Poverty Reduction and Health : A Formidable Challenge?

Let us make no mistake or lull ourselves into believing that we will reduce world poverty and lift the health conditions of the poor by distributing drugs at low. . . Some critical help with health goods certainly will make some difference for some time for some of the population. Yet for a real breakthrough and to build strong and sustainable foundation upon which to structure defining strategies and implement these, much else has to happen. The prevailing global economic order and trade regime will have to shed much of its rigidity and some of its self-fulfilling omnipotence.

by Dr. M. Zakir Husain

THE Director General of the World Health Organisation (WHO) launched the "Massive Effort" movement as the global response by WHO to the commitment by the G-8 countries (the Group of Eight rich countries) to reduce world poverty at the Okinawa (Japan) Summit meeting in July 2000. Unlike previous statements, this time around the G-8 Summit came out with concrete targets . The test of the G-8's commitment however will be in the amount of resources they will be investing into what they have committed to. Yet, this opens up a window of opportunity for global initiatives such as the one announced by the DG of WHO. Will WHO be able to generate sufficient political will to back its "Massive Effort " movement? Indeed, WHO will be challenged to launch strong advocacy in favour of substantial transfer of real resources sufficient to make a real difference.

But why WHO should be taking an initiative in poverty reduction? The reason is simple enough . Ill health and poverty are closely inter-linked and aggravate each other. A family trapped in poverty is more likely to suffer more often from ill health due to poor diet, adverse living conditions, lack of education and exposure to repeated infections. Being in poor health, the family would earn less but spend more to get well. Poor parents would forego buying many basic needs and become even more vulnerable to ill health. When there are such direct and close linkages, any improvement in health would be a significant contribution to lifting the poor households from below the poverty line and improve the chances of remaining above the line of poverty. Statistics of world poverty are stark yet these may fail to describe the tragic social and economic consequences upon individuals as parents and their children . In addition to the physical deprivations, poverty also causes suffering and loss of dignity, reduces the options and opportunities, and often induces harsher deprivations and even premature death and destitution.

In a world that has entered a new millennium, in a world that already has the means and methods to battle many if not all the causes that induce and perpetuate poverty, there is no reason why more than two thirds of the world population should live in conditions of absolute and near poverty. The world has to come to terms with this contradiction. The G-8, for one, must accept its obligation to reduce world poverty. The window opened at the G-8 Summit has to be opened wide and the Group must dig and dig deep into their pockets to release sufficient resources to make good its commitment to reduce world poverty. Only then the programmes and technical interventions such as those contemplated by WHO and by others will begin to make a difference for the world's poor in all the five continents. The G-8 in July 2000 set targets specific to reduction of the toll from HIV, malaria, and from tuberculosis by the year 2010. These are achievable targets with already known technologies if only the scale of their application is raised up sufficiently to reach the many who will benefit from them. Fortunately, there is some evidence to suggest, notably the global target to eradicate poliomyelitis in spite of the difficulties encountered. The heavy but unnecessary burden of malaria, tuberculosis, and even HIV/AIDS can be lifted with the combined efforts of the international community if enough human , technological, and financial resources are applied. But it is also true that much more will be necessary to lift the world population out of the poverty trap of today. Health improvement is only one lever; many more are needed in this historic task that the G-8 has endorsed.

Health improvements will undoubtedly make a tangible , and perhaps a big , difference in the quality of life through reduction of unnecessary illnesses and deaths, and begin to eliminate one of the prime obstacles to the reduction of poverty. In fact poverty reduction will itself lead to further health gains that are enduring and which may improve income and further reduce poverty itself. But there is another good and sound rationale that speaks in support of health improvement and disease reduction. It is not just a matter of altruism which should attract international efforts. There is a very good practical case for addressing poverty through health improvement. Admittedly, direct transfer of resources by charity or concessions by the rich to the poor will get little support in a current market economy regime within and across countries. Yet, some concessional co-operation by the rich in creating health infrastructure, providing drugs and vaccines, and preventing the spread of infections may well be seen necessary in enlightened self-interest of the rich countries themselves. World health cannot be safe by keeping islands of health security for the few surrounded by oceans of ill health for many ; world health can only be sustained with overall health improvements for all by narrowing the present disparity in the health status of people within and between countries.

Thus, it is in the long term interest of countries and peoples who enjoy better health to lend a helping hand to those who do not. It is therefore not merely a cause founded on benign charity that there should be greater international co-operation in health including concessional resource transfers and re-directed medical research that specifically address the major health problems of the poor. Most of these interventions are known and are often of proven cost-effectiveness such that relatively modest investments are likely to give high health returns. These high returns on investments are from direct savings of health care costs and indirect increase of economic and social productivity namely through income, spending and education.

