

Look at the Situation Today: Equity as a Determinant of Health

CHAPTER 14

*Corporations have been enthroned ¼ An era of corruption in high places will follow and the money power will endeavor to prolong its reign by working on the prejudices of the people ¼ until wealth is aggregated in a few hands and the Republic is destroyed.*²¹⁶

—Abraham Lincoln

It is often the case that the people of rich nations are healthier than those of poor nations. But a comparative look at the world's countries—poor and rich—reveals some outstanding exceptions. A wealthy nation is not necessarily a healthy nation, nor is a poor nation necessarily unhealthy. This is evident if we compare the data in the “Basic Indicators” chart of UNICEF's 1995 *The State of the World's Children Report* (see excerpt: figure 3–1 on page 75).²¹⁷

For example, Vietnam, China and Sri Lanka are all countries with a gross national product (GNP) per capita of US\$600.00 or less, yet each has achieved an under 5 mortality rate (U5MR) under 50 (in other words, fewer than 50 out of 1000 children die before age 5). By contrast, Gabon, Libya, South Africa, Brazil, Botswana and Iran are all countries with a GNP per capita of over US\$2000, yet all have a U5MR of 56 or more. Gabon, despite its relatively high GNP per capita of \$4450 has an appalling U5MR of 154! Compare this with Jamaica which, with a GNP per capita of \$1340, has a U5MR of just 13.²¹⁸ Clearly, the contrasting wealth of these two countries does not reflect the relative health of their children.

Of course, GNPs per capita are misleading because they are a national average that tells us nothing about income distribution. For this reason the UNICEF report also includes income disparity indicators. We see that in countries with high child death rates, despite relatively high average income, income disparity is often extreme. Brazil and Botswana (the only two countries of the above six for which income distribution data are available) show the widest income disparity of all countries for which such data are listed. In Brazil—reputedly “among the most unequal and unjust nations in the world”²¹⁹—the poorest 40% of the population earn only 7% of the national income, while the wealthiest 20% earn 68% of the income. Land distribution in Brazil is even more uneven than income: the richest 0.9% of landholders own 44% of the land while the poorest 53% hold just 2.7%.²²⁰ From these and similar data, as shown on the chart in Figure 3–1, it appears that health levels of nations are strongly influenced by *distribution of wealth*, and in some cases more so than by the *average wealth* (GNP per capita) or *total wealth* (GNP) of nations. Equity in terms of people's basic needs also appears to be of key importance. The extent to which a society meets all its members' basic

needs may have a greater influence on the population's health and well-being than does the nation's aggregate wealth or economic growth. This would seem to hold true not only in poor countries, but also in rich ones. For example, Hong Kong and Singapore have GNPs per capita of US\$13,340 and US\$14,210 respectively, as compared with US\$22,240 for the United States of America. However, Hong Kong and Singapore have U5MRs of 7 and 6 respectively, significantly lower than the US with a U5MR of 10. This is in part explained by greater commitment in Hong Kong and Singapore to meeting the entire population's basic needs. For example, in Singapore and Hong Kong the percentage of children fully immunized against polio and diphtheria, pertussis (whooping cough), tetanus and tuberculosis ranges from 80 to 99%. By contrast, in some poor inner city areas of the USA immunization coverage is as low as 10%.

The more equitable a society is — i.e. the more fairly its wealth, land, housing, access to health care and education, other basic resources and services are distributed — the healthier its people are likely to be. In short, there is a strong correlation between health and social equity. In this chapter, to understand the importance of equity in achieving a healthy population, we look at contrasting examples. First, to observe *poor health at high cost* we focus on one of the richest countries with the greatest inequities: the United States. Then, to examine *good health at low cost* we look at several poor countries which have striven to meet all people's basic needs and have achieved exceptionally high levels of health and low child mortality.

Poor Health at High Cost — The Socioeconomics of Health and Health Care in the United States

The United States of America may be the world's wealthiest nation, but it is certainly not the healthiest. For the growing number of American families living below the poverty line, the standard of living continues to deteriorate. According to UNICEF's 1994 *State of the World's Children Report*,

An increasing proportion of children in the world's richest nation are in trouble. While America's economy grew by approximately 20% in the 1980's some 4 million more American children fell into poverty. A total of one in five children now lives below the poverty line.²²¹

The United States has the eighth highest GNP per capita in the world²²² ... and the highest *real gross domestic product (GDP) per capita*,* a better indicator of real wealth.²²³ The nation also ranks first in the world in total spending on health care. (In 1990 the US alone consumed 41% of the global total spent on health care.)²²⁴ Yet its health indices are worse than those of other rich nations and lag behind some countries with much lower GNPs. Of the 19 major industrial countries, the US has the highest mortality rate of children under age five (U5MR). In disease prevention the US also lags.

Whereas in many underdeveloped countries at least 80% of young children currently receive complete immunization, in the US over 40% of 2-year-olds are not fully immunized and in some inner cities fewer than 10% of children are fully immunized. With an overall immunization rate of 58%, the U.S. immunization rate is lower than in Mexico, Thailand, India and Uganda.²²⁵ Therefore, it is not surprising that in the 1990s the death rate from measles in the US has been rising.

