

Turning Health Into an Investment:

The World Bank's Death Blow to Alma Ata

CHAPTER 13

The World Bank's social reform efforts are an attempt to legalize, normalize, and even naturalize the fiscal neglect of the health sector.

—Dr. Javier Iguíñez, economist from the Instituto Bartolomé de las Casas, Peru

The “adverse economic climate” of the 1980s was accompanied by a conservative shift in domestic and foreign policies of the most powerful industrial countries, especially the United States and Great Britain. The new policies—dubbed *neoliberal* because they liberalized or freed major markets from government regulation—systematically put the growth of national economies before the basic needs and rights of the poor. Programs assisting poor people were cut back or dismantled, both in the North and the South.

One particularly insidious way in which the conservative policies of the 1980s undercut such programs was by introducing more vertical health and development strategies. Instead of promoting equity and social change, these top-down strategies tended to reinforce and legitimize the inequities of the status quo. To promote development of poor countries and communities, the empowering methodologies that had surfaced in the 1960s and 1970s were systematically replaced by strategies that—if not by design, certainly in effect—were disempowering. Although the rhetoric of participation and empowerment proliferated, in policy implementation emphasis shifted from encouraging the strong participation of decision-making control to the weak participation of compliance. At the same time, in high-level development planning there was a shift from social to technological interventions, from cooperatives to private enterprise, from process to product, from problem-solving learning to pre-charted training techniques, from critical analysis to social marketing, and—in health care goals—from a comprehensive vision of “health for all” to raising survival rates.

This conservative restructuring of development policy has permeated almost all aspects of foreign relations, but especially foreign aid. During the early 1980s the strategies and objectives of nearly every US government-run or government-sponsored charitable organization were redefined to favor the private sector. For example, the Peace Corps, which for years had focused on setting up community cooperatives, was told to redirect its energies toward setting up small private businesses and microenterprises. Even the Inter-America Foundation—which in the 1960s had been mandated by the US Congress to support grassroots initiatives for social change—had much of its top staff replaced and its objectives re-targeted toward fostering private entrepreneurs.

Some of the most extreme examples of the use of development aid to further the political and economic interests of the donor country—often to the detriment of the poor in the recipient countries—can be observed in the agenda of the United States Agency for International Development. USAID, a largely political instrument of the US government, exhibits mixed and often contradictory motives. One of its stated aims is to promote private sector-dominated, profit-oriented national economies.¹⁹⁵ In practice, this often involves the undermining of equity-oriented economies and encouraging free market economies, most frequently dominated by powerful corporate interests in the North.

Privatization of Health Services

Health services in many parts of the world have been affected by the conservative development policies of the 1980s, especially by structural adjustment programs (SAPs) and the strong push for privatization. USAID's assistance to health ministries of poor countries with nationalized health systems has often been conditional: requiring steps toward privatization or “cost recovery” for services. For example, the US provided badly needed shipments of medicine to Mozambique on condition that the country compromise its egalitarian policy of “free medical service to all.” Mozambique was forced to introduce user charges for both medicines and services.¹⁹⁶

Bamako and other cost recovery schemes

UNICEF has also promoted user-financing of village health posts through the Bamako Initiative, now functioning in many African countries and elsewhere. While UNICEF has some reservations about the Bamako Initiative, it argues that in today's hard times it sees no better alternative. Cutbacks in health budgets during the 1980s resulted in the closure of many rural health posts, largely for lack of medicines. UNICEF, aware that poor people are usually willing to pay for medicines, advocates charging enough for drugs to keep the health posts stocked and functioning.

The Bamako Initiative is an attempt to address the problem of financing primary health care in the face of

economic recession, SAPs, and cuts in public spending. It makes concessions to these socially regressive policy trends, while at the same time seeking to cushion their impact on the most vulnerable groups.¹⁹⁷ UNICEF has tried to make the Initiative user-friendly and community controlled, and the program does have a number of positive features. For one, only medicines included on WHO's essential drug list are used (although ORS packets are sold as an "essential drug" for home use). Also, in some of the Bamako community-run health posts, local participation has been active and enthusiastic.

