Exposing Poverty and Inspiring Medical Humanitarianism

Howard Markel; Lawrence O. Gostin

JAMA. 2008;300(2):209-211 (doi:10.1001/jama.2008.45)

http://jama.ama-assn.org/cgi/content/full/300/2/209

Exposing Poverty and Inspiring Medical Humanitarianism

Howard Markel, MD, PhD
Lawrence O. Gostin, JD

NEWSPAPER HEADLINES AND TELEVISION REPORTS ARE disturbing and mind-numbing: Hurricane Katrina, the Asian tsunami, the Myanmar cyclone, earthquakes in China, genocide in Darfur. A unifying theme of these tragedies is how often they are met by shrugged shoulders, glazed eyes, or complete indifference, proof positive of the aphorism "one half of the world knows not how the other lives."

How the Other Half Lives

Although Rabelais[1] coined this adage in 1532, Jacob A. Riis made it a household expression in his 1890 magnum opus, *How the Other Half Lives*,[2] in which he exposed the horrible living conditions of New York City's Lower East Side, one of the most crowded areas in the world and most famous immigrant ghettos in human history. With more than 523 inhabitants per acre, this neighborhood of less than 1 square mile of tenements and poverty was largely ignored by other New Yorkers, not to mention the millions of Americans who lived west of the Hudson River.

Not exactly the most elegant of prose stylists, Riis was initially frustrated by his inability to get newspaper readers to ameliorate a miserable situation within their own backyard. Soon enough, technology buttressed Riis' case where his literary technique could not. In 1887, Riis read about a new type of magnesium flash powder that when lit allowed photographers to illuminate hitherto dark and hidden recesses. Armed with his bulky camera and accompanied by several journalists, city officials, and "do-gooders," Riis scoured the murky corners of the Lower East Side and captured shocking pen and photographic images of those who lived there.[3]

Apparently the combination worked. *How the Other Half Lives* became an instant best-seller and Riis an international authority on poverty. Almost voyeuristic in expression, Riis described a neighborhood distinguished for its overcrowding, dirt, foul odors, unsanitary living conditions, and cacophony of harsh and guttural tongues.[4] Yet even as Riis portrayed his subjects in terms many today would find stereotypical and even derogatory, his approach was not to blame the individual but the environment and to encourage citizens to act based on altruistic principles. As Riis concluded his powerful story, "I know of but one bridge that will carry us over safe, a bridge founded upon justice and built of human hearts."[2(p296)]

Awakening Medical Humanitarianism

Although written with a declarative emphasis on the dichotomy between the moneyed and educated "us" vs the impoverished and disenfranchised "other," *How the Other Half Lives* remains relevant to understanding the plight of today's poorest people. Long before globalization was the idée du jour, Riis' unflagging idealism about the capacity of the wealthier to help the poor, motivated by concerns about human equality and social justice, inspired legions in the United States and beyond. Indeed, Riis and fellow social reformers improved the lives of the urban poor worldwide with the construction of public bathhouses, safe playgrounds, and ball fields; tenement house reform; modern sewage and waste systems; community health clinics; and many other basic public health measures that too many take for granted today.

The Riisian ethos continued to motivate medical humanitarianism during World War I and the influenza pandemic of 1918, as demonstrated by the dedicated volunteerism of the Red Cross and women's organizations. Riis' concern with the vulnerable and uprooted became codified into federal policy with Franklin Roosevelt's New Deal, which sought to assuage the familial, economic, and cultural devastation of the 1930s.[5] Most notably, medical humanitarianism blossomed after the United Nations was formed in 1948 following the horrors of World War II. The World Health Organization, the first specialized United Nations agency, elevated global health and the eradication of epidemic and endemic diseases to an international priority.[6] In the years since, a large number of international aid, health, and religious organizations; the US Peace Corps; nongovernmental and governmental organizations; and volunteer agencies have significantly expanded basic public health infrastructure and community health programs in developing nations around the world. Such focus has been particularly important given that the burdens of poverty and diseases fall disproportionately on the world's poorest citizens, who everyday face the

Author Affiliations: University of Michigan, Center for the History of Medicine, Ann Arbor (Dr Markel); and O'Neill Institute for National and Global Health Law, Georgetown University Law Center, Washington, DC (Mr Gostin).
Corresponding Author: Howard Markel, MD, PhD, University of Michigan, Center for the History of Medicine, 100 Simpson Memorial Institute, 102 Observatory, Ann Arbor, MI 48109-0725 (howard@umich.edu).

risks of malaria, tuberculosis, diarrheal diseases, HIV infection, and many other deadly maladies.[7]

With his immigrant outsider's eye, Riis was an astute observer of the cultures he inhabited and visited. One can only wish for the likes of his talent today to instruct on the folly of too many people assuming immunity to the endemic, emerging, and resurgent diseases raging in the developing world. His pen could simply but forcefully explain that pathogens do not respect national borders and, via international travel and migration, can spread easily to neighboring countries and beyond.