The nutritional status of US children is equally disturbing. Although obesity is a growing health concern for middle-class children, undernutrition impedes children's physical as well as mental development in poor families. Of the 30 million Americans who regularly go hungry, over 12 million are children. These tend to be the same children who are not covered by any form of health insurance, and who often fall through the inadequate and increasingly under funded safety nets for high risk families. The United States ranks last among major industrial countries in percentage of population covered by health insurance.²²⁶ And with the increasingly astronomical costs of services within the private, profit-hungry medical system, for those who lack health insurance, professional medical or dental care is ruinously costly. In the United States millions of citizens, undocumented immigrants, and growing numbers of the middle class suffer painful and chronic conditions without treatment because they simply cannot afford it.

*This is true because *real GDP per capita* takes into account the varying costs of items across countries—something GNP per capita does not do. Real GDP per capita compares how much it costs to buy the same bundle of goods in different countries. It shows that, while the US is eighth in average income, Americans can buy more with their money than citizens of other countries.

The substandard health levels in the US compared to many other countries can be explained by growing inequality, not only in access to health care and essential services, but in education, employment opportunities, and fundamental human rights. Inequity, poverty, and hunger have worsened dramatically in the US during the last 15 years. Spiraling social deterioration has been largely a result of the regressive economic and social policies introduced by the Reagan and Bush Administrations, now being carried to greater extremes as the current conservative majority in Congress competes against President Clinton for the vote of big business. These market-friendly, poor-people-hostile policies parallel the Structural Adjustment Programs imposed on poor countries by the World Bank. They have drastically rolled back welfare benefits and social services, including health care, food subsidies, low-cost housing, and the Head Start program for poor inner city children. While taxation of the poor has increased, further tax benefits have been awarded to rich investors and corporations.²²⁷

THE REALITY AND THE IDEAL

*Big time Chief Executive Officers (CEOs) [in the US] ¼ averaged \$4.1 million in 1993 ¼ 149 times the earnings of average factory workers.*²²⁸

—Business Week

No one in a community should earn more than five times the pay of the lowest paid worker.

— Plato said to Aristotle

By 1987, the income gap between rich and poor Americans was wider than at any time since the federal government began calculating it 40 years ago. Between 1977 and 1988, the inflation-adjusted income of the richest 5% of the population increased by 37%, while the income of the poorest 10% decreased by 10.5 percent.²²⁹ Correspondingly, the number of Americans living below the poverty line has increased: from 24.7 million in 1977 to 32.4 million in 1986. Those with no health insurance rose over 30% from 1980 to 1992.²³⁰ At the same time the rate of preventive health coverage for children, including immunization, has been falling, largely because parents are charged for such services.²³¹ It is estimated that in the USA at least 10,000 and possibly as many as 21,000 children die of poverty-related causes each year.²³²

Wealth Class (% of population)	1962	1983	1989
Richest 0.5%	25.2	26.2	30.3
Next 0.5%	8.2	7.8	8.0
Next 4%	21.6	22.1	21.6
Next 5%	12.4	12.1	11.3
Next 10%	14.3	13.3	13.1
Richest Fifth (20%)	81.7	81.5	84.3
Fourth (20%)	12.9	12.5	13.0
Middle (20%)	5.2	5.2	2.7
Second (20%)	0.8	1.1	0.2
Lowest (20%)	-0.5	-0.3	-0.2
Poorest Four Fifths (80%)	18.3	18.5	15.7
Total	100	100	100

Fig. 3-16 Changes in Distribution of US Net Worth, 1962-1989. The poorest 20% of people owe more than they have, thus they have a negative net worth²³³

The Children’s Defense Fund has the following to say about the new cutbacks on programs for high-risk children proposed by the conservative Congress’ so-called Contract with America (a right-wing austerity plan to balance the national budget on the backs of the poor while increasing profits for the rich):

“Under the guise of welfare reform, House Republican leaders would permanently tear up the 60-year old federal safety net for poor, disabled, abused, and hungry children and replace it with a policy of national child neglect. If they succeed, millions more children will be left behind and denied a Healthy Start, a Head Start, a Fair Start, and a Safe Start in order to pay for tax breaks for rich corporations and individuals.”²³⁴

Altogether, 67% of the massive budget cuts to finance tax breaks for the rich fall on children.²³⁵ These cutbacks, which by default violate the basic rights of children, are sowing the seeds of future social breakdown and mounting violence. In the long run, initiatives like Head Start are probably among the most effective programs for violence prevention. Yet these protective programs are being ruthlessly gutted while expenditures on prisons and law enforcement are being increased. Every year the United States spends \$25 billion on its prison services alone.²³⁶

With diminishing public assistance for poor urban communities, the sanitation infrastructure has been allowed to deteriorate, health education and preventive health mea-

sures have been reduced, as has the access by poor Americans to health care. In the US today, it is estimated that one in four families does not have safe tap water. Deteriorating conditions have in turn set the stage for the rapid spread of tuberculosis and measles (two diseases of poverty that had been largely eradicated²³⁷), and AIDS.