But cost-recovery schemes often have serious—and perhaps life-threatening—drawbacks. Just because poor families are *willing* to pay for medicines does not mean they can *afford* to pay for them. As with ORS packets, poor families will often spend on medicine the last pennies they have, which they need to feed their sick children.¹⁹⁸ And because the poorest families get sick more frequently and tend to require more medication, they may carry more than their share of costs for the health post. While Bamako has provisions to charge less to *the poorest of the poor*, such safety nets work better on paper than in practice.

Studies in some countries have shown that *when cost-recovery has been introduced, utilization of health centers by high risk groups has dropped*.¹⁹⁹ For example, in Kenya the introduction of user fees at a center for sexually transmitted diseases caused a sharp decline in attendance and probably increased the number of untreated STDs in the population.²⁰⁰ An editorial in *The Lancet* in November 1994 suggests that the introduction of user fees, along with other SAPs, may be contributing to the rapid spread of AIDS in Africa.²⁰¹ In Zimbabwe a study by the British aid agency, OXFAM, which reported negative effects from the introduction of user fees, led the government to threaten evicting the charity.²⁰² In the Upper Volta region of Ghana, health care utilization decreased by 50% when cost recovery was introduced.²⁰³ When in 1981 China introduced user payment for tuberculosis treatment, between one and 1.5 million cases of TB remained untreated, leading to 10 million additional persons infected. Many of the 3 million deaths from TB in China during the 1980s might have been prevented.²⁰⁴

The Bamako Initiative has won support from major donors, especially the US, because it shifts much of the cost of primary health care from governments to consumers. Multi-national drug companies applaud the Initiative because it actively promotes and increases the sale of drugs to the poor. When health workers know that their salaries and health posts are financed through drug sales, the temptation to over-prescribe is almost irresistible.

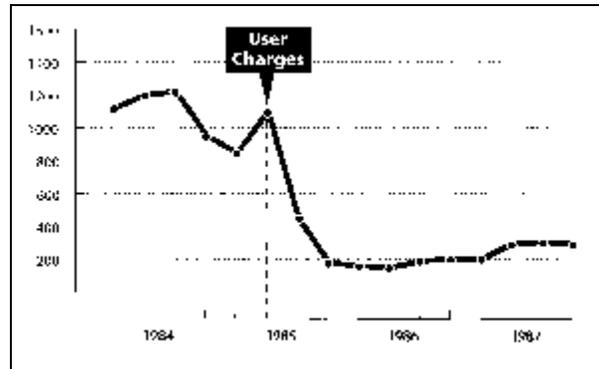


Fig. 3-11 Outpatient attendances at Dwease Health Post, Ghana, before and after introduction of user charges in 1985.²⁰⁵

Whatever their apparent impact, the introduction of these cost-recovery schemes has disturbing social and ethical implications. It is part of a far-reaching rollback of gradual progress toward a fairer, more democratic social order. This conservative shift is reflected in the recent reversals in the rates of child mortality after decades of gradual improvements in children's health.

The World Bank's Take-over of Health Policy Planning: *Investing in Health*

The World Bank and International Monetary Fund (IMF) were set up by the victorious Western powers in 1945. The role of the Bank was to assist in the reconstruction and development of European countries after World War II. The role of the Fund was to provide short term loans to trading nations to smooth out balance of payments fluctuations. The Bank and the Fund are often referred to as the "Bretton Woods institutions" after the town in New Hampshire where their establishment was agreed upon.

By the 1960s, Europe was finished with its post-war reconstruction phase and the bulk of World Bank development lending was going to large scale development projects in developing countries. Many of the projects supported by the Bank have been criticized for damaging the environment and adding to the burdens of the poor.

The role of the IMF was also changing as the private financial markets took over the role of smoothing out short term balance of payments fluctuations. By the 1960s the IMF was mainly lending to governments that were facing structural deficits rather than short term trading deficits and increasingly these were in developing countries. By the late 1970s the main role of the IMF was as a lender of last resort to severely indebted and out-of-credit Third World countries. The loans were tied to structural adjustment

packages as referred to above. During the 1980s the Bank became more involved in structural adjustment lending, directing an increasing proportion of its development lending through structural adjustment packages negotiated by the IMF.

