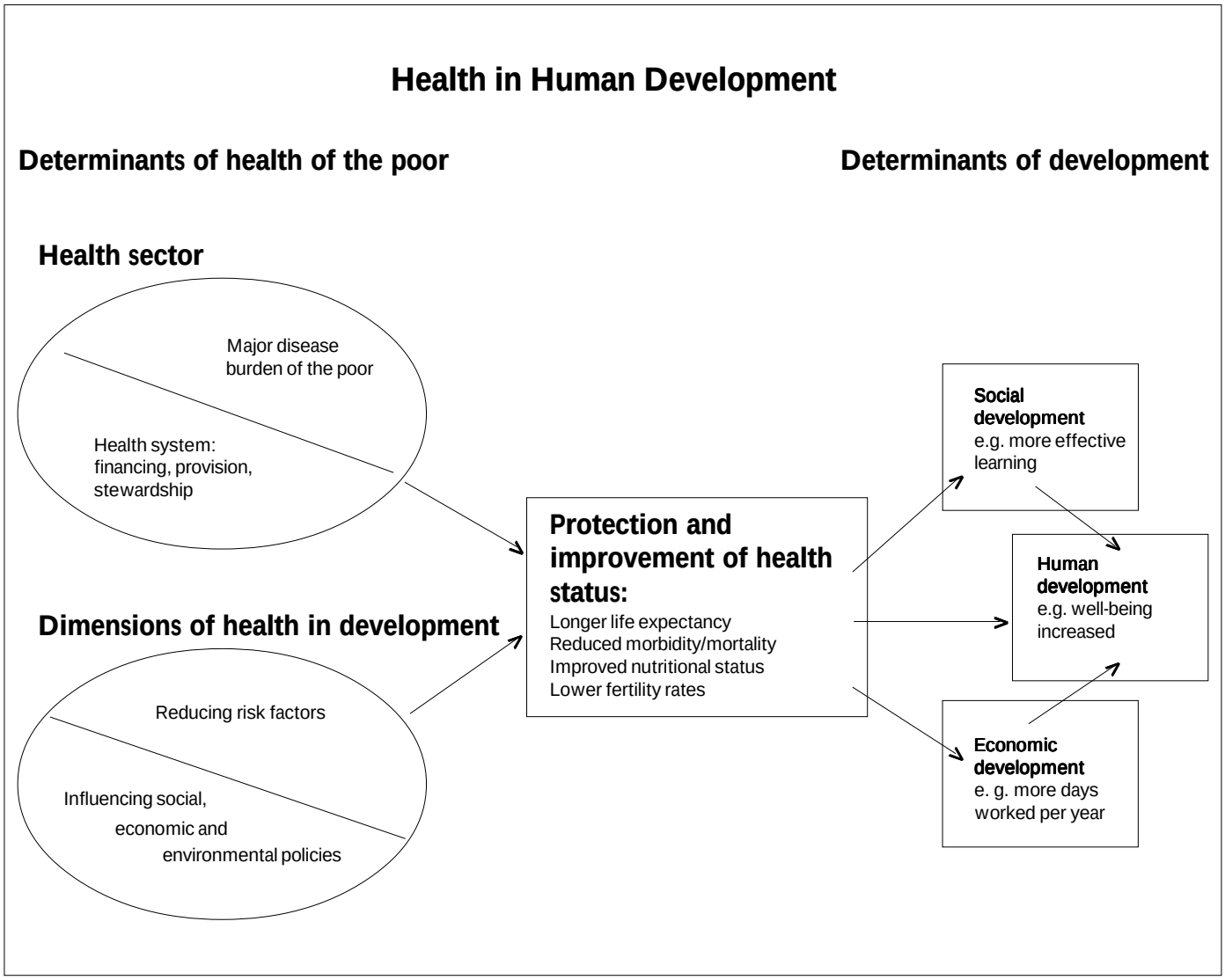
A multisectoral vision

The Copenhagen Declaration and Programme of Action accorded responsibility for health to basic health services. This narrow perception of health undervalues the contribution of improved health status to development. At the same time, it does not recognize the potential of many sectors to foster the health of poor people in the interests of furthering human wellbeing. Any positive contribution to human and social capital is the result of the improved health status of populations, and not merely the output of health service industry. Better health contributes to sustainable livelihoods and human development.

Universal access to health services *is* important. But if health is to fulfil its potential in human development, the services required need to have the capacity to improve health status *and* to reduce the inequities in health. Health inequities are in themselves contributors to ill health.

The World Health Organization believes that the Special Session of the UN General Assembly in Geneva in June 2000 offers an extremely timely opportunity to build on the commitments of the Copenhagen Summit by obtaining an endorsement for a more robust, multidimensional approach to human

"When breadwinners die or experience episodes of ill-health or long-term disability, the results can be disastrous for the entire household."



Source: WHO/HSD

Poverty eradication as part of the overall development goal

In societies with clear policies on equality and democracy, and where the overall goal of equity is the improvement of the health status of the entire population, the chances of health development for the poorest people is higher. Experiences from countries with a historical commitment to health as a social goal, and to equality as a political goal, confirm this. Costa Rica, Sri Lanka and the state of Kerala in India have achieved considerable improvements in the health status of their populations by a series of political, social and economic interventions in society as a whole, actively involving communities in the process. In Costa Rica, where health is considered an "investment in the nation, a necessity for social vitality and economic progress," progressive health policies have increased the income of the poorest 10% of the population by more than 65%. Source: *"Poverty and health: Who lives, who dies, who cares?"* Macroeconomics, Health and Development Series, No. 28 by Margareta Sköld, Department of Health in Sustainable Development (HSD), WHO/ICO/MESD.28

development with strengthened social components, particularly relating to health.

