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HEALTH IN DEVELOPMENT

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EXECUTIVE SUMMARY

A sizable literature exists on the intersection between health and development. Studies have highlighted the health–development link leading countries and international organizations to recommend, in various forums, an integrated approach to development, including the component of health, as defined by WHO.

The development paradigm evolved to enlarge all human choices, not just income, and is based on human centrality, sustainability and empowerment. After the Alma-Ata conference on primary health care in 1978, WHO initiated several studies which showed clearly the intersectoral linkages between health and development. It was demonstrated, through empirical evidence, that health is a prerequisite to development. Better health means less premature mortality and higher life expectancy and thus greater potential for socioeconomic development. Success stories showed that control programmes for diseases such as smallpox, onchocerciasis and schistosomiasis, contributed to freeing agricultural lands which could then be used for development. Unhealthy lifestyles, morbidity, disability and mortality have a negative economic impact. The global burden of diseases assessed using the DALY (disability-adjusted life years) approach reflects losses in economic production due to ill health. Gradually, it became clear that investing in health is essential to economic growth, and that primary health care is a cost-effective approach to health service delivery.

The reverse is also true. Improvements in income and living conditions have a positive impact on health status as shown by reduction in mortality, higher life expectancy and changes in the epidemiological profile of developed countries. Economic growth has been accompanied in most countries by progressive development of health system infrastructure and technological innovations. However, there is concern about the negative impact of macroeconomic changes on poverty alleviation, the environment and health. In many developing and indebted countries, structural adjustment programmes have led to cuts in public spending, including spending on health, with negative consequences for poor and vulnerable populations. The impact of agricultural development policies, such as the health hazards posed by irrigation systems, use of pesticides and resettlement, are well documented. The negative consequences of development policies were clearly highlighted during the 1992 United Nations Conference on Environment and Development which called for the integration of environmental concerns in development. In a review carried out by WHO on the impact of development policies on health, it was shown that health implications were rarely taken account of in developmental programmes and that institutional and technical obstacles still hinder policy changes aimed at improving health.

WHO has always advocated intersectoral collaboration in health development itself. Initiatives were taken to demonstrate the health–development link and to promote health in development. In the Eastern Mediterranean Region, emphasis is placed on the improvement of economic status and living conditions, and community empowerment through the basic development needs and quality of life approach and healthy cities programmes.

Although the link between health and development is well established, the necessary interaction does not exist by itself. This calls for multisectoral focal groups to be established at national and regional levels to act as catalysts. Such forums would offer an opportunity to improve the dialogue between health professionals and development specialists.

1. INTRODUCTION

It is satisfying to note that, as the 21st century approaches, critical issues concerning health have moved to the top of the social and political agenda of countries. The interplay between health and development remains an area of interest for scholars and researchers in the fields of both health and socioeconomics. Studies have illustrated the intersectoral linkages between health and development in both developing and developed countries. International meetings have highlighted these linkages and concrete recommendations calling for an integrated approach to development, including health, have been made.

Countries and the international community are taking greater interest in the idea of integrated and sustainable human development, with health at the centre. Health is increasingly recognized as a prerequisite for sustainable development and the health impact of development programmes is now carefully examined. The recent series of 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 Fourth World Conference on Women, have all reflected this dimension.

Sustainability requires social mobilization and community involvement at the local levels. There is, indeed, sufficient evidence that the success of integrated social development projects is linked to community-based, participatory approaches which can work under any political and economic system. The contribution to development of particular sections of society, and particularly women, is well documented and deserves particular attention.

This international move towards a more human-centered approach to development has also affected the financial organizations, particularly the World Bank. In its *World development report 1993, Investing in health* [1], the World Bank focused on health as an objective in itself and not only as a means to development. A monetary value cannot be placed on life or on good health. The World Bank recognized this, measuring ill health in non-economic units, in terms of disability-adjusted years of life lost (DALYs) to estimate the global burden of disease.

WHO stressed clearly the need to integrate health in socioeconomic development in the Ninth General Programme of Work, covering the period 1996–2001 [2]. Equity and an integrated approach to health development are among the main policy orientations of WHO.

Referring to the need to integrate health and human development in public policies, the Ninth General Programme of Work states:

> While health is an essential objective of development, the capacity to develop is itself dependent on health. A better understanding is now emerging of the crucial contribution that health makes to economic activity, to improving human environments and—through these—to all processes of development. The achievement of appropriate health objectives is now seen as an important measure of the effectiveness of development strategies.