During the 1980s the IMF and the World Bank increasingly became the targets of criticism for the damaging effects of much of the Bank's development lending and for the disastrous effects of the conditions imposed as part of structural adjustment lending. But in recent years, the Bank claims to have learned from its mistakes, turned over a new leaf and committed itself to the "elimination of poverty." However, the Bank has so consistently financed policies that exacerbate the situation of disadvantaged people that it is difficult to avoid questioning its ability to change its course. A number of critics have suggested that perhaps the most effective step the World Bank could take to eliminate poverty would be to eliminate itself.²⁰⁶

As part of its effort to reposition itself, the Bank has become increasingly involved in questions of Third World health policy, both through lending for health sector programs and by including health policy reforms in the conditions of structural adjustment lending. The Bank's agenda for redirecting health policy and restructuring Third World health systems is spelled out in its 1993 World Development Report, entitled, *Investing in Health*. This report has had (and continues to have) a profound influence on health policy in developing countries. Countries willing to implement Bank-endorsed policies are regarded as appropriate candidates for aid and the Bank encourages other donor agencies to assist these compliant countries to finance the transitional costs of structural change in the health sector.

The report is based on propositions about the links between health and economic growth which are deliberately misleading. It asserts that economic growth will lead to good health and better population health will lead to more secure economic growth. The report does not acknowledge that industrialization has never been achieved without heavy human and environmental costs.

The report recognizes poverty as a threat to health but does not refer to the evidence linking economic inequality and poorer health standards. Indeed, underlying the whole report is an attempt to reconcile the goal of better health with the inequalities which are the pre-conditions for, and the consequences of, the Bank's model of economic development (see tables on page 105).

On first reading, the Bank's strategy for improving health status in developing countries sounds comprehensive, even modestly progressive. It acknowledges the links between poverty and ill health, and that improvements in social, economic and environmental factors are critical pre-requisites for improvements in health. It calls for increased family income, better education (especially for girls), greater access to health care, and a focus on basic health services rather than tertiary and specialist care. It quite rightly criticizes the persistent inefficiencies and inequities of current Third World health systems. Ironically, in view of its track record of slashing health budgets, the Bank even calls for increased health spending.... So far so good.

But on reading further, we discover that under the guise of promoting cost-effective, decentralized, and country-appropriate health systems, the report's key recommendations spring from the same sort of structural adjustment paradigm that has worsened poverty and lowered levels of health wherever it has been applied.

The Bank's three-pronged approach. According to the World Bank's prescription, in order to save "millions of lives and billions of dollars" governments must adopt "a three pronged policy approach to health reform:

1. Foster an enabling environment for households to improve health.
2. Improve government spending in health.
3. Facilitate involvement by the private sector."²⁰⁷

These recommendations are said to reflect new thinking. But from the "fine print" in the text of the Report, we can restate the policy's three prongs more clearly:

1. "Foster an enabling environment for households to improve health" is a return to "trickle down" development. Policies for economic growth must take priority. Family health will improve when household income starts to rise.
2. "Improve government spending in health" means trimming government spending by moving from comprehensive service provision to a number of narrow vertically planned programs, selected on the grounds of cost-effectiveness: in other words, *a new brand of selective primary health care*. It also means user charges, requiring disadvantaged families to cover the costs of their own health care, despite the fact that for many it will prohibit the use of health care services.