Further information

This report is necessarily brief and selective. It responds to the request of the preparatory committee for the Special Session of the UN General Assembly for information on progress in achieving universal access to primary health services.

The report begins with a summarized global update on the main diseases and conditions which disproportionately affect the poor. It also describes current problems in health services. The second section sets out a number of proposals for action, within the Copenhagen framework, which the World Health Organization believes can make health a significant force for poverty reduction.

The information in this document will be supplemented by the World Health Report 2000.

Five years after the Copenhagen Summit

THE HEALTH REVOLUTION THAT LEFT OUT A BILLION PEOPLE

The 20th century has seen a global transformation in human health unmatched in human history. Over the past three decades, overall improvements in health and human development can be illustrated as follows:

- Infant mortality rates have fallen from 104 per 1000 live births in 1970-75 to 59 in 1996. On average, life expectancy has risen by four months each year since 1970.
- Per capita income growth in developing countries has averaged about 1.3 percent a year, bringing relief from poverty for millions of people.
- Governments report rapid progress in primary school enrolment. Adult literacy has risen, from 46 to 70 percent.[1]

We can soon expect a world without poliomyelitis, with no new cases of leprosy, and with no more deaths from guinea worm.

But over one billion people – one in six of the world's population – will enter the 21st century without having benefited from the health and human development revolution. The lives of these people are difficult and short, and scarred by a ruthless disease called "extreme poverty". Extreme poverty is categorized as a disease under code Z59.5 in WHO's International Classification of Diseases.

Growing disparities

Unacceptable and growing disparities in the health of rich and poor countries, rich and poor people, and between men and women, are important characteristics of human kind at the start of this new millennium. It is only if the health problems of the poor can be reduced that human assets can be liberated for social development.

It is hard to give a detailed, up-to-the-minute account of trends in the health of poor and vulnerable populations since 1995. We must frankly acknowledge that the poor quality or, in some instances the absence, of data is a significant obstacle to tracking the health status of the poor.

However, it is now generally recognized that the many dimensions of poverty including lack of basic education, inadequate housing, social exclusion, lack of employment or opportunities, environmental degradation, and low income all pose a threat to health. On every health indicator studied by the World Health Organization, the poor fare worse than the better off in any given society. Specifically, compared to fellow citizens, those living in absolute poverty are:

- Five times more likely to die before reaching the age of 5 years
- Two and a half times more likely to die between the ages of 15 and 59 years.

Potentially deadly infections, such as HIV/AIDS, malaria, tuberculosis and diarrhoeal diseases, disproportionately affect poor people producing devastating effects on households and national economies. As a result, the World Health Organization accords high priority to controlling these diseases – a task made especially difficult by the evolution of drug-resistant microbes. Major current health problems such as malnutrition and maternal mortality also have a greater prevalence among the poor.

"One in six of the world's population will enter the 21st century without having benefited from the health and human development revolution."

Health status of the poor versus the non-poor in selected countries, around 1990

Country	Percentage of population in absolute poverty	Probability of dying per 1000 between birth and age 5, females		Probability of dying per 1000 between ages 15 and 59, females		Prevalence of tuberculosis	
		Non-poor	Poor:non-poor ratio	Non-poor	Poor:non-poor ratio	Non-poor	Poor:non-poor ratio
Aggregate		38	4.8	92	4.3	23	2.6
Chile	15	7	8.3	34	12.3	2	8.0
China	22	28	6.6	35	11.0	13	3.8
Ecuador	8	45	4.9	107	4.4	25	1.8
India	53	40	4.3	84	3.7	28	2.5
Kenya	50	41	3.8	131	3.8	20	2.6
Malaysia	6	10	15.0	99	5.1	13	3.2

Poverty is defined as income per capita of less than or equal to $1 per day, expressed in dollars adjusted for purchasing power.
Source: *World Health Report 1999, Making a difference.*

MAJOR HEALTH PROBLEMS OF THE POOR

HIV/AIDS[2]

The prevalence of HIV/AIDS is associated with poverty:

- More than 95% of all HIV-infected people now live in the developing world, which has likewise experienced 95% of all deaths to date from AIDS, largely among young adults who would normally be in their peak productive and reproductive years.
- The economic effect of HIV/AIDS on households is devastating. From household surveys in Africa and Asia we know that families living with HIV/AIDS have an income reduction of 40-60%. The inevitable response is the spending of savings, borrowing, and reductions in consumption.[3]
- HIV/AIDS illustrates the effect of multidimensional poverty on health. The socioeconomic factors contributing to the spread of HIV/AIDS include: illiteracy related to income poverty; gender inequality; increased mobility of populations within and between countries; and, rapid industrialization involving the movement of workers from villages to cities, with consequent breakdown of traditional values.[4]
- HIV/AIDS also illustrates the global equity gap. Successful public health measures have stabilized the epidemic in most developed countries, but the same is true only of some developing countries. Developing countries have 95% of cases, and many poor countries are experiencing exponential growth of HIV/AIDS cases. Yet, developing countries only receive about 12% of global spending on HIV/AIDS care.[5]

"Developing countries have 95% of cases … Yet, developing countries only receive about 12% of global spending on HIV/AIDS care."