Health status cannot be exchanged for economic gain. The pursuit of development in the economic, educational or health sphere alone may obscure the purpose of development as a whole, which is to improve the quality of life of all people. In recent years, however, there have been instances where a narrow focus on economic development has had adverse effects on the health and social status of the population, particularly the most vulnerable groups such as women, the elderly, the unemployed, and children. Increasingly these most vulnerable groups have been excluded from the benefits of development. All too often the development process has only served to aggravate their vulnerability through degradation of the environment, increasing unemployment, global recession with its consequent reduced social benefits and poorer chances of education, inadequate nutrition, unclean water, poor waste disposal, unsafe housing, and lack of essential health services. All these consequences of development stand in the way of equity, social justice and satisfaction of basic human rights. It has also become clear that greater wealth—whether for countries, communities or individuals—is not a sufficient guarantee of improving health status because of the random nature of choices about how the resources will be allocated.

Expenditure on health and related aspects of human development is sometimes perceived as a drain on national or community resources, whereas it is a real investment in a nation's human capital, enhancing people's ability to contribute actively to overall economic and social development and to enjoy a satisfactory quality of life. The health sector is a major employer and creator of economic activity—a fact sometimes overlooked.

Despite this enhanced awareness about the centrality of health in development, the dialogue between health professionals and development specialists is still cautious and needs to be strengthened. The interaction between health and development does not take place spontaneously and health professionals and policy-makers need to interact in order to better manage the health–development link.

In this paper, we will recall the main determinants of health which led to WHO's definition of health, discuss the interplay between health and development and, finally, highlight the initiatives taken or supported by WHO to strengthen the health dimension of human development.

2. MAJOR HEALTH DETERMINANTS

2.1 Socioeconomic factors

Socioeconomic factors play an important role in determining health status. In countries which are now considered to be developed, the fall in mortality during the eighteenth and nineteenth centuries was not the result of effective health and medical care, since there was little such care, but of improvements in general living conditions and socio-economic indicators. The rapid decrease in mortality and morbidity continued after the Second World War, even before some active drugs were discovered.

Case studies carried out by WHO [3] on intersectoral linkages in some developing and developed countries have further demonstrated the importance of socioeconomic development in positively or adversely affecting health status. In addition to economic growth, good nutrition, literacy and a clean environment play a considerable role, particularly in developing countries. Data from the EMRO HST (health situation and trend assessment) database show the positive correlation between adult literacy, per capita gross national product (GNP) and access to safe drinking water, and life expectancy (Figures 1–3), and the negative correlation between adult literacy, per capita GNP and access to safe drinking water, and infant and under-five mortality (Figures 4–9). Macro-economic and social policies, such as agrarian reform, free and mandatory education, subsidized housing and empowerment of women, are key components of a socioeconomic strategy which will lead to improvement in health indicators.

Ill health is often poverty-related. The poor generally have a reduced life expectancy at birth and are at greater risk of disability. They are more exposed to hazards in their houses and also in their working environment. Being malnourished and weakened by previous diseases, the poor are more vulnerable. When a productive member of the family is ill, other members tend to work more to compensate for economic losses, and to reduce their food intake, contributing to a worsening of their health status. If there are financial barriers to health care, the poor will borrow money to pay for treatment, thereby increasing their poverty.

The major social changes taking place in many developing and developed countries, such as nuclearization of families and urbanization, further contribute to ill health in certain situations. Indeed, social disintegration is among the determinants of mental health disorders, often leading to alcoholism, drug abuse and suicide.

2.2 Cultural and spiritual factors

Cultural and spiritual values reshape the lives of human beings and societies. General well-being is achieved through self-determination and attachment to national values and ethics. The spiritual dimension is also very important for a balanced health. In all religions, healthy lifestyles are advocated for health promotion and protection. The Islamic religion provides an excellent example in how the Holy Quran and the Sunna inspire positively the code of conduct of believers. The Health Education through Religion Series issued by EMRO gives numerous examples of the principles that govern that code of conduct.

2.3 Environment

Changes taking place in the environment are directly responsible for health status. Gastrointestinal diseases are highly correlated with bad sanitation and lack of appropriate and safe drinking water. Data from the EMRO HST database show the positive correlation between adequate excreta disposal facilities and life expectancy (Figure 10) and the negative correlation between coverage with such disposal facilities and infant and under-five mortality (Figures 11, 12). Pollution of all kinds is implicated in an increasing number of health disorders. The long-term effects of some pollutants on health and the environment

have yet to be established but more and more products and processes that were once thought safe are proving to be otherwise.