Region	Population, economic indicators, and progress in health by demographic region, 1975-90							
	Population, 1990 (millions)	Deaths, 1990 (millions)	Income per capita		Child mortality		Life expectancy at birth (years)	
			Dollars, 1990	Growth rate, 1975-90 (percent per year)	1975	1990	1975	1990
Sub-Saharan Africa	510	7.0	510	1.0	212	175	48	52
India	850	9.5	360	2.5	195	127	53	58
China	1,134	8.9	370	7.4	85	43	56	69
Other Asia and islands	683	5.5	1,320	4.6	135	97	56	62
Latin America and the Caribbean	444	3.0	2,190	-0.1	104	60	62	70
Middle Eastern crescent	503	4.4	1,720	1.3	174	111	52	61
Formerly socialist economies of Europe (FSE)	346	3.8	2,850	0.5	36	22	70	72
Established market economies (EME)	798	7.1	19,900	2.2	21	11	73	76
Demographically developing group ^a	4,125	39.1	900	3.0	152	106	56	63
FSE and EME	1,144	10.9	14,690	1.7	25	15	72	75
World	5,267	50.0	4,000	1.2	135	96	60	63

Note: Child mortality is the probability of dying between birth and age 5, expressed per 1,000 live births; life expectancy at birth is the average number of years that a person would expect to live at the prevailing age-specific mortality rates.

a. The countries of the demographic regions Sub-Saharan Africa, India, China, Other Asia and islands, Latin America and the Caribbean, and Middle Eastern crescent.

Fig. 3-12 Contrast the World Bank's optimistic table above which indicates universal improvement in health with figure 3-15 below which shows the widening gap in mortality between people in wealthy and poor countries (data drawn from same source).²⁰⁸

Age Group	1950	1980	1990
<5	3.4	6.4	8.8
5-14	3.8	6.5	7.0
15-59	2.2	1.8	1.7
60>	1.3	1.4	1.4

Fig. 3-13 Relative probability of people in developing countries dying (across the ages indicated) expressed as DDC/(FSE+EME) (the ratio of Demographically Developing Countries to the combined Formerly Socialist Economies plus the Established Market Economies). Calculated from data in the World Bank's 1993 World Development Report by David Legge.²⁰⁹

3. "Facilitate involvement by the private sector" means turning over to private, profit-making doctors and businesses most of those government services that used to provide free or subsidized care to the poor ... in other words, *privatization of most medical and health services*: thus pricing many interventions beyond the reach of those in greatest need.

Disability Adjusted Life Years (DALYs) Many of the recommendations of *Investing in Health* are based on the concept of DALYs, or Disability Adjusted Life Years.

DALYs incorporate a number of very questionable assumptions about the value of life. The Bank assigns different values to years of life lost at different ages. The value for each year of life lost rises from zero at birth to a peak at age 25 and then declines gradually with increasing age. For the Bank, the very young, the elderly, and disabled people are less likely to contribute to society in economic terms; hence fewer DALYs will be saved by health interventions which address their ills. Therefore, asserts the bank, such interventions are less deserving of public support.

According to the Report, placing a dollar value on individual human lives, DALYs can be used to design more efficient health care. DALYs which might be lost through death, disease or injury may be saved, the Bank suggests, by selected health interventions. Inexpensive interventions which substantially reduce the number of DALYs lost are considered cost effective, and merit public support. Interventions which do not alter the future stream of disability-free years are not considered cost-effective, and are unworthy of support.

The Report compares 47 different public health and clinical interventions in terms of their cost-effectiveness, expressed in terms of the cost per DALY achieved. For example, leukemia treatment is not cost-effective, achieving only 1 DALY for every \$1,000 spent, while vitamin A supplementation achieves 1 DALY for just under \$1.

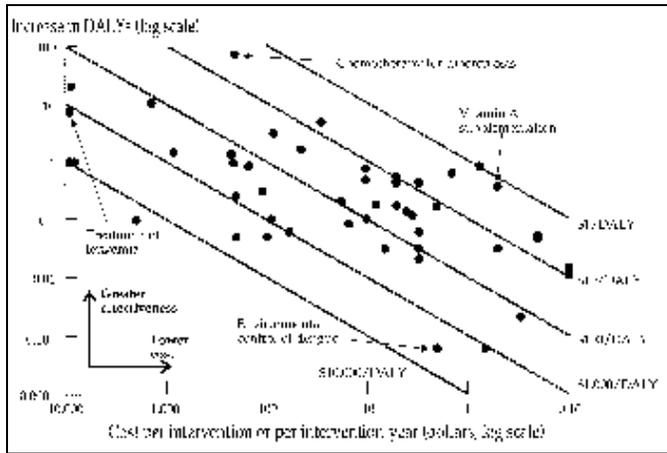


Fig. 3-14 Benefits and costs of forty-seven health interventions. Source: World Bank 1993 World Development Report.²¹⁰