Malaria[6]

Malaria hits hard on the poor and the vulnerable:

- Over one million people die of malaria each year of which almost 90% occur in sub-Saharan Africa.
- Malaria is directly responsible for one in five childhood deaths in Africa. Indirectly, it contributes to illness and deaths from respiratory infections, diarrhoeal disease and malnutrition.
- For reasons which are not fully understood, women are more susceptible to malaria during pregnancy. This is particularly so during the first pregnancy. Fetal growth, and the survival of the new-born, may be seriously compromised.[7]

Malaria flourishes in situations of social and environmental crisis, such as mass migration, military conflict and social unrest, where health systems are weak and communities disadvantaged.

The severity and urgency of the problem has led to the formation of global partnerships to control malaria. **Roll Back Malaria,** a World Health Organization initiative, is a coalition involving the United Nations Development Programme (UNDP), UNICEF, WHO and the World Bank. Roll Back Malaria assists health systems to deliver the cost effective interventions that exist to control malaria. The initiative harnesses the support of the private and public sector in developing new malaria drugs and vaccines.

Tuberculosis[8]

Tuberculosis and poverty are closely linked. Both the probability of becoming infected, and the probability of developing clinical disease are associated with factors which are associated with poverty. These factors include malnutrition, overcrowding, poor air circulation and inadequate sanitation. Given the often crowded conditions in which poor populations live, they are more likely to contract tuberculosis. At the same time, those who contract the disease are more likely to become poor given the economic consequences of the disease. Ninety-five per cent of cases and deaths occur in developing countries.

Tuberculosis is a growing problem in many regions of the world. It is on the rise in developing and transition economies due to a combination of economic decline, insufficient application of control measures, and the HIV/AIDS epidemic. People whose immune defences are weakened by HIV infection become an easy prey for other microbes, including the bacillus that causes tuberculosis. The resulting infections (along with some cancers) are responsible for the recurring illnesses which in their late stages are called "AIDS", and which ultimately lead to death.[9]

- Between 1993 and 1996 there was a 13% increase in estimated tuberculosis cases world-wide, one third of which can be attributed to HIV.[10]

Global distribution of death by main causes

Communicable diseases, such as tuberculosis and respiratory infections as well as maternal, perinatal and neonatal causes account for about 20 million, or 40% of global deaths. Ninety-nine per cent of these deaths occur in developing countries.
Source: *"Bridging the gaps"*, World Health Report 1995.

- Around 30% of all AIDS deaths result directly from tuberculosis.[11]
- WHO estimates that by the end of the century, HIV infection will cause an additional 1.5 million cases of tuberculosis annually.[12]

Concerted efforts to end social apathy towards TB; to expand the global coalition of partners involved in TB control; and, to advocate for TB to be placed high on the international agenda are currently being mounted through the **STOP TB Initiative** based at the World Health Organization. The initiative is creating a social and political movement against TB by promoting the use of the cost effective Directly Observed Treatment Short-course (DOTS).

Malnutrition[13]

Nearly 30% of humanity is currently suffering from one or more of the multiple forms of malnutrition. Protein-energy malnutrition and iron deficiency anaemia are major sources of concern, iodine deficiency is the greatest single preventable cause of brain-damage and mental retardation (affecting 740 million people or 13% of the world's population) and Vitamin A deficiency (VAD) remains the single greatest cause of preventable childhood blindness. Overall, malnutrition accounts for 15.9% of the global burden of disease.[14]

Each year some 49% of the 10 million deaths taking place among children under five in the developing world are associated with malnutrition. Currently, 26.7% of the world's children under five years are malnourished when measured in terms of weight for age.

Recent achievements:

- Remarkable progress has been made in controlling iodine deficiency disorders (IDD) in the last decade. More than two-thirds of households living in IDD-affected countries now consume iodized salt, and 20 countries have reached the goal of universal salt iodization (USI) defined as more than 90% of households consuming iodized salt.
- There has been progress since 1990 in combating VAD. In 1997, it was estimated that in about 30 countries, 50% of children were either given vitamin A supplements or had access to fortified food.

However, progress in reducing protein-energy malnutrition (PEM) among infants and young children is exceedingly slow, and little progress has been made in reducing the prevalence of anaemia over the past two decades.

Maternal mortality

The death of a mother is a catastrophe in any family. In many developing countries, it deprives a household of a vital income as well as love and affection. When a mother dies in a poor families, the loss is such that it may also spell death for her children.

Every year 585 000 poor women die from the complications of pregnancy and childbirth. In developing countries, maternal mortality and morbidity is by far the greatest cause of premature death and disability amongst women aged 15 to 44 years. Women in Northern Europe have a one in 4000 risk of dying from pregnancy–related causes. For women in Africa, the ratio is one in 16. There could hardly be a more striking disparity between North and South than this.

The target of the International Conference on Population and Development (ICPD) in 1994 was to reduce 1990 levels of maternal mortality by half by the year 2000 – a target which will not be met – and by a further half by the year 2015.[15] New targets were agreed in the five-year review of the ICPD in 1999. They are that at least 40% of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80% globally by 2005; these figures should rise to 50% and 85% respectively by 2010; and to 60% and 90% by 2015.[16]

In October 1999, WHO, the United Nations Population Fund (UNFPA), UNICEF and the World Bank combined forces in a joint commitment to fight maternal mortality more effectively.

Water-borne diseases[17]

Diarrhoeal diseases, largely preventable through access to adequate clean water and sanitation, claim nearly two million lives a year and account for 1.5 billion bouts of illness each year in the under-five age group. Diarrhoeal diseases impose a heavy burden on developing countries. The World Health Organization estimates that diarrhoeal diseases accounted for 73 million disability adjusted life years (DALYs)[18] lost in 1998.[19]

Out of the total global population of six billion:

- More than 1 billion people are highly vulnerable to diarrhoeal diseases because they do not have ready access to an adequate and safe water supply.
- Approximately 3 billion people are vulnerable because of they lack access to any form of improved excreta disposal services.