But how will the necessary political will and commitment of resources translate into concrete and visible action? It is useful to recapitulate some of the salient strategies at this time.

First, the international health community must build up a strong advocacy to address the underlying conditions that induce and aggravate poverty, many of these predisposing conditions also influence negatively health and well being of people. In this, the national governments and societies have the primary duty to adopt unequivocal policy agenda, assume and play the ownership and stewardship role. The international community cannot and should not be seen as the lead player. What is needed to support and sustain national ownership and policy is a strong and articulate social movement – one that genuinely seeks to build and strengthen the foundations for better distribution and sharing of today's wealth which are by definition limited yet are essential inputs. Side by side, the international community must create and support through, for example, the existing international financial and trade organisations , the sharing of world prosperity within and between countries and peoples.

Redistribution within and building strong foundations of conducive social policy are national duties; building foundations for fairer distribution of global prosperity is the function of a new enlightened version of international solidarity and co-operation. These are awesome tasks requiring a level of political courage and economic reforms with social imperatives to overcome conventional wisdom and dictates of learned theory and practice. None of these will be easy in the present climate of globalisation and market domination. Let there be no mistake that much more than political rhetoric emanating from global forum, and deeper reforms well beyond those that have so far been merely contemplated by the global financial and trade institutions (the Monetary Fund, the World Bank, and the World Trade Organisation for example) will be called for. Otherwise, the world poverty will be receiving small and ineffectual palliatives without making a change of significance or substance.

The scenario is not entirely bleak in spite of some pessimistic and cautionary notes given above. Let us return to the health sector with which the writer is more familiar. There are some encouraging developments . For one, there is greater awareness of the need for health sector to extend beyond its traditional boundaries into other sectors, into where people live and work, learn and earn, and into international trade and commerce. All of these have a bearing on people's health and well being which health sector has not taken sufficient account of.

Poor patient being treated at a public hospital.

Second, the importance of popular participation and the power of the people's movement is starting to be factored in health planning and health care delivery notably by some non-governmental organisations. A people-led movement to determine health needs and participate in health care is a long felt need such that the traditional care providers are partners rather than distant providers determining and prescribing health care. People have the right and responsibility to determine how well they wish to be and how they can promote and protect their own health and that of their families and communities. This has been so long lacking either due to an excessive faith in the power of health technologies to create health or due to unrealistic dependence on institutions of health care. Numerous behavioural alternatives to technologies are only recently being seriously recognised and explored inspite of the continuing resistance from aggressive persuasion and resistance by the pharmaceutical and health care industry conglomerates in rich and poor countries alike. This resurgence of interest and belief in the power of the people in creating and nurturing health must be scaled upwards and made stronger. The People's Health Assembly held in Dhaka is an example of popular health movement that seeks to return to the people some of the responsibility that rightfully belongs to them.

The civil society and consumer movements need to rediscover their strength and their determination against strong currents opposed to people's power and self-reliance. Promotion of traditional medicine and its integration into the national health care systems are not mere concessions to time tested practices but are rights of the people to use cultural practices to alleviate suffering , to restore balance with nature in life style choices in preference to exclusive dependence on technological products that primarily maximise manufacturers' and distributors' profits and incomes. The present health and medical care enterprise is disproportionately tilted in favour of industry, commerce and practice of medicine and is less sensitive to the real interests of the consumer, and least sensitive to the poor.

Thirdly, it is no longer intelligent to treat the health sector in isolation even if such exclusivity is preferred by those with entrenched interest or with narrow vision. If historical evidence is needed, countries in west Europe provide clear historical evidence that peoples' health and well being are not the products of medical care in hospitals and clinics nor of miracle drugs and vaccines; people are healthier and more socially and economically productive when their nutrition, education, sanitation and housing improve and they enjoy higher standard of living . The health sector cannot and need not work in splendid isolation ; it will do better when its strategies and actions are integrated with those of other sectors that secure welfare and well being of the public, and thus have significant bearing on peoples' health. Many essential public health functions that make far greater contributions to health than is made by hospitals and drugs are best performed by public services sectors in partnership with people and voluntary initiatives.

