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The health of the world's poor is under severe threat from the global economic crisis, yet recent breakthroughs in technology, if properly applied, can surmount those threats. As in so much of our world today, we are in a race between economic crisis and social disintegration on the one hand, and rising, unharnessed technological capacity on the other. The biggest challenge is, therefore, operational: how to engage the public, private and social sectors as partners to scale up life-saving technologies.

There is little mystery about the threat. Poor countries are caught in the global economic and environmental maelstrom. While the poor are not losing their stock market portfolios in the current crash, they are suffering in countless other ways: export prices of many commodities, such as copper, rubber and tin, have collapsed; export volumes are down; banks are yanking their loans from emerging market economies; remittances are plummeting; expatriate workers are being sent home; long-planned foreign investments are being suspended; and promised foreign aid is being slashed.

These economic shocks are coming on top of a trajectory of worsening environmental and demographic conditions. While we cannot attribute each climate disturbance to long-term human-induced climate change, there is growing evidence – and certainly a very powerful feeling worldwide – that climate patterns are increasingly unstable in highly vulnerable regions, especially dry lands that depend on rainfall for crops and pastures. Droughts are becoming more frequent; rainfall is coming in shorter and in more intense bursts; higher temperatures are threatening crop yields; and all of this is hitting against rapidly rising populations.

The result is a rise of deep hunger, perhaps affecting an additional 100m people compared with 2003-2005 (according to the methodologies used by the Food and Agriculture Organisation for counting the hungry). This, in turn, leaves whole populations vulnerable to infectious diseases. Chronic undernourishment is a co-factor in about one-third of the 9m or so deaths per year of children under five. Moreover, the numbers of people displaced by violence, and environmental and economic catastrophes are sure to be increasing, though we lack any comprehensive and up-to-date enumeration.

These adverse trends, however, need not overwhelm us, given advances in technologies that could counter their consequences. Targeted technologies to fight infectious diseases have made enormous headway in recent years. The incidence and mortality rates of malaria have been cut decisively in many parts of Africa (for example, in Ethiopia) as a result of the free distribution of insecticide-treated bed nets and access to a new generation of medicines. Measles deaths are down by more than 90 per cent in sub-Saharan Africa following sustained immunisation efforts. Similarly, polio has been cut by a factor of roughly 1,000 following the launch of an eradication campaign. Soil-transmitted helminthes, lymphatic filariasis, onchocerciasis, and other parasitic diseases are similarly controllable, with powerful success stories in some regions. So too are the deaths of mothers in childbirth and infants in the first four weeks after birth.

New systems of delivery and the requisite financing are urgently needed to overcome the emerging pressures on health systems. Above all, public health requires the mass application of science-based interventions at the scale of whole populations through

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well-designed and locally appropriate management systems.

Two management breakthroughs are paving the way to a rapid and low-cost scale-up of disease control efforts. The first is the explosion of interest in community health workers. Four decades after China's "barefoot doctors" demonstrated great success in the local control of basic rural disease conditions, a global movement is afoot to expand the training and professionalisation of village-based workers in the health sector. Given the pervasiveness of international brain drain (still today) and the difficulties of luring doctors to remote villages, the public health community has finally accepted the need to train villagers where they live, and to do so in large numbers. India is currently training more than 600,000 such workers as part of its rural public health scale up. Rather than relying, as in the past, on poorly trained volunteers, the emphasis is at long last shifting to proper training and pay.

The second equally important breakthrough is m-health, meaning the application of mobile phones and other handheld wireless devices to empower the health sector. Mobile phones can do it all: train community health workers; connect them to the clinics; make possible an emergency response system; report disease outbreaks; monitor aid flows; provide telemedicine; and much more.

With the advent of third-generation mobile telephony, offering broadband wireless connectivity even to the most remote villages of the world, the opportunities for highly connected, information-rich health systems in poor rural areas is moving from dream to reality. Admittedly, these advances are at an early stage, but all who are seeing them feel the enormous transformative power of these new technologies.

Finally, there is the challenge of global solidarity – perhaps the toughest step of all. Since I chaired the World Health

Organisation's Commission on Macroeconomics and Health at the start of this decade, its estimate of the needed donor assistance for health has been validated by many independent studies.

We found that a mere 0.1 per cent of rich-world income (one-tenth of one percentage point, or a penny for every \$10) could ensure the financing of universal access to basic health. That sum, about \$35bn per year, pales in comparison with the trillions now being thrown at the banks (and still being retrieved by the bankers as year-end bonuses).

The Global Fund to Fight AIDS, TB and Malaria, the world's most successful disease-fighting institution, is strapped for cash because the donors have not yet fulfilled their commitments.

If the rich world fulfils its aid pledges, the technology, management and will at the country level in the poorest parts of the world will be ready to move. We can not only resist the current crisis but fulfil the world's long-standing commitment to health as a basic human need.

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Doctor's casebook: GP Margaret McCartney looks at health in downturns

There is plenty of evidence showing that difficult economic times are bad for us. Unemployment is associated with anxiety, depression and even an increased risk of suicide. A study published in the Canadian Medical Association Journal reviewed the evidence and found a strong positive association between unemployment and increased use of healthcare services, physical and mental disorders and mortality.

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Mental health fares especially badly with unemployment. A recent paper, published in *Social Science and Medicine*, examined rising suicide rates in east and south-east Asia during the region's economic crisis in 1997-98. It suggested the crisis was associated with 10,400 more suicides in 1998 compared with 1997 in Japan, Hong Kong and Korea. In Taiwan and Singapore, where the crisis had less impact, there was no similar rise in suicide rate.

Job insecurity is also harmful. US studies show that symptoms of depression and increased alcohol consumption occur even when people survive company lay-offs. Other large-scale UK studies have shown that "lay-off survivors" report more physical and psychiatric symptoms.

What can be done to minimise the adverse effects of these times? To answer, we have to know the mechanism of the association between poverty, unemployment and poor health.

Sir Michael Marmot, in his book *The Status Syndrome*, suggests that unemployment represents loss of social role and that it is this that leads to ill health. This has been borne out by the Whitehall II studies of London civil servants that began in 1985. The results have suggested a "demand-control" explanation for ill health: people who feel they have a low amount of control over their work are more likely to be unwell. This is more likely to affect people with "lower" status jobs than those in managerial classes.

So what else can doctors like me recommend? It is important to remember that low mood – even very low mood – stress or anxiety is extremely treatable. It is, therefore, worth contacting the doctor to discuss options. Medication is not the only intervention that can be considered. Regular exercise, a healthy diet, work (voluntary, if necessary) and social activities, such as team sports, are all important. None of this is easy, or even very "medical". But it is the start of

trying to translate research into real life, where it can do most good.

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