A 21st-century Riis would also have to articulate that the international effects of health threats are hardly limited to infectious diseases. In a globalized world, consumer products, services, food, energy, pharmaceuticals, vaccines, and medical devices often circulate widely, posing potentially significant health risks everywhere. Recent safety concerns in the United States illustrate the threats faced by international trade and commerce, ranging from diethylene glycol in toothpaste, lead paint in children's toys, *Escherichia coli* in spinach, and tomatoes contaminated with salmonella to heparin contaminated with *Serratia marcescens*.

Responsibilities of Wealthy Nations to the Global Poor

There is little doubt that developed countries see global health as essential to their interests.[8] The United States and the Group of Eight (G8) countries have declared that HIV/AIDS is a matter of national security.[9] The President's Emergency Plan for AIDS Relief (PEPFAR) has invested $15 billion over the last 5 years primarily in sub-Saharan Africa, and Congress promises to allocate an additional $30 billion to $50 billion over the next 5 years.[10] During the last 2 decades, wealthy countries have increased development assistance for global health from nearly $2 billion in 1990 to $12 billion in 2004.[11] Furthermore, philanthropic organizations have devoted historic sums to these endeavors. For example, the Bill and Melinda Gates Foundation, buttressed by a $37 billion gift by Warren Buffett in 2006, is donating up to $3 billion per year to improve global health equity, comprising nearly one-fourth of all development assistance.

This level of financial assistance may appear substantial but sits modestly beside the $1 trillion spent globally on military expenditure and $300 billion in agricultural subsides paid annually by rich countries.[12] The recently enacted US Farm Bill and ongoing European subsidies—which make it exceedingly difficult for the world's poor farmers to compete fairly—demonstrate the continuing political propensity to favor domestic business interests over the global poor. Recent increases in development assistance are largely attributable to extensive resources devoted to a few high-profile problems: AIDS, pandemic influenza, and the Indian Ocean tsunami.[13]

Notwithstanding these investments, developed countries have not honored the pledges they made in 1975 to provide 0.7% of gross national income per annum for official development assistance. More than 30 years later, their real contribution has only recently increased to reach a high of 0.33%. The United States has yet to take a substantive leadership role in international health assistance. For example, whereas the United States allocates 0.22% of its gross national income for international health assistance, the United Kingdom allocates 0.47%, and Norway 0.94%.[14] If rich countries fulfilled their previously made commitments to global health, the World Health Organization projects that tens of millions of lives would be saved every year.

Out of synchronization with the international community, the United States has not ratified the International Covenant on Economic, Social, and Cultural Rights recognizing the right to health; the Kyoto Protocol on climate change; nor the Framework Convention on Tobacco Control. It has eschewed the International Criminal Court to prosecute cases of genocide, crimes against humanity, and war crimes, which means the United States loses moral authority when, for example, Myanmar willfully refuses to allow humanitarian assistance.[15] The United States has actively resisted international treaties to ban land mines and cluster bombs, which disable thousands of civilians each year. Although it did accede to the International Health Regulations, the United States issued a key reservation saying it would not comply fully because of principles of federalism. That is, if 1 or more states decided not to comply with International Health Regulation requirements, the federal government would not ensure conformance with international standards or recommendations issued by the World Health Organization.

In recent years, the United States and many of its industrialized allies have increasingly expressed public concerns about the health of the world's poor. Yet when real action is considered, they have simply not done enough to adequately address these problems—either by investing the funds needed or by acting in concert with one another. As a result, there is increasing fragmentation and duplication of funding and services by a large array of actors, including international government organizations, public/private partnerships, philanthropies, and nongovernmental organizations.

The Need for Global Health Systems

As noble as the existing efforts of these humanitarian organizations and governments are, the efforts often compete with each other and, worse, compete with local programs by drawing away human resources needed for coordinated global health systems. Moreover, the efforts tend not to share the same values or visions for the future and often focus on the donors' own pet projects wanting rapid, measurable progress rather than long-term sustainable solutions. Rarely do all of these organizations truly listen to what the host country wants and needs to ensure the long-term health of its people. Consequently, donors and service providers typically address a single disease or salient health crisis but not the "basic survival needs" of the world's poor, such as clean

air and water; sanitation; surveillance; vector control; and a strong health system with well-trained physicians, nurses, pharmacists, and other health care professionals.[14]

What is urgently needed is an effective system of global health governance that harmonizes objectives, establishes priorities, coordinates activities, sets funding levels, and monitors progress. All of these functions require enormous fiscal support and it is incumbent on the wealthier nations of the world to meet their responsibility in supplying such capital. Effective management of global health in the 21st century simply cannot rely on 19th-century notions of "how the other half lives" noblesse oblige, as well-intentioned and successful as Riis' rallying cry once was. Because the world is so interconnected today, what is required is a unified vision emphasizing the powerful sum of these global health problems rather than a zero-sum game of competing interests. In other words, Jacob Riis' most significant error in the composition of his otherwise brilliantly powerful treatise on poverty and its effects on human society and global health resides in its evocative title. There really is no other half.

