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The Close and Multiple Relationship between Health and Development

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Editorial
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Abbreviations: WHO: World Health Organization; SUS: Unified Health System.

Editorial

Health and development are linked concepts. The pioneering studies of Samuel H. Preston (1975) showed a strong, positive and non-linear correlation between life expectancy (longevity) and the per capita income of countries at three different times (1900s, 1930s and 1960s) [1]. In Brazil, research from various disciplines has found results that corroborate and dialogue with international research in identifying associations between socioeconomic status and health, confirming that those in underprivileged situations have the worst health conditions, whether from the point of view of income or better educational level [2].

In this way, health inequalities can be observed along a socioeconomic gradient - a drop in the social position of individuals is accompanied by a linear reduction in health conditions. This means that vulnerable groups located at the bottom of the social pyramid suffer a particularly higher burden of mortality and disease. These groups include, among others, people living in poverty, those living in deprived urban and rural areas, the unemployed, the underemployed, seasonal or subsistence workers, ethnic minority groups, immigrants and refugees [3].

According to the position adopted by the World Health Organization (WHO), based on the proposition of Croatian sanitarian Andrija Štampar (1888-1958), who coordinated the 1st World Health Assembly (1948): health is a state of complete physical, mental and social well-being and not just the absence of disease. Development today addresses broader issues than just economic growth, such as policies that underpin a genuine national project to tackle social inequalities and build full citizenship [4].

There are multiple dimensions to the relationship between development and health. They arise when health is perceived as a right through the de-mercantilization of its access; when health is considered an economic good with the mercantilization of the supply of services and medical salaries; and when health becomes a space for the accumulation of capital with the formation of the health industrial complex. Although these dimensions of health were not processes that took place at the same time in history, nor were they associated, they currently coexist in a complex and contradictory way in the same health system [5].

In Brazil, the process of de-mercantilization of access resulted in health as a right and the formation of modern social protection and health systems, which became responsible for the social risk of an individual falling ill. This risk became a collective responsibility, covered by society as a whole, in other words, guaranteed by the idea of a social right - a citizen's right and collective responsibility, and therefore a duty of the state. As for the commercialization of the supply of health services, this began with the salarization of health professionals, mainly doctors, at the beginning of the 20th century, by the social security and public service apparatuses, went through the formation of medical companies for the provision of care services and ended with the formation of health plan and insurance operators, which began to carry out intermediation (between users and service providers) of a financial nature in health. With

regard to health as a field for capital accumulation, we can highlight the formation of the large industries that operate in the sector, forming the so-called health industrial complex, a process that is highly dependent on technological innovation and scientific progress in the biomedical field [6].

The broad perspective of development has clear links to health, just as economic growth has well-established links to health and influences the standard of health. Higher per capita income and greater consumption of goods and services contribute, to a certain extent, to expanding people's autonomy and ability to make decisions about their lives. On the other hand, health can also be identified as a cause of economic growth. According to a World Bank report on health, improved health conditions should lead to improved economic performance at national level. The report highlights five contributions of a population's good state of health to the country's economic growth: (a) gains in labor productivity; (b) better use of natural resources; (c) benefits from a better level of education for future generations; (d) reduction in health care costs; and (e) poverty reduction [7].

Thus, health and development are interrelated, since both can be understood as a dynamic process that combines, at the same time, economic growth with technological innovation and seeks to improve the population's standard of living. Health cannot be disregarded in the context of development, as it has a direct impact on the quality of life of Brazilians, and indirectly produces effects on economic variables through the health economic industrial complex. In Brazil, health demands approximately 9% of the country's GDP, with impacts on income generation and employment reaching a level of 10% of all qualified jobs, i.e. 10% of jobs in the country are directly or indirectly related to the health production system. Consequently, health is also seen as a great potential for increasing productivity and generating economic development, not as a segment of the economic structure, but as a social area that favors human capital, in other words, health is an end in itself and, in addition, it is a favorable factor for economic development, in such a way that it constitutes an intrinsic value for people and countries [5].

The territorial dimension of development is conditioned by health actions in the territory, since it is in space and on its various scales that policies meet and can generate the synergy necessary for the development process. From this perspective, health plays a role in driving development and is a relevant field for social and economic cohesion. This territorial perspective is particularly important for a country with the continental and unequal characteristics of Brazil. As such, health is central to the organization of urban networks, influencing the delimitation of territorial scales and boundaries, and is a structuring factor in territorial occupation. In addition, health has the potential to define new investment flows and, therefore, to reverse traditional trends of concentration of production and income in space [8].

Despite these factors, Brazilian macroeconomic policy ignores the importance of investment in public health. In Brazil, public spending on health does not reach 4% of GDP, which means that 75% of the population, who only use the Unified Health System, have only US$ 385.00 per capita/year to meet all their health needs. This is less than Cubans, Chileans, Colombians and Mexicans, to name but a few in Latin America [4]. Even though health is a basic factor of citizenship, which places health as a strategic area within national development. Although supplementary to the public health system, medical plans in Brazil invest more in the sector than the federal government does in the SUS (Unified Health System). This is the only case in the world, according to a study by the World Health Organization.

Finally, in more democratic societies, where education, health and creativity are valued, there is an increase in the capacity to generate wealth, since these factors allow for a more equitable distribution. Health is both part of the social protection system and an essential factor conditioning development and regional dynamics, with an impact on income, employment, investments and strategic innovations in the context of the ongoing technological revolution. Health, considered as quality of life, is intrinsically linked to economic development, equity, environmental sustainability and the political mobilization of society. From this perspective, health becomes a central element in the discussion on development models.

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