In all of the above mentioned strategic choices and actions which are primarily to be owned and performed by national governments with good and responsive governance , the civil society in synergy with informed government polices have the catalytic role and responsibility. That being said the generation and dissemination of global evidence of strategy development and implementation for health improvement welded within a broad welfare system is eminently the function of international research and study centres engaged in fostering exchange of knowledge and information world wide; it is also an important agenda for the United Nations Organisations and Programmes including that of the World Health Organisation – the lead agency in health. Given the expansionary role of the international financial institutions notably the World Bank extending into the social sector lending , it has become imperative for them to fine tune their lending programmes in social sector including the health sector to be sensitive to equity and inclusiveness of all sections of the population especially the poor.

The World Bank has demonstrated considerable clout on national policy making and reforms process. Now it has to use that clout to pursue economic long term goals that do not short change the minimum social goals. In doing so, the Bank can support essential research that produce valid information and evidence of the better choices before governments and societies. In this new effort, the Bank can forge genuine partnership with international health agencies notably the World Health Organisation with its extensive reservoir of technical knowledge and memory spanning over more than 50 years in international and national health co-operation. Global poverty and health deprivation of billions will not go away by short term and expedient manipulations that usually have very short half lives. The road will be long but it will be littered with obstacles that only innovative and non-conventional wisdom can surmount. That is why the G-8 should be taken up on its words at the Okinawa Summit by the world community and by all the UN and other international organisations.

Viewed in this perspective, specific health interventions to reduce the burden of malaria, tuberculosis, and many other common infectious diseases for which affordable technologies are available and deliverable are welcome. Such interventions need large scale expansion – the aim of WHO's Massive Effort initiative. Chances are that given sufficient resources and preferential use in scaling up and intensification, significant reduction of morbidity and mortality from these diseases will be made in a short time of say 5 to 10 years. This will not only improve the quality of life of millions including the poor but will also improve their productivity and income such that more is available to lift them out of the poverty trap and its disempowering impact. But will that be sufficient to keep millions of poor above the precarious level they find themselves and will they be free from the danger of reverting back again into poverty ?

Improving the opportunities for cure of diseases will mean more and make a real difference in the lives of the poor when opportunities for equitable participation in the economy also improves. Otherwise, freedom from illness will have no security against falling ill again and reverting to worse poverty. The issue of poverty reduction cannot be de-linked from the broader issue of economic and social rights of the poor. Therefore, health interventions as such would not go far enough either towards reduction of poverty or sustainable health gains for the poor without addressing some of the underlying determinants of poverty and ill health. The reality is that even efforts to reduce the burden of communicable diseases affecting the poor more than the rest of the population need to be massive and need to be supported by real reforms in the health sector. But health sector reforms alone will not do : these need to be supported by adequate resources to implement the reforms . The reduction of poverty will demand even more resources and harder choices some of which will indeed go against the current world economic trends and tenets dictated by gloablisation.

While "massive efforts" are welcome and obviously necessary, it is also obvious that many countries with adverse economic and trading situation will be hard pressed to either accept large loans with conditions that in effect causes the diversion of resources towards stronger and equitable public health policy and higher investments in public health programmes. The World Bank lending has attempted to favour the entrenched health establishment rather than self-reliant health development at the local and community level, tilted towards nurturing the private sector in health and market friendly medical practice. How realistic or feasible is it for the poor countries to spend on their health systems while it takes, say $ 60 or more, per capita to deliver even the semblance of minimum essential health care ? Many countries will need more to build their health infrastructure and even more to maintain its full functioning level. Improving the access to essential drugs by the poor may require more than some charity or concession by the pharmaceutical industry.

Let us make no mistake or lull ourselves into believing that we will reduce world poverty and lift the health conditions of the poor by distributing drugs at low cost or by wise counselling of people on good health behaviour. Some critical help with health goods certainly will make some difference for some time for some of the population. Yet for a real breakthrough and to build strong and sustainable foundation upon which to structure defining strategies and implement these, much else has to happen. The prevailing global economic order and trade regime will have to shed much of its rigidity and some of its self-fulfilling omnipotence. It has to bend to be fairer if not radically or entirely more humane. Countries with large poor population will have to invest more on human capital and health by reallocating present resources and by mobilising new resources. These are difficult tasks in a different time and will inevitably require very hard choices to be made. Above all, the ideal will have to co-exist with the real ; trade off will have to be balanced with social justice and societal values that are firmly anchored in human rights and dignity of all.