Financial Disclosures: None reported.
Additional Contribution: We thank Alexandra M. Stern, PhD, for providing her wisdom and insight in the composition of this Commentary.

REFERENCES

1. Rabelais F. *The Five Books of Gargantua and Pantagruel*. Le Clercq J, trans. New York, NY: Modern Library; 1944.
2. Riis JA. *How the Other Half Lives: Studies Among the Tenements of New York*. New York, NY: Charles Scribner's Sons; 1890.
3. Leviatin D. Framing the poor: the irresistibility of how the other half lives. In: Riis JA, Leviatin D, ed. *How the Other Half Lives (The Bedford Series in History and Culture)*. New York, NY: Bedford/St Martin's Press; 1996:3-50.
4. Richin M. *The Promised City: New York Jews, 1870-1914*. Cambridge, MA: Harvard University Press; 1962.
5. Leuchtenberg WE. *Franklin D. Roosevelt and the New Deal*. New York, NY: Harper Perennial; 1963.
6. Howard-Jones N. The World Health Organization in historical perspective. *Perspect Biol Med*. 1981;24(3):467-482.
7. Hoffman EC. *All You Need Is Love: The Peace Corps and the Spirit of the 1960s*. Cambridge, MA: Harvard University Press; 2000.
8. Gostin LO. Why rich countries should care about the world's least healthy people. *JAMA*. 2007;298(1):89-92.
9. Folkers GK, Fauci A. The AIDS research model: implications for other infectious diseases of global importance. *JAMA*. 2001;286(4):458-460.
10. United States Leadership Against Global HIV/AIDS, Tuberculosis, and Malaria Act of 2003. Pub L No. 108-25, 117 Stat 711.
11. Schieber G. Getting real on health financing. *Finance Dev*. 2006;43(4):46-62. http://www.imf.org/external/pubs/ft/fandd/2006/12/schieber.htm. Accessed June 11, 2008.
12. Okie S. Global health: the Gates-Buffet effect. *N Engl J Med*. 2006;355(11):1084-1088.
13. Lee K. The challenge to improve global health: financing the millennium development goals. *JAMA*. 2004;291(21):2636-2637.
14. Gostin LO. Meeting basic survival needs of the world's least healthy people: toward a framework convention on global health. *Georgetown Law J*. 2008;96:331-392.
15. United Nations. Millennium Development Goals report 2007. http://www.un.org/millenniumgoals/pdf/mdg2007.pdf. Accessed June 11, 2008.

Health Policy and Public Trust

Robert H. Brook, MD, ScD

NEARLY EVERY US NEWSPAPER ON ALMOST EVERY DAY will include stories about health care in the United States. Many of these stories focus on the intersection of business or professional entities and trust. Can a study be trusted that compared drug A to a placebo or to drug B? Should research assessing the performance of one device compared with another be given credence? However, journalists rarely ask if research that examines the function and structure of the health care system with the goal of changing health policy should be believed.

I have spent the last 30 years conducting health services research intended to produce new knowledge that, if used correctly, would improve health. Both as a researcher and as director of a large health services research program, I have overseen the expenditure of more than $1 billion. It is legitimate to ask whether the results of this or other work in the field can be trusted. I hope the answer is yes, and in this Commentary I focus on 3 issues that strongly influence the answer: (1) obtaining the data necessary to conduct the work, (2) presenting the results in an unbiased manner so that they can inform the policy debate, and (3) involving the public in understanding the issues and developing responses.

I will draw on personal examples from studies with which I was associated because the studies illustrate the enormous pressure to produce results that are wanted by the funder or that are politically acceptable, as opposed to results that reflect an unbiased assessment. Such pressure can foster a culture of mistrust between the public and the research community.

One of the first of these studies monitored patients discharged from emergency departments at both Johns Hopkins and the Baltimore City Hospitals.[1,2] As a house officer in these institutions, I had an interest in understanding whether the efforts expended in the emergency department benefited patients. For example, 6 months after being seen in the emergency department for a condition that did not require hospitalization, such as hypertension or an ulcer, were patients receiving needed care and getting better?

This early work taught several lessons. First, getting the study approved by the institutional review board (IRB) was difficult and lengthy. The reluctance to allow gathering basic information from patients made it seem to a naive investigator that the IRB's focus was not to benefit all pa-

Author Affiliations: RAND Corporation, Santa Monica, California; and David Geffen UCLA School of Medicine and UCLA School of Public Health, Westwood, California.
Corresponding Author: Robert H. Brook, MD, ScD, RAND Health, 1776 Main St, PO Box 2138, Santa Monica, CA 90407 (robert_brook@rand.org).