Respiratory infections

In 1998, acute respiratory infections (ARIs) were responsible for approximately 3.5 million deaths among people of all ages world-wide. Almost 2 million of these deaths were in children under the age of five years. Pneumonia kills more children than any other infectious disease, and 99% of these deaths occur in developing countries.

The World Health Organization estimates that acute respiratory infections accounted for 83 million DALYs lost in 1998.[20] An over-

"Currently, 26.7% of the world's children under five years of age are malnourished."

Trained childbirth assistance drastically reduces the risk involved in becoming a mother.

whelming proportion of this burden of disease is attributable to environmental factors. Children the world over die of respiratory infections associated with poverty and poor housing.

Mothers are also vulnerable to respiratory infections. Hundreds of millions of adult women in developing countries are exposed to extremely high levels of airborne particles when cooking with biomass fuels. Studies in India and Nepal have shown that chronic obstructive lung disease and *cor pulmonale* are common, and develop at an early age, in women exposed to high levels of indoor smoke.[21]

Childhood immunization

Globally, immunization coverage has continued to increase slowly. Yet, one in five children is not fully immunized against the six major killer diseases: diphtheria, whooping cough, tetanus, polio, measles and tuberculosis.[22]

On 31 January 2000, the new Global Alliance for Vaccines and Immunization (GAVI) was formally announced at the World Economic Forum in Davos, Switzerland. It represents a commitment by the World Health Organization, UNICEF, the World Bank, industry, philanthropic foundations and public sector agencies to work in partnership towards the protection of all children against major vaccine-preventable diseases.

Four out of five children are fully immunized against six major killer diseases.

HEALTH SERVICES IN CRISIS

In the 25 years since the Alma-Ata Declaration was signed, the rapid and sustained progress towards "Health for All" that was hoped for has not been realized. Figures which give reliable, comparable and recent estimates on health care coverage and access to care are not always available. However, the picture which does emerge is profoundly disturbing. In too many countries health systems are ill-equipped to cope with present demands – let alone those they will face in future. Certainly the call for universal access to basic health services made five years ago at Copenhagen has not been heeded.

The inequities in health are striking, both between countries and within them.

Inequities between countries

The differences between developed and developing countries in terms of access to services can be illustrated as follows:

- In developed countries there may be one nurse for every 130 people and one pharmacist for every 2000 to 3000 people. A course of antibiotics to cure pneumonia can be bought for the equivalent of 2 to 3 hours' wages. A one-year treatment for HIV infection costs the equivalent of 4 to 6 months' salary. And the majority of drug costs are reimbursed.
- In developing countries there may be only one nurse for every 5000 people and one pharmacist for 1 million people. A full course of antibiotics for pneumonia may cost one month's wages. In many poorer countries, a one year HIV treatment costs the equivalent of 30 years' income. And the majority of households must buy medicines with money from their own pockets.

Total government expenditure on health services is too low in poor countries. This is true despite the fact that social services may comprise 20% of government spending. A serious, aggravating factor has been the low level of international aid during the past decade. On current trends, the absolute levels of resource transfers required to help the poorest countries attain the international development goals will not be achieved.

Inequities within countries

Within countries, the distribution and delivery of health care is often anti-poor. In most countries of the world the distribution of services remains highly skewed in favour of the better-off.

Recent studies have underlined patterns of resource allocation, both human and financial, that are *de facto* anti-poor. For example, the majority of health personnel is found in urban areas, while the great majority of the poor live in rural areas. Financial resources favour hospital-based curative care whereas the poor need accessible and affordable primary health care. Allocations also favour personal medical care when the poor benefit most from broad public health measures such as clean water and sanitation.

Anti-poor delivery of services

The delivery of health care itself is often profoundly anti-poor. There is rarely, if ever, a focus on the risk factors that are the root causes of the ill health of the poor. And services are rarely designed with the poor in mind. For the poor, time is truly money and opportunity lost. This is reflected in how far they have to go to obtain a service, how long it takes them to travel there, how much the transport costs, whether only one service (or several services) is available in any given session, and how much waiting time there will be. Any of these factors may be financial barriers to the services – in addition to official and non-official hospital, laboratory and medication charges.

Women face particular constraints of time and mobility, and with regard to the decisions they can make about their own health and that of their children. For them, these barriers in access to care represent a clear obstacle to health.[23]

Another obstacle is the way poor people are received in hospitals. A number of studies have brought to light the lack of dignity and respect shown by health personnel. One study in a primary health care centre serving a primarily poor population in a developing country highlighted that an average of only 54 seconds was given to each patient.[24] No time for dialogue, no time for explanation, barely time for any human contact.

In times of sickness, those without assets do not even attempt to seek treatment. Those who do have some assets may sell them to raise money for care, or may use them as security to borrow from moneylenders at high rates of interest. Herein lies the route from sickness, or injury, to poverty and destitution. With assets disappearing, especially if it is the breadwinner who has fallen ill, the loss of the precious income-earning asset makes the situation particularly desperate.

"Within countries, the distribution and delivery of health care is often anti-poor."

Voices of the poor

"We watch our children die because we cannot pay the high hospital bills." – Ghana 1995

Source: *"Voices of the Poor, Can anyone hear us?"* Oxford University Press for World Bank, 2000.

"Spontaneous, unmanaged growth in any country's health system cannot be relied upon to ensure that the greatest health needs are met."