2.4 Medical technology and health services

The health status of the world's populations is indebted to progress achieved in the areas of medical technology and the provision of health care. Discoveries in drugs, vaccines, diagnostic procedures, laboratories, imaging technologies, etc., have contributed to the prevention of diseases, reduction of pain, and cure and rehabilitation of patients, and have led to decreases in morbidity and mortality. The success achieved by WHO in a number of communicable disease control programmes has made it possible to vastly reduce the burden of morbidity and mortality. Smallpox was responsible for millions of deaths and disabilities until it was eradicated; other diseases, such as poliomyelitis, are now targeted for eradication with equal public health benefit. The extension of basic health services to remote and rural areas has resulted in better coverage and has, as a consequence, contributed to improvement of health status. Meanwhile, WHO and national health systems are aware of the need for constant vigilance in order to prevent and better manage emerging and re-emerging diseases.

3. HEALTH AND HUMAN DEVELOPMENT

The brief review in section 2 of the major health determinants clearly illustrates the validity of WHO's definition of health, first stated in 1948, "Health is a stated of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This concise definition encompasses all social and psychological dimensions of health and highlights the intersectoral linkages which were clearly incorporated in the Global Strategy of Health for All to be achieved through primary health care. Those who drafted the constitution of the World Health Organization envisioned health within the context of human rights, peace and security. The constitution affirms:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
>
> The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and states.

In 1977, the Thirtieth World Health Assembly decided that the main social target of governments and WHO should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". In 1978, the Declaration of Alma-Ata [4] stated that primary health care was the key, in national health strategies, to the achievement of an acceptable level of health for all. It was emphasized that health is not the concern of the health sector alone but also requires the action of other social and economic sectors.

In 1979, the World Health Assembly endorsed the Declaration of Alma-Ata and called for the formulation of national and regional strategies and coordination of a wide range of sectoral activities in order to achieve health goals. Health was recognized as a

social goal which had to be integrated into a strategy of social development. In 1981, a project on intersectoral linkages and health development was initiated by WHO. This project was aimed at enhancing the interrelationships between health and development through a series of studies which would be followed by a programme of research activities. This programme was aimed at promoting cooperation between government agencies in different sectors, such as agriculture, education and health, and at addressing the health aspects of development policies. The studies covered five countries: India, Jamaica, Norway, Sri Lanka and Thailand, and were conducted on a national scale except for India, where activities were confined to Kerala State in order to be better managed. The results of the research activities were published in a WHO document entitled *Intersectoral linkages and health development* [3].

In 1986, the technical discussions of the World Health Assembly addressed the issues involved in intersectoral collaboration for health and produced a number of recommendations which formed the basis for a resolution, WHA39.22. In 1988, WHO and the World Bank began a joint initiative aimed at reflecting the international concerns about the effect of development policies on health.

The momentum gained by the Global Strategy for Health for All by the Year 2000, contributed to the development and promotion of a new development paradigm based on human centrality and sustainability and advocated by many United Nations agencies. The publication of the first *Human development report* by UNDP in 1990 was a very important milestone in this respect. Since its publication, the concept of human development has evolved; the link between people and development is now addressed and the real wealth of a nation is recognized as being its people. The purpose of development is therefore to create an enabling environment for people to enjoy long, healthy and creative lives and not only to seek material and financial wealth. The measurement of human development relies on a simple composite index, the human development index (HDI). The index is based on the definition of human development as the process of enlarging people's essential choices, these being: to lead a long and healthy life, to acquire knowledge and to have access to decent living standards. It has three sets of indicators: life expectancy, educational attainment and real gross domestic product (GDP). Other choices valued by human beings include the freedom to participate in social and political affairs, to exercise cultural and spiritual values and to have their human rights respected.

Economic growth models deal with expanding GDP rather than enhancing the quality of human lives and human resources are primarily treated as inputs in the production process rather than an end to development. According to this concept, the purpose of development, then, is to enlarge all human choices, not just income as stressed in the conventional theories of economic development.

The human development paradigm as described by the *Human development reports* has four essential components:

- Productivity: people must increase their productivity and participate fully in the process of income generation and remunerative employment;
- Equity: people must have access to equal opportunities;