THE EMERGING MARKETS SYMPOSIUM

GREEN TEMPLETON COLLEGE | OXFORD

Urbanization, Health and Human Security in Emerging Markets

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Findings, Conclusions and Recommendations

Summary

The economic health of emerging market countries increasingly depends on the physical and mental health of their cities. Long term solutions to problems of urban health rooted in *absolute* poverty depend on sustained economic growth supported by public and/or private investment in housing, infrastructure and services. Long term solutions to problems of urban health rooted in *relative* poverty must ultimately be resolved through fiscal and other redistributive policies and programmes.

Meanwhile, national and local governments could enhance the efficiency and effectiveness of public health and healthcare policies and programmes by (i) developing technological and organizational solutions grounded in local realities rather than models imported from wealthier countries; (ii) coordinating health policies and programmes within city governments and between national and city governments; (iii) coordinating improved health and healthcare planning with improved city planning; (iv) reforming health and healthcare education to cover urban health, the social determinants of health and collaboration between public health and healthcare practitioners; and (v) building urban health and healthcare knowledge networks to promote mutual learning between cities.

These initiatives would amount to nothing less than the reinvention of urban public health in emerging markets.

Findings

On Economic Health and Urban Health

Emerging market cities have generic similarities and common problems. But because every city has a unique geography, history, culture, economy and society it is ultimately a special case. And its problems, including its health and healthcare problems, may have distinct causes and demand distinct solutions.

These distinctions are reflected in the fact that while the economic assets of all emerging markets are concentrated in cities, some (e.g. Brazil, Argentina and Chile) are more than 80% urbanized whereas others (e.g. India, Pakistan and Thailand) are less than 40% urbanized. The economic significance of emerging market cities thus depends more on concentration than urbanization and even more on their performance as producers of goods and services and sources of enterprise, innovation and creativity.

To perform well, an emerging market city must be fit for purpose. To be fit for purpose it must support productive activities. It must therefore have adequate infrastructure and services, predictable and reasonably efficient government and legal systems and a functioning financial system. It must also have a population that is physically and mentally well rather than not sick (i.e. adults who are well enough to work productively and learn new skills and children who are well enough to benefit from formal education).

Emerging market cities have sharp socio-economic contrasts. Income differentials are typically reflected in geographically segmented high, middle and low income areas. Wealthy areas may have (by global standards) superior housing, infrastructure and services and world class health and healthcare services. Middle income neighbourhoods – often former territories of the upwardly mobile – may have adequate housing, infrastructure and services including adequate public health and healthcare. The urban poor in barrios, favelas, townships, slums and other low income areas may have primitive housing, pirated, if any infrastructure and few if any services. Although circumstances and conditions vary enormously, in most emerging market cities at least a third of the population lives in unsatisfactory and inherently unhealthy conditions.

On Physical and Social Environments and Urban Health

The health of emerging market cities is strongly influenced by the quality of their physical environments (i.e. housing, infrastructure, pollution, green space) and social environments (i.e. internal socio-economic differentiation).

Persistent absolute poverty and physical deprivation is incompatible with physical and mental wellbeing and human security. Absolute poverty in emerging market cities is associated with diseases linked to malnutrition; with infectious disease; with chronic disease including cardiovascular disease, diabetes and cancer; and with mental disorders related to economic marginality, financial uncertainty, arduous journeys to irregular work and unhealthy working conditions. A poor urban neighbourhood is not a healthy neighbourhood.

Relative poverty in urban communities is also incompatible with good health. Evidence from wealthy countries shows that, as Sir Michael Marmot puts it, “Poverty is more than a lack of money”; that the relative poverty of those at or near the bottom of social gradients is associated with perceived lack of opportunity, disempowerment and insecurity and consequent lack of autonomy; and that these perceptions are directly associated with poor physical and mental health and life expectancy. Evidence from emerging market countries is thinner but contrasts between those who have almost limitless freedom and those who have little or none may be greater in emerging market cities than anywhere else in the world.