Decline of the government health sector

Unfettered market intervention in health care is anti-poor. A recent review of health services in one country concluded: "Due to the prevailing situation in the government sector, there has been an unprecedented growth of the private sector, in both primary and secondary health care all over the country. Given the current ethical standards of the medical profession and totally free market technology-driven operational principles, the private sector generally does not provide quality health care at reasonable cost. Before this sector becomes a public menace, it is necessary to introduce participatory regulatory norms."[25]

A clear historical lesson emerges from health systems development in the 20th century: spontaneous, unmanaged growth in any country's health system cannot be relied upon to ensure that the greatest health needs are met. In any country, the greatest burden of ill-health and the biggest risk of avoidable morbidity or mortality are borne by the poor. Public intervention is necessary to achieve universal access. While the equity arguments for universal public finance are widely accepted, the fact that this approach also achieves greater efficiency is less well known.[26]

WHO's Proposals for Action

MAKING HEALTH A FORCE FOR POVERTY REDUCTION

The ultimate objective of development is improvement in the human condition – of which enjoyment of good health is an essential part. However, while improving health status is an essential objective of the development process, the capacity to develop is itself dependent on good health.

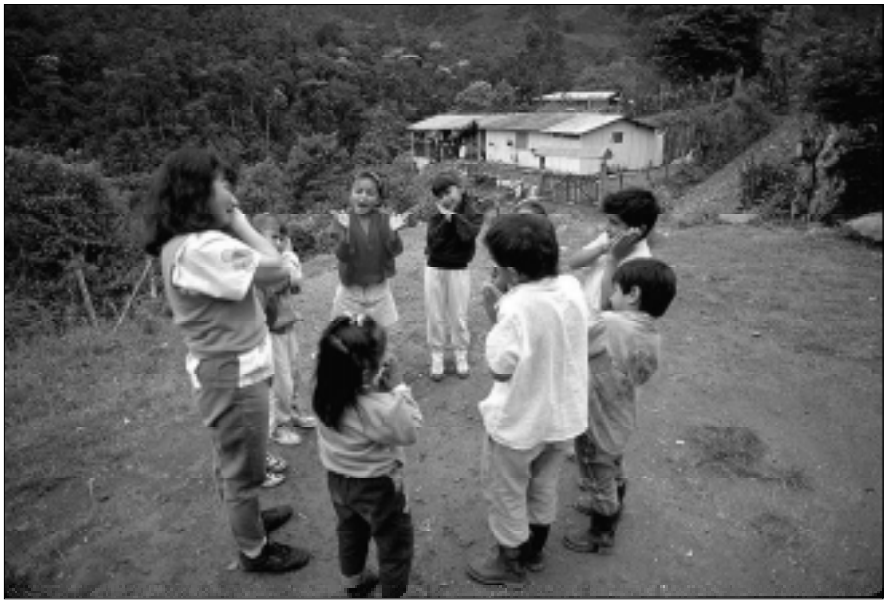
If health interventions are to ensure a maximum contribution to development, they should be planned and implemented within an integrated development framework. Today, the health components of poverty reduction programmes remain largely absent or marginal. On the one hand, health authorities limit their responsibility to the production of publicly funded health services. On the other, the architects of poverty reduction policies neglect the human and social capital contributions of health to sustainable livelihoods.

Universal access to basic health services **is** important, and achieving that goal in a way which will make a significant input to poverty reduction will require a massive international effort. However, the fact remains that leaving health to the health sector alone will not work. The major determinants of health, including poverty itself, are beyond the control of health services.

Copenhagen Plus Five can set future development policy on a new and more effective track by recognising the value of good health status as one of the most important assets of the poor. On that basis, the Copenhagen Plus Five meeting should recommend that the protection and improvement of the health status of poor and vulnerable populations be adopted as a core international development strategy. It should be shared by all actors in the development process – social, economic and environmental.

Strategy areas for follow-up

As its particular contribution to this new strategy, the World Health Organization proposes the following three areas of action as integral components of the follow-up to Copenhagen Plus Five.



Health is an asset for playing, learning and working.

- **Strengthening global policy for social development**
- **Integrating health dimensions into social and economic policy**
- **Developing health systems which can meet the needs of poor and vulnerable populations**

Partnerships

These initiatives will require action at global, regional and country levels in close collaboration with a range of partners, including the World Bank and IMF. In addition, it is suggested that some activities should take place under the auspices of the UN Economic and Social Commissions. This would be in view of the need both to ensure holistic and integrated approaches to poverty reduction, and to take account of significant differences in health issues between regions. **The Economic Commission for Africa (ECA)** and the **Economic and Social Commission for Asia and the Pacific (ESCAP)** would be particularly important partners since their responsibilities span the regions with the greatest concentra-

"The Copenhagen Plus Five meeting should recommend that the protection and improvement of the health status of poor and vulnerable populations be adopted as a core international development strategy."

Health and development

Conventional wisdom holds that income growth results in improved health, but that is only part of the health-income story. The remainder concerns the role of health as an instrument of self-sustaining economic growth and human progress. Poor health is more than just a consequence of low income; it is also one of its fundamental causes. To be sure, health and demography are not the only influences on economic growth, but they certainly appear to be among the most potent.

Source: *The health and wealth of nations*, David Bloom and David Canning, *Science* Vol. 287, 18 February 2000.

tion of the extreme poor. Both ECA and ESCAP could also serve as fora to bring together representatives of national social and economic ministries and sectors.

STRENGTHENING GLOBAL POLICY FOR SOCIAL DEVELOPMENT

"Reducing the striking health inequities … requires determined international action to turn globalization to the full advantage of poor and marginalized populations."

