

Economic Aspects of Public Health in Developing Countries

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I live in a small country in central Africa called Zimbabwe. It is actually smaller than you think, because real size is measured by a country's gross national product. Since 1779, when Adam Smith stated that a country's wealth depends on its ability to produce, and not the amount of gold it has, power has shifted increasingly to large economies.

We must also recognize that public health is not merely primary health care, as established twenty-two years ago in the Alma Ata Declaration. Public health encompasses all factors that can improve the health of the community. It is usually described as disease prevention, health promotion, disease management (including cure), and rehabilitation. In my view, public health's function is to shift that equation towards the left. In other words, prevention must ultimately be the purpose for public health.

However, because of the strength of economic theory, emphasis is placed on another paradigm. According to the World Trade Organization's (WTO) philosophy, development is viewed as the production of incremental, financial growth. Therefore, the science of curative medicine has taken center stage and has created global expectations that must be sufficiently satisfied to enable us to continue functioning as health structures.

Because of our country's economic insignificance, it is not essential that we network inter-regionally in order to promote public health. We must establish objective needs via intra-regional, international, and global means. These challenges are more easily met through the availability of improved information technology. A tremendous explosion in technology has occurred in the last ten years, matching the expansion of pharmaceutical and biotechnological knowledge; however, it has

not been utilized by public health authorities. Interestingly one hundred years ago, at the *fin de siecle*, electricity suddenly progressed in a similar way, revitalizing the stagnating Industrial Revolution. Similarly, the investment in electricity was not justified in terms of productivity for the next thirty years, until techniques for using the new technology were properly understood and applied appropriately.

I, therefore, believe that this is the greatest challenge for public health in poor countries with overwhelming public health problems. The following examples from my own country show that the economic effects of adjustment policies, adopted within the last twenty years, have reduced governmental access to financial resources.

- Although 27.2% of the government's discretionary budget is allocated to education, over 94% of the amount in primary education and 87.8% in secondary education is used for teachers' salaries and similar expenses.
- Internal and external debt servicing is 6% more than that budgeted (33.7% of total budget allocation). This amount is three times the health, child, and welfare budgets combined (6.8 billion Zimbabwe dollars).
- Investment for infrastructure improvements has been affected. Foreign Direct Investment (FDI) is virtually nonexistent, private sector investment has diminished, and transfer of capital to regional alternatives, especially to South Africa, has reduced job opportunities.

Therefore, youth unemployment is increasing, and poverty is increasing, which has caused increased prostitution. Hence, growth of the AIDS epidemic in Sub-Saharan Africa has resulted.

The loss of human resources to neighboring countries and to international organizations has been particularly acute. South Africa has especially benefited, even before democratization, and the migration of skills has accelerated because of differences in salary. South Africa offers up to six times our salaries for medical doctors. One academic hospital in South Africa has sixteen senior lecturers – thirteen are Zimbabweans, who were trained and graduated in Zimbabwean schools. Therefore, we have been producing health personnel for export, reducing the critical mass of competent policy makers, planners, and technologists.

Currently, the developed world spends more than 25% of its medical expenses for treatment of patients during the last six months of their lives. This phenomena has shifted resources into pharmaceutical and medical innovations, causing funding to decrease for the majority of the world's population, in order to allow wealthy people, at their lives' end, to buy a few extra weeks of life at a high premium. This shift may explain the global drift toward right wing concepts of the individual's responsibility for health care costs in the United States. In 1997, United States pharmaceutical companies invested 2.6 billion American dollars of non-research funds into research for new antimicrobials. If this money had been applied toward debt relief, the indebtedness of every highly in-

debted poor country (HIPC) in the world would have been eliminated or, alternatively, the total external debt of Sub-Saharan Africa would have been extinguished.

Additionally, some consequences flow from the requirement of new compulsory patenting for pharmaceutical invention, innovation, and application, established by the TRIPS Agreement and recognized by all members of the World Trade Organization (WTO). This requirement has the effect of imposing price controls on products, which may increasingly impact public health. While some options are available to larger countries to protect their pharmaceutical industry, most small countries do not have these available options.

We must develop a new concept of unity between the extremely significant numbers of developing countries, for the common goal of making our economies function for public health. We have to create linkages to ensure that "brain drain" and loss of donor support are reversed. This is critical because, currently, international development aid is at its lowest level in thirty years.

The stakeholders are many, the demands are even greater, and the resources are scarce and expensive. We cannot allow "jungle law" to overwhelm the important imperative of public health. Leadership, fortitude, resistance, and resilience are needed. A clear voice for public health for the majority must clearly state that sectional interests, especially commercial interest motivated by selfishness and greed, are secondary to the public good.