The alleviation of absolute poverty ultimately depends on sustained economic growth, income creation and public/private investment in housing and health related infrastructure and services. The alleviation of relative poverty depends on socio-economic improvements and the reduction of inequalities through public and or private investments and progressive fiscal policies.

Pending the alleviation of absolute and relative poverty in EMC cities, improved urban health depends on compensatory public health and healthcare policies and programmes.

On Urban Health, Public Health and Healthcare

Urban health in emerging market cities is conditioned by administrative, political, and intellectual barriers that, in varying degrees, impede coordination, collaboration and innovation in the design and delivery of public health and healthcare programmes. The main problems – and opportunities – concern inadequate coordination of health policies and programmes, inadequate integration of urban health and healthcare planning with urban planning, inadequate integration of health and healthcare education and inadequate cross-fertilization of health and healthcare knowledge. The common thread is that the reach and quality of public health and healthcare in emerging market cities is constrained by barriers.

First, the health of emerging market cities is directly or indirectly affected by actions taken or not taken in almost every branch of national and local governments. Few emerging market countries or cities coordinate health-related policies and programmes either horizontally (within national or city governments) or vertically (between national and city governments). The consequences include duplication, competition, contradiction and lower returns on health related expenditures and a smaller impact on public health than could be achieved if policies and programmes were coordinated.

Second, health and healthcare planning is an essential condition of cost effective urban public health and healthcare in emerging markets. Current practices and results vary. Some cities do an outstanding job, employing advanced information management, scenario planning and other techniques to address potentially overwhelming problems arising from rapidly growing demands for housing, water supply, sanitation, solid waste management, education and public health and healthcare services. Others seem to believe that if problems are ignored they will go away. Yet even emerging market cities that have squared up to these unprecedented challenges have failed to integrate health and healthcare planning with comprehensive city planning. All too often health planners and city planners work in separate spheres, use different assumptions and pursue different objectives. Here too the opportunity costs are measured in lower levels of health and healthcare than could have been achieved through cooperation.

Third, the segregation of education and training in public health and medicine - in emerging markets and virtually everywhere else – means that public health professionals and medical doctors lack mutual understanding and respect and are poorly equipped to work collaboratively to deliver cost effective health and healthcare. The consequences are aggravated by the fact that very few public health or healthcare education programmes offer specialized courses in urban health and healthcare (although schools of public health usually pay more attention to urban health than medical schools) and the fact that very few schools of public health or medical schools offer courses on the social determinants of urban health.

Fourth, and again with few exceptions, managers and practitioners in urban public health and healthcare are mutually ignorant of what has been learned in other cities. In most emerging markets this applies to other cities in the same country and (in spades) to other cities in other countries. The consequences are as inevitable as they are obvious. Problems that have been resolved in one city are not resolved in others because the other city does not know about the solution. Different cities devote time and resources to addressing identical problems when they could have developed joint solutions. Language barriers impede the flow of explicit knowledge between cultures. Tacit knowledge remains inaccessible. The opportunity costs are incalculable. And the losers are urban populations, particularly the poor, whose environments could be improved and whose health problems could be addressed if only health and healthcare providers knew what to do.

On Bad and (Potentially) Good News

Demographic and economic concentration means EMC cities are vulnerable to epidemics, social disorders and natural disasters, particularly in primate urban systems where disproportionate numbers of urban eggs are in single city baskets. The risks of concentration are real. Planners must manage them, learning wherever possible from countries with more resources and stronger institutions but relevant experience that can be adapted to local conditions. But (from a health and healthcare perspective) these disadvantages are heavily outweighed by the inherent advantages of urban agglomeration including economies of scale, operation and specialization for building low income housing; constructing and maintaining water supply, sewerage, and other health related infrastructure; and developing and running hospitals, clinics, health centres and other facilities. If the city is the problem, it is also the solution.

Conclusions

Emerging market cities are dynamic contrasts of wealth and poverty. Broadly put, urban elites have healthy physical environments and world class healthcare, expanding middle classes have adequate physical environments and adequate healthcare and the poor have unhealthy physical environments and limited if any healthcare. There is room for improvement across the board but the greatest challenge by far is to create healthy environments for and to deliver at least minimal healthcare to the urban poor.