The international concern for accelerated social development that was initiated at the Copenhagen summit is continuing to grow. It has given rise to still-early-steps towards defining the principles of future global policy for social development. Much work still remains to be done to bridge the gap between growing social concerns and current global practice, particularly in global trade and international relations.

Reducing the striking health inequities between and within countries requires determined international action. The benefits of globalization need to be turned to the full advantage of poor and marginalized populations. The concepts, content and strategies for a global social development policy require further development. Thinking needs to move beyond traditional concepts of provision of basic social services towards defining an explicit pathway to the creation of social wellbeing, social capabilities, livelihoods and human development.

The World Health Organization proposes to engage in the UN-wide initiative to help take forward the process of global policy development. WHO's particular contributions will include:

- **building country capacities to assess the impact and design responses to economic, technological, cultural and political aspects of globalization on helth equity and the health status of poor and vulnerable populations**
- **building a global knowledge base on social development with regard to health and good practices in protecting and improving health status of poor and vulnerable populations**
- **strengthening governance for social development through development and advocacy of health protection norms and standards for the guidance of the international and national business sectors.**

Global governance for health

There is an urgent need for a public health involvement in key discussions about the future structure of the global political economy and the development and implementation of much needed governance to manage the rapidly growing spectrum of global activities. These discussions include: the promotion of a fairer trading system; debt relief; a global code of best practice of social policy; new practices in international cooperation to secure the provision of adequate public services for all, and contributing towards a more reliable supply of and access to global public goods (such as global health). WHO is currently working with the UN, the Bretton Woods institutions, the World Trade Organization (WTO) and leading non-governmental and academic institutions worldwide to place better health on these agendas and to promote the production, supply of and access to health as a global public good. We need to analyse and monitor how new international agreements can support public health. Making trade work to improve health is a major part of our agenda in our ongoing technical discussions with WTO.

Source: *"Making globalization work better for health"* by Tomris Türmen in "Responses to globalization: Rethinking health and equity", *Development* Vol. 42 No. 4 December 1999.

INTEGRATING HEALTH DIMENSIONS INTO SOCIAL AND ECONOMIC POLICY

Macroeconomic policy has a major impact on countries' abilities to protect and improve the health status of their citizens, particularly the poor and vulnerable. Human migration, rapid urbanization and increased road traffic are both the results of economic policy and, through their effects on the environment and on human health, also the cause of massive drains on public expenditure. For example, road traffic accidents are predicted to become the second major global cause of injury and ill health by the year 2020.

Recent econometric studies and the experiences of the East Asian countries have brought out the important role of good health status in stimulating economic as well as social development. Good health is also known to be crucial to effective learning and, for example, improving the effectiveness of microcredit programmes.

Maximizing the positive opportunities of globalization whilst minimizing the negative impacts poses particular challenges. Policy makers need to ask themselves questions such as what opportunities exist for identifying new sources of revenue for health services, or for regulating the trade of goods and services in the interests of health equity? New tools such as health impact assessment analysis need to be developed to help countries to achieve the maximum contributions of good health to economic, social, environmental and development policies.

Health in macroeconomic policy

Considerable international support now exists for the inclusion of greater investment in social determinants of development within macroeconomic policy. The well documented experiences of the East Asian economies have contributed to this new awareness. The nature of investments will vary according to need. In sub-Saharan Africa and South Asia both health and education are important priorities.

With regard to health, countries require considerable guidance on the specific mix of investments across a range of sectors to ensure optimum health impact on poverty reduction. The World Health Organization has established an international Commission on Macroeconomics and Health to advise WHO and the international development community on how health relates to macroeconomic and development issues. The Commission's main areas of analysis will include: the economics of investment in protecting and improving health status; public policies to stimulate development of drugs and vaccines for the poor; health in the international economy; and, health in international development assistance.

The World Health Organization proposes to provide the evidence for elaborating technical options and costs as the basis for more informed macroeconomic decision-making to improve the health of the poor by 2015 by governments, the World Bank, the International Monetary Fund (IMF), and Regional Development Banks.

"Considerable international support now exists for the inclusion of greater investment in social determinants of development"

Trade in health goods and services

Increasing trade in drugs, biotechnology and health services, including private health insurance, have important implications for health equity. The international agreement on the trade-related aspects of intellectual property rights (TRIPS) could result in the development of new drugs and vaccines for treating the diseases of the poor. But it could also worsen access by poor people through price rises.

Trade in health services includes foreign direct investment, the movement of consumers and providers across borders to receive and supply health care, and the emerging areas of e-commerce and telemedicine. In principle, increased trade in health services could bring needed technology and management exper-

The East Asian experience

In East Asia, the working-age population grew several times faster than the dependent population between 1965 and 1990. The whole process seems to have been triggered by declining child and infant mortality, itself prompted by the development of antibiotics and anti-microbials (such as penicillin, sulfa drugs, streptomycin, bacitracin, chloroquine and tetracycline, all of which were discovered and introduced in the 1920s, 1930s and 1940s), the use of DDT (which became available in 1943), and classic public health improvements related to safe water and sanitation. Health improvements can therefore be seen to be one of the major pillars upon which East Asia's phenomenal economic achievements were based, with the demographic dividend accounting for perhaps one-third of its "economic miracle".

Source: *The health and wealth of nations*, David Bloom and David Canning, *Science* Vol. 287, 18 February 2000.

Without health, people cannot contribute to development. Policies such as free health care contribute to the health status of the poor by reducing a major cause of poverty.