According to this logic the overwhelming majority of nursing care would be judged to be of little or no value. As public health researcher David Legge puts it: “Caring activity which does not contribute to cure or prevention is rendered infinitely expensive, or infinitely ineffective by this methodology.” This concept, which assumes that a disabled or chronically unhealthy person’s life is less valuable than that of a non-disabled person, reflects the Bank’s view that economic productivity is paramount.

Using DALY-based cost-effectiveness, the Report defines a minimum essential package of clinical and public health services. This package consists of a relatively small number of large-scale interventions which “cost-effectively” address those problems which are “among the largest afflicting developing countries.” There is no consideration of how the community is to participate in or even understand this form of global health planning.

The Report’s contradictions and wider agenda

The World Bank’s *Investing in Health* Report’s most positive features are that it acknowledges that poverty and ill-health are causally related, and that improved health is likely to result from economic improvement and advances in non-health sectors. Also it urges countries to focus on basic health services rather than tertiary and specialist care. Nonetheless, as David Legge has pointed out, “there are ambiguities, selectivities and inconsistencies in the Report and it appears that the analysis and recommendations have been shaped by considerations from a wider agenda.”²¹¹

Many of the recommendations contradict the more progressive health objectives stated in the report. For example, the Report confirms that poverty which results in poor living conditions, unhealthy occupational exposures and maldistribution of household income is a health hazard. It then states that economic growth—particularly when guided by growth policies designed to benefit the poor—is a condition for health improvement, “including, where necessary, adjustment policies that preserve cost-effective health expenditures.” Yet the Report does not address seriously the health consequences of unbridled economic growth, which has led in some countries to greater inequalities and widening health differentials, nor the negative impact of SAPs, particularly on the poor and vulnerable. Indeed, it claims that economic growth following adjustment has generally led to improved health. However, as we discussed in Chapter 11, a close examination of the data reveals that there is no basis for this conclusion.

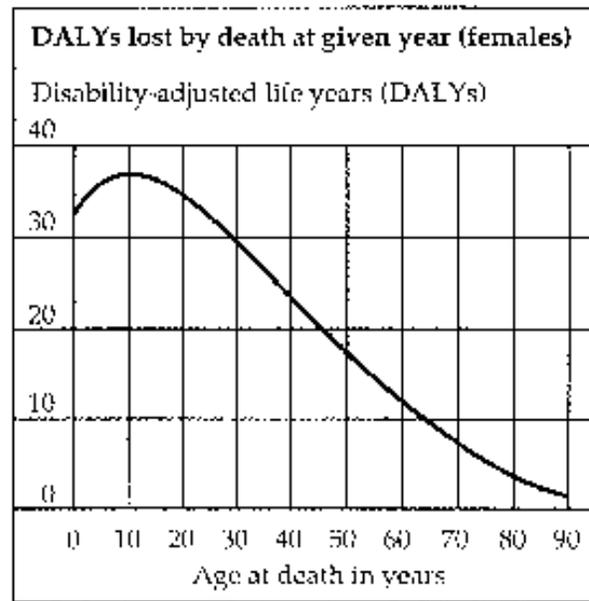
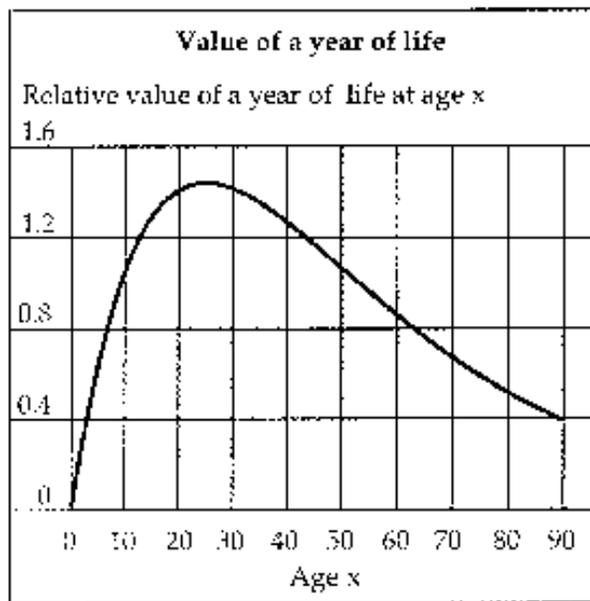


