

Pro-poor Health Policies

Poor health not only undermines a person's self-esteem but also reduces their productivity. As Jeffrey Sachs has noted, where malaria prospers, people usually do not. While in the parasite's grip, people usually cannot work and their relatives must tend them, rather than look after the crops. Jeffrey Sachs believes that in Tanzania, where 94 per cent of people are at risk of catching the disease, people would be twice as rich without malaria.⁴¹ Malaria is not the only disease that has such disastrous consequences; lack of access to clean drinking water, sanitation and the prevalence of tuberculosis have similar dramatic impacts on the health and productivity of the poor.

As Dreze and Sen (2002) have observed, the burden of disease falls very unevenly on different sections of the population.⁴² Improving the health of the poor requires both a better health policy – spending money where it has greatest impact in reducing morbidity and mortality – and enhanced budgets for health. The healthcare systems in many poor countries are often captured by the elites; where the private sector is the main source of delivery, the poor – who are not served by either the public or the private sectors – are often left to fend for themselves.

As the Tanzania Essential Health Interventions Project (TEHIP), a joint venture of the Health Ministry of Tanzania and the Canadian International Development Research Centre (IDRC), shows, by redirecting money towards the diseases that cause the most suffering but are the cheapest to treat (for example malaria and diarrhoea), the health of the community, particularly the poor, can be improved dramatically with visible benefits to their well-being.⁴³ The success of Cuba and China in providing basic health care also shows the potential for public action.⁴⁴

While much can be done through a better health policy and redistribution of public health expenditure, more money is also needed. Health spending is as little as \$10 per head per year in much of sub-Saharan Africa. This needs to rise, if one contemplates the additional demands arising from such diseases such as HIV/AIDS. Some estimate that poor countries will eventually need to spend at least \$30–40 per head per year, far above the present levels. While part of the increase in delivery must come from cutting waste and corruption and a reallocation of the national budget, a significant part of the additional spending needs to be funded by the global community as part of its efforts to combat poverty. Last year, the Commission on Macroeconomics and Health, which is backed by the World Health Organisation, called on the richer countries to donate an extra \$27 billion an year towards grappling with poor countries' health problems.

The experience so far with regard to the global community's efforts to raise money for combating HIV/AIDS is not promising. When the Global Fund to fight HIV/AIDS,

tuberculosis and malaria was launched, UN General Secretary Kofi Annan announced that it would require \$7–10 billion a year once it was up and running. Since then, rich country governments (together with some contributions from private sources such as the Gates Foundation and others) have pledged \$2.1 billion, but only \$300 million of it has so far materialised. Given the high incidence of HIV/AIDS and its impact on the poor and women in some countries, and its potentiality to spread to others, more determined action is needed.

Action by the poor countries is constrained by the high cost of drugs, underpinned by the current intellectual property regime and by a lack of capacity to undertake research and develop drugs appropriate for the diseases afflict them. As the Commonwealth Heads of Government called for in their Fancourt Declaration, there is a need for the world community to extend 'the benefits of global medical research through the provision of drugs at affordable prices to the poor in developing countries'.