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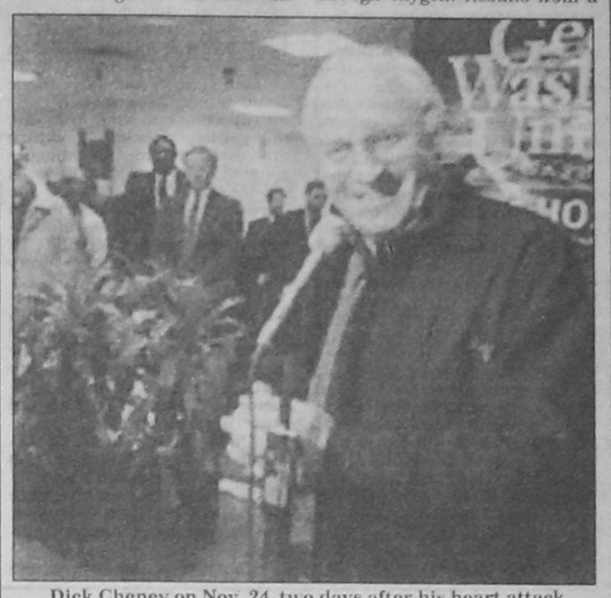
Cardiac Advances Benefit Prime Patient in 48 Hours

DICK Cheney, who sworn in as US vice president on Saturday, 20 January, owes his quick recovery from a heart attack to a quiet revolution in coronary care.

Case study: Cheney, 59, was admitted to George Washington University (GWU) Medical Center's coronary care unit early on November 22, 2000 hours before his fourth heart attack in two decades. The day before Cheney had his heart attack ended like so many other days in a bizarrely unpredictable election year. The 11 p.m. news brought word that the Florida Supreme Court had ordered a recount of contested votes in certain counties. That day, Cheney worked until midnight, went home, got a bite to eat and went to bed. But he wasn't destined to get much sleep. At about 3:30 a.m., Cheney awakened with what he calls "discomfort" in his left arm and chest. He asked the Secret Service Agents parked outside his McLean, Va., home to drive him to GWU.



Dick Cheney on Nov. 24, two days after his heart attack.

Cheney suffered his first heart attack in 1978, while in his 30s, and two more, in 1984 and 1988. After the third attack, Cheney had a quadruple bypass, an operation in which doctors used healthy blood vessels to reroute blood past four blocked arteries to Cheney's heart.

Katz, the hospital's chief of cardiology, was on call that night. Summoned to the emergency room at about 4 a.m., he met Cheney, and, under the watchful eyes of Secret Service Agents, oversaw his care until Cheney's cardiologist, Jonathan Reiner, arrived an hour later. By then, ER staffers had given Cheney nitroglycerin, which he dissolved under his tongue. Nitroglycerin dilates arteries and veins, increasing blood flow to the heart and easing chest pain.

Within an hour of Cheney's arrival at GWU, he was taken from the emergency room to the coronary care unit. There, he was given an infusion of low molecular weight heparin (Clexane®), a research molecule of Rhone-Poulenc Rorer. Jonathan Reiner regularly prescribes the drug to prevent new blood clots and sustain the heart's blood supply in patients like Cheney. Clexane, a low-molecular-weight heparin from a distinct class of antithrombotic agents, is about one-third the molecular size of standard heparin. Clexane is indicated in treatment of Non-Q-Myocardial Infarction and Unstable Angina. It is also indicated for prophylaxis and treatment of Deep Venous Thrombosis.

Once in the coronary care unit, doctors found the first evidence that Cheney's heart was in trouble. At about 7:30 a.m., doctors noticed a disturbing dip in the pen-and-ink tracing of a second EKG, indicating the heart isn't getting enough oxygen. Results from a second set of blood tests would soon show a minute rise in Cheney's cardiac enzymes, the proteins that signal heart-cell damage. Cheney's level of the enzyme MB-CPK, for instance, was roughly one-hundredth the level found in someone having a massive heart attack, but double that of someone who hadn't had a heart attack.

The doctors decided to recommend an angiogram. Cheney's angiogram disclosed a 90 per cent blockage in a diagonal branch of the left anterior descending artery, one of the three main arteries that supply the heart. His doctors cleared the branch using angioplasty, a procedure that involves threading a tiny surgical balloon and a thin mesh cylinder, or stent, to the narrowed section of the artery, inflating the balloon cleared the blockage; positioning the stent in the artery propped it open, reducing the risk of closure.

To prevent clots from forming, Cheney's doctors gave him an intravenous drug called abciximab. Abciximab is a costly, man-made antibody that blocks clot-forming blood cells from clumping together to form clots.

Doctors say that Cheney's artery has only about a 15 per cent chance of narrowing over the next few months, thanks to the stent now propping it open. "Almost every aspect of the care he received didn't exist 10 years ago," says Jonathan Reiner, Cheney's cardiologist. "Cheney is a prime example of how far we've come in the treatment of coronary artery disease patients."

Doctors say the same approach, if adopted by hospitals nationwide, could benefit millions of others.