Fig. 3-15 Source: World Bank 1993 World Development Report

It is the almost total silence on SAPs that is especially telling and leads one to doubt the seriousness of the Bank's call for poverty reduction as a key to better health. For example, the Report singles out female education as a critical factor in health improvement. Yet it fails to acknowledge the many ways that SAPs have increased poverty and poor health: how cuts in education budgets and imposition of school fees have resulted in significant school dropouts, especially of girls, or how production of cash crops for export instead of production of traditional foods has led to higher food prices. The Report fails to address how SAPs have terminated food subsidies, leading directly to increased hunger, have promoted privatization and user fees which have placed health services out of reach of the neediest, and have "streamlined" public services resulting in increased unemployment.

With its call for "greater diversity and competition in the provision of health services, promoting competitive procurement practices, [and] fostering greater involvement by nongovernment and other private organizations" the Bank's new policy for the Third World sounds suspiciously like the health care model of the United States. It argues that private health care for individuals gives more choice and satisfaction and is more efficient. But there is little evidence to support this claim. The US health system, dominated by a strong profit-hungry private sector, is by far the most expensive in the world, yet US health statistics are among the worst among the Northern industrialized nations. Indeed, Washington DC, with its large low-income population, has poorer child and maternal mortality rates than Jamaica.²¹² (The health situation in the United States is discussed in detail in Chapter 14.)

The Bank's new health policy is little more than old wine in new bottles: a rehash of the conservative strategies that have systematically derailed Comprehensive Primary Health Care, with elements of structural adjustment to boot.²¹³ It is a market-friendly version of Selective Primary Health Care, supplemented by privatization of medical services and user-financed cost recovery. As with other Selective PHC schemes, it focuses on technological interventions and glosses over the social and legislative determinants of health. David Legge observes that the World Bank Report is "primarily oriented around

the technical fix rather than any focus on structural causes of poor health; it is about *healthier poverty*."²¹⁴

The medical establishment in many countries has celebrated the Bank's 1993 World Development Report as a major breakthrough toward a more *cost-efficient* health care strategy. But many health activists see the Report as a disturbing document with dangerous implications. They are especially worried that the Bank will impose its recommendations on the countries that can least afford to implement them. With its enormous money-lending capacity, the Bank's financial leverage can force poor countries to accept its blueprint, as it has done with structural adjustment.

It is an ominous sign when a giant financial institution with such strong ties to big government and big business bullies its way into health care. Yet according to the British medical journal *The Lancet*, *the World Bank is now moving into first place as the global agency most influencing health policy*, leaving the World Health Organization a weak second.²¹⁵

Despite all its rhetoric about the alleviation of poverty, strengthening of households, and more efficient health care, the central function of the World Bank remains the same: to draw the rulers and governments of weaker states into a global economy dominated by large, multinational corporations. Its loan programs, development priorities and adjustment policies have deepened inequalities and contributed to the perpetuation of poverty, ill health, and deteriorating living conditions for at least one billion human beings.



It is time to look for alternatives. Fortunately, there are many examples, small and large, of approaches to health and development that place the well-being of all members of society as top priority. Although none of these approaches is flawless, and many have run into powerful obstacles, we can still learn a lot from them. The next chapter examines some of these more promising alternatives. It shows that a society's level of equity (or inequity) is a key determinant of its health. Examples are provided from different countries, both of *poor health at high cost* and of *good health at low cost*.