The most basic needs of the urban poor can be marginally alleviated through subsidies, income transfers and public expenditures but cannot be satisfied without sustained economic growth, job and income creation and public and/or private investment in housing and health related infrastructure and services including healthcare services.. A few countries – China in particular – have made spectacular progress towards sustainable solutions in relatively short order. But most emerging markets, like now wealthy countries before them, will need time to reach such solutions.

The question therefore is what national and local governments can do in the short run (pending sustainable longer term solutions) to improve urban health, most specifically that of the urban poor. The answer is to focus on enhancing the efficiency and effectiveness of public health and healthcare programmes through bold innovations designed to remove or modify the administrative, political, cultural and intellectual barriers that constrain the planning, design and delivery of public health and healthcare programmes.

The barriers include intellectual barriers that impede the development of *sui generis* solutions to *sui generis* problems; conceptual barriers that impede recognition and understanding of critical relationships between urban health and absolute and relative poverty; and cultural and technical barriers that inhibit the coordination of health and healthcare policies and practises, the integration of public health and healthcare education, the diffusion of health and healthcare knowledge and the fusion of health and healthcare planning and city planning. Their unifying theme is that the best and fastest returns on human, financial and institutional investment in most emerging market cities will come from actions that eliminate the silos that constrain the efficiency and effectiveness of urban health and healthcare programs and create systems that facilitate collaboration and reward innovation. Taken separately, these challenges may seem small, even trivial. Taken together they add up to nothing less than the reinvention of public health for emerging market cities.

Recommendations

1. Develop Local Approaches to Public Health and Healthcare Problems

National and local governments could improve the efficiency and effectiveness of urban health and healthcare programmes by grounding them in local realities rather than models developed by, in and for wealthier countries. Opportunities include creative uses of advanced technologies (e.g. mobile telephony) and the creation of non-traditional roles (e.g. low cost, semi-skilled community level public health and healthcare workers supervised from remote locations). The tendency to assume that models developed in different times and places are best suited to contemporary use in other places must be resisted.

2. Remove Constraints to Health Policy and Programme Coordination

The efficiency and effectiveness of public health and healthcare could be improved by removing barriers to the coordination of urban health and healthcare within city governments and between city and national governments. This initiative would be an urban element of national ‘Health in All’ strategies. It would implement systemic (nationwide and citywide) coordination programmes, focussing on the development of collaborative skills and capabilities. The design of coordination programmes should take account of what can be learned from successful examples of coordination at national and city levels including healthcare governance models that (as in Bogota) vest accountability and the necessary authority and resources for health and healthcare in city governments.

3. Integrate Improved Urban Health Planning with City Planning

Taking account of successful examples elsewhere, emerging market cities should improve urban health planning by developing anticipatory health/healthcare planning systems based on realistic demographic forecasts of urban population growth; developing specific strategies to address the needs of the urban poor; developing mechanisms to allow clients and patients to participate in structured evaluation processes and feedback systems; and developing citywide patient information systems linked to nationwide systems developed by national governments. City governments should also act to integrate urban health and health care planning with overall city planning.

4. Make Health and Healthcare Education More Relevant to Urban Health

Emerging market governments should promote the reform of public health and healthcare education and training courses to enhance mutual understanding and appreciation and to prepare graduates in public health and medicine to work collaboratively in urban health programmes. They should also promote the design and execution of urban health training in schools of public health and medical schools including specific training in the social determinants of urban health.

5. Share Knowledge on Urban Health

Emerging market economies should develop national urban health knowledge networks to promote knowledge sharing between cities to facilitate mutual learning. These networks should enable cities to share explicit knowledge and to access tacit knowledge. Governments should also consider the potential benefits of participating in international knowledge sharing networks to access and share knowledge on public health and healthcare in other environments.

GREEN TEMPLETON COLLEGE | OXFORD

Woodstock Road Oxford OX2 6HG | College Tel. +44 (0)1865 274770 | ems@gtc.ox.ac.uk