"Improving and protecting the health status of poor and vulnerable people … (is) one means of improving their employability and access to livelihoods"

tise and, for some countries, increased export earnings. But it could also deepen current inequities in access to services and promote the migration of skilled health professionals from already underserviced areas to private-sector jobs in wealthy, urban communities.

The new openness to trade in health goods and services presents a need to ensure that trade agreements improve access to good quality services particularly for poor and vulnerable populations.

The World Health Organization proposes to build upon its collaboration with the World Trade Organization (WTO) and other agencies to help strengthen the capacities of less developed countries to analyse the consequences of agreements on trade in health services for health equity and for meeting the health needs of the poor. WHO also intends to help develop policies and collective negotiating strategies to ensure the promotion and protection of public health.

Health and the promotion of full employment

Copenhagen Plus Five will focus particular attention on promoting full employment, including self employment and employment in the informal sector. The health dimensions of this policy are significant. People need to be fit in order to work, and to continue to work effectively, their health needs to be protected. If the person is the sole breadwinner, the health of their dependants also needs to be considered.

First, millions of people are unable to access livelihoods or compete for employment due to chronic ill health, undernutrition and disability. Second, for those who are employed, particularly in the informal sector, lack of occupational health and safety protection can lead to death, permanent disability and destitution. The International Labour Organization (ILO) estimates that some 250 million workers suffer accidents at work and over 300 000 are killed every year. The annual death toll rises to more than 1 million when deaths due to occupational disease are taken into account.

The World Health Organization proposes to work with ILO and other agencies to promote health protection measures in future international and national policies for full and productive employment. These measures will include:

- **Improving and protecting the health status of poor and vulnerable people, including the disabled, as one means of improving their employability and access to livelihoods**
- **Promoting safe and healthy settings for work, particularly for women in informal employment**
- **Promoting social insurance and solidarity mechanisms, formal and informal, to protect households from the burden of health care costs arising from occupational causes, including in the informal sector**
- **Promoting the employability of women by creating community-based health and social services for sick and dependent family members.**

Surviving in the informal sector

The majority of the poor work in the informal sector with no social security or social protection from any source. Innovative micro-insurance schemes are needed to protect poor workers. Over 90% of the labour force in India is estimated to be in the informal sector, and the share is believed to be extremely high in many other countries as well. Most informal sector workers are causal workers with no direct access to government provided social security. The Self-Employed Women's Association (SEWA) has developed the largest and most comprehensive contributory social security scheme in India at the present time. It presently insures over 32 000 female workers and may offer a promising model for bringing urgently needed health, life and asset insurance to the informal sector.

Source: *"Voices of the poor, Can anyone hear us?"* OUP for World Bank, 2000.

DEVELOPING HEALTH SYSTEMS WHICH TARGET HEALTH PROBLEMS AFFECTING POOR AND VULNERABLE POPULATIONS

"Pro-poor" health systems are needed which effectively target resources on the most critical health problems affecting the poor and which are financed and organized to address the determinants of health among the poor and vulnerable populations.

Many countries have fallen short of providing basic health services which are universally accessible. The majority of resources go to expensive curative care. Basic health services are not provided for free or low-cost to the poorest people. Public health programmes often ignore the health needs of household breadwinners. And national health systems generally fail to effectively manage private sector providers from whom the poor receive much of their care.

To halve the number of people in extreme poverty by 2015, health systems must be more effective in achieving greater equality of health outcomes and greater equity in health financing between rich and poor. Thus, renewed efforts must be made to build sustainable health systems for the poor that:

- aggressively prevent illness and protect health,
- protect the poor and near-poor from impoverishing health costs,
- direct more resources to improving and maintaining the health of household breadwinners, and
- marshal the efforts of private providers towards improved health of the poor.

The World Health Report 2000 will address in greater depth what policy makers and programme managers can do to create more equitable and effective health systems based on evidence about alternative ways to deliver, finance and "steward", or "responsibly manage", the health care system.

Based on what is known already about what works to improve the health of the poor, the World Health Organization urges the international community to join forces to develop sustainable, pro-poor health systems by focusing on the following three areas:

Substantial reductions in the major diseases affecting the poor

A large proportion of the excess burden of disease among the poor can be attributed to a limited number of health problems – particularly communicable diseases such as HIV/AIDS, malaria, measles, and TB – as well as diarrhoeal diseases, respiratory infections, and complications from pregnancy and childbirth. For nearly all of these diseases or conditions, a set of cost-effective interventions exist.

Four things must happen if these health interventions are to have a greater impact in improving the health of the poor.

- First, prevention and treatment resources must be redirected to focus on cost-effective interventions for the diseases and conditions that disproportionately affect the poor. These "pro-poor" interventions include the Expanded Programme on Immunization, the Integrated Management of Childhood Illness, the Adult Lung Health Initiative, the Integrated Management of Pregnancy and Childbirth, and targeted interventions for HIV/AIDS and malaria – many of which have been jointly developed and implemented by the World Health Organization in collaboration with UNICEF.
- Second, health systems must better target the poor and vulnerable by directing funds, staff and supplies to facilities located in areas near where disadvantaged people work, live and learn. The benefits can also be enhanced by designing systems to protect the poor from out-of-pocket costs (see page 20) and by linking the delivery of these services with other poverty reduction programmes, such as microcredit and employment training.
- Third, more resources must be mobilized for the purchase of cost-effective medicines and supplies, such as mosquito nets, anti-TB and anti-malaria drugs, treatments for

"Protect the poor and near-poor from impoverishing health costs"

Countries need equitable, pre-payment health financing which subsidizes the poor.

sexually transmitted diseases, vaccines and oral rehydration therapy. These can be considered "global public goods" to the extent that they are directed to low-income countries contributing most to the spread of communicable disease.