TOM & JERRY By Hanna-Barbera

Rethinking Economic Development

The Goose Island Story

TIF is a powerful tool that enables cities to finance their own economic development programmes. TIF funds can pay for public improvements and other economic development incentives using the increased property tax revenue the improvements generate. 44 states in the US currently allow tax increment financing.

by Rukhsana Ahmed

CONTRARY to the popular notion that manufacturing is dying in urban America, Chicago is experiencing an industrial renaissance. Manufacturing is growing, expanding and thriving in Chicago. Dismissed in the 1980s as a dead end for business, Goose Island is today at the forefront of Chicago's industrial renaissance. The city has had great success using Tax Increment Financing (TIF) as an industrial development tool. The most well known of these successes have occurred on Goose Island on the Near North Side along the North Branch of the Chicago River, and at the Old Stockyards site on the Southwest side. Both of these industrial areas have been successful in attracting new industrial development, maintaining existing business and jobs, creating new jobs and enhancing the tax base.

As a Fulbright scholar, I had the opportunity to participate in the 2000 Chicago Fulbright Foreign Student Seminar, "Economic Development in a global Economy: Strategies for Successes", held in Chicago from February 17-20, 2000. Hosted by the United States Department of State, we were introduced to a broad range of economic development practices providing exposure to the economic, political, financial, cultural, community and human milieu of the US. In addition to panel discussions and workshop-like presentations, we went to visit local sites of urban economic development and growth within socially and culturally diverse communities. I was pre-assigned to visit Goose Island Industrial Park, an industrial oasis in the heart of Chicago. The programme covered overview of Goose Island Industrial Park and neighbouring communities with presentation on issues concerning financing, land use, infrastructure improvements and job creation followed by tour of the area and several manufacturing sites. I had the opportunity to witness community economic development in action on Goose Island.

Observation and interaction with community leaders on site helped to learn about the evolution of Goose Island Industrial Park and gain a better understanding of how public and private institutions can work together. Created in the 1950s, Goose Island was initially popular as a residential enclave. But as the city grew, business began to displace its housing and its namesake geese. By the 1950s, the island completed its transition to an active industrial district with favourable rail, barge and highway accesses.

However, the early 1980s saw a discouraging effect on private investment. The general economy and competitive pressures forced many businesses to relocate out of Chicago or cease operations. But things began to change in the 1990s when, at the behest of Mayor Daley, the Chicago City Council designated the Island as a Planned Manufacturing District. All prospects of conversion to residential zoning were removed fostering confidence among existing companies that the city was dedicated to their success.

Goose Island's subsequent designation as a TIF District, the completion of numerous infrastructure improvements, and enhancement of community-based partnerships have made it a classic example of Chicago's success with industrial revitalisation. Located 2 miles north-west of downtown in the North Branch of the Chicago River, the 146-acre Island is awash with city of Chicago redevelopment strategies that have fostered more than $130 million in private investment over the last decade. Replacing a sea of vacant lots and decrepit buildings are new and modernised facilities housing 35 companies, including recent arrivals like Republic Inc., Federal Express, Sara Lee and Jetro Cash and Carry. The Island's 1990 workforce of 1,300 people has today swelled to more than 5,000.

TIF has been the most powerful tool for encouraging private investment on Goose Island since it was designated as a TIF district in 1996. TIF is a powerful tool that enables cities to finance their own economic development programmes. TIF funds can pay for public improvements and other economic development incentives using the increased property tax revenue the improvements generate. 44 states in the US currently allow tax increment financing.

In Illinois, there are more than 500 TIF districts, 66 of which are located in Chicago. Industrial TIFs revitalize older manufacturing areas, creating new, modern industrial facilities. Goose Island TIFs have created a national model of urban industrial revitalization, helping companies like Tripp Lite grow and compete in Chicago. Today the Goose Island area is once again a booming industrial area. Companies such as Republic Windows and Doors have built modern facilities on Goose Island, creating and retaining hundreds of jobs for Chicagoans. The industrial area has recently become the home of modern facilities such as, River North Distributing, Essanay Studio and Lighting Company, CMC Development and Republic Aluminum. The success of Goose Island stands as a shining example of what can be accomplished through the strategic use of economic development tools, namely industrial TIFs.

The Chicago Seminar had been designed to increase participants' understanding of how economic development happens in the United States. It helped me to identify the driving forces behind this economic development project and determine the impact it has had on the community. With a view to enhance this unique experience, I would like to draw the attention of our economists, policy makers and the civil society to rethink economic development. Can Bangladesh take any lesson from the Goose Island success story?

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