- Fourth, significant investment should be made in the development of new and improved tools for the control of health problems which disproportionately affect the poor. On the one hand, there is a serious lack of efficient tools due to "market failure" issues; on the other, some of the drugs now in use are rapidly losing their efficacy due to increasing drug resistance.

"WHO endorses several key principles of health system financing."

Equitable health financing systems

Achieving greater fairness in health financing is not just a laudable goal of the health system. It is also key to protecting the income of the poor and insulating them from economic shocks. One of the major factors leading to poverty is illness, which prevents people from working and earning income, and in some cases leads to high health spending that depletes household savings or assets.

To increase financial risk protection of the poor, the World Health Organization endorses several key principles of health system financing to increase financial risk protection of the poor.

First, countries must seek to increase the level of pre-payment for health care via general taxation or mandated social health insurance contributions. This approach allows costs to be spread in accordance with ability to pay and helps to reduce dependence on out-of-pocket financing. Direct payments systems restrict health care access to those who can afford it and tend to exclude the poor from health services.

Second, efforts should be made to subsidize the poor by expanding the pool of contributors widely so that the rich are not able to "opt-out".

Third, progressive taxes or contributory rates are recommended. While multiple pools may be organized for particular groups of contributors, subsidies across the pools should be used to ensure fair financing.

Many low-income countries have institutional constraints – high levels of informal work and weak revenue collection systems – that make it difficult to develop pre-payment systems (based on taxes or social insurance). In the short-term, community-based pre-payment schemes can be promoted by the World Health Organization, the International Labour Organization and other UN agencies. But, in the long-term, health officials must work closely with other sectors in developing the financial infrastructure to promote greater social solidarity in health financing.

Source of funds	Private	More private than public	More public than private	Public
Form of payment	Out-of-pocket insurance	Private insurance	Social	General revenues
Locus of cost burden	Individual	Increasingly pooled risk →		Whole population
Coverage	Poorest excluded	Increasingly equitable →		Universal
Current example	Most low income countries	USA	Middle income and some OECD countries	Other OECD countries

Health system financing

This figure shows how risk pooling in health, and the share of public spending in total, increase as countries move away from out-of-pocket payment methods. Various institutional alternatives exist for achieving universal coverage. Recent comparative research, measuring equity in both the financing burden and the use of services by different income groups in countries, shows that the least organized and most inequitable way of paying for health care is on an out-of-pocket basis; people pay for their medical care when they need and use it. The financing burden falls disproportionately on the poorest (who face higher health care costs than the better-off), and the financial barrier means that use of services is lower among the lower income groups, in spite of their need being typically higher.

Source: *"Making a difference"*, World Health Report 1999.

Promotion of responsible health stewardship

Health systems of the 20th century have grown to encompass multiple actors, agencies, and institutions. As a result, they have become more fragmented and narrow, self-interested goals are often pursued at the expense of overall health objectives.

The new context has made it critical for states to ensure that the key *functions* of the health system - raising and pooling funds, purchasing health services, and providing care – work in harmony to achieve overall health system goals. This role can be called stewardship – the responsible management of the functions and interactions among a health system's multiple actors and interests to achieve societal goals.

Responsible health stewardship implies two key attributes:

The first is **oversight of all components of the health system**. Rather than a focus on publicly-provided services, Ministries of Health need to make efforts to engage the resources of the private sector. The provisions of the private sector are especially important for the poor given the high reliance on the private market for health care in many low-income countries. A combination of approaches can be employed to harness the resources of the private sector including financial incentives, use of purchasing power via contracts with private providers, consumer information and government regulations. Government oversight and intervention in sub-sectors of the private market for example insurance, pharmaceuticals, and human resource production, are necessary to ensure that these industries are contributing to the overall goals of the health system.

To carry out these stewardship responsibilities implies a fundamental shift in the focus of Ministries of Health. It means a shift from directly providing health services to broad oversight, advocacy, strategic purchasing, setting rules for financing and delivering health care by multiple actors, and assessing overall system performance. This shift – from rowing to steering – must be accelerated through training and technical cooperation to build the skills needed to carry out these functions.

Ministries of Health must be better at consensus-building, negotiation and mediation among all relevant actors – within and outside government – in order to create stronger partnerships and coalitions across diverse interests and sectors. They must be able to hold all actors accountable for country performance on agreed-upon national and international health goals. This requires stronger systems for monitoring which provide not only average trends in health status, health care use, and health care spending, but also socio-economic trends in these indicators.

The second attribute of responsible health stewardship is a **duty to engage in cross-sectoral advocacy** to influence policy on the wider determinants of health of the poor.

When the policies and practices of other sectors of the economy present both risks and opportunities for improving health, it is not enough for Ministries of Health to concern themselves only with the delivery of publicly-provided health services. Thus, for example, the Ministry of Health should become a strong advocate for better nutrition by participating in policy discussions regarding access to land, crop subsidies and other agricultural issues. Likewise, health ministries should support efforts to raise the level of female education and advocate for more equal distribution of incomes. Compelling evidence exists that both are positively related to better health outcomes.

The World Health Organization believes that this vision of strengthened health stewardship must be realized for health to fulfil its potential contribution to poverty reduction and human development. It is particularly needed in those countries where health governance is weak.

Fulfilling this vision of strengthened health stewardship will require strong international political, financial and technical support, especially in sub-Saharan Africa and South Asia.

"Responsible health stewardship implies … oversight of all components of the health system."

Health Mnistries should support effort to raise the level of female education.

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