Racism in the USA is another factor contributing to poor health. Of children living in poverty, a disproportionate number are African-American, Hispanic, or Native American. Members of these ethnic groups are systematically marginalized and discriminated against, and have fewer opportunities open to them. As a result of such inequality, life expectancy of African-Americans is five years less than that of whites.²³⁸

With such extreme and growing inequalities in the USA, between rich and poor, and between Caucasians and people of color, rates of crime and violence are bound to increase. According to the California Wellness Foundation:

Murder has become an epidemic ravaging our youth. It is the leading cause of death among 20 to 24 year-olds... Most young people are neither victims nor violators. But they learn to live with violence in the schools and parks, on the streets, in their homes, in the movies and television programs they watch.²³⁹

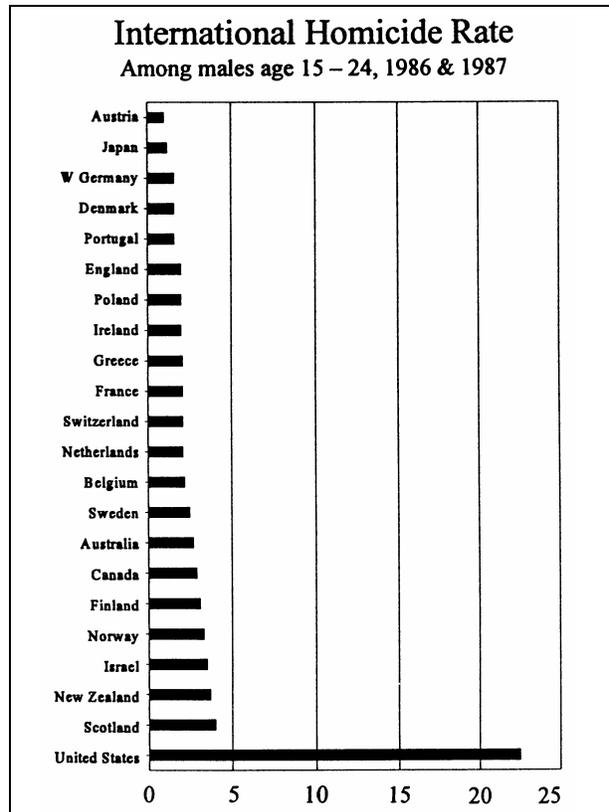


Fig. 3-17 Homicides per 100,000 population²⁴⁰

Startling Statistics on US Health, Race and Equity

- Number of Americans living in poverty:
1977: 24.7 million
1986: 32.4 million.²⁴¹
- Percentage of children living in poverty:
In 1980: 17%²⁴²
In 1994: 25%.²⁴³
- Number of Americans who regularly go hungry: 30 million
Children: over 12 million²⁴⁴
- Number of millionaires in US:
In 1969: 121,000
In 1989: 1.3 million²⁴⁵
- Between 1977 and 1988, the inflation-adjusted income of the richest 5% of the population increased by 37%, while the income of the poorest 10% decreased by 10.5 percent.²⁴⁶
- Of the nineteen major industrial countries, the country with the highest U5MR: United States.²⁴⁷ (Higher than that of Singapore and Hong Kong.)
- Number of American children who die of poverty-related causes each year: At least 10,000.²⁴⁸
- Country which ranks last among major industrial countries in percentage of population covered by health insurance: United States²⁴⁹
- Number of Americans who have no health insurance: 40 million
Children: 12 million
(Another 20 million have inadequate coverage.)²⁵⁰
- Number of American children without health care: Approximately 8 million²⁵¹
- Percentage of inner city children not fully vaccinated against childhood illnesses: Fewer than 10%²⁵²
- Infant mortality:
White Americans: 8 per 1000
African-Americans: 18 per 1000.²⁵³
- 35% of Hispanic children and 43% of African-American children live below the poverty line.²⁵⁴
- The rate of incarceration for African-American teenagers is nearly 44 times that for white teens.²⁵⁵
- African-American infants born in Chicago, Detroit, and Philadelphia are more likely to die before their first birthday than infants born in Shanghai, Jamaica, Costa Rica, or Chile.²⁵⁶
- Over half of all young children with AIDS in the US are African-American.²⁵⁷
- Number of teen-age girls in the US who become pregnant annually: 1 million.²⁵⁸
- Number of adolescents who contract sexually transmitted diseases: 2.5 million.²⁵⁹
- Number of prostitutes under the age of 18: 300,000.²⁶⁰

Inequality breeds violence

Murder rates in the US have been increasing 6 times faster than the population. Rape and other forms of violence have also escalated. A contributing cause, in addition to the widening gap between rich and poor, may be commercial television: *the drug with a plug*. For the sake of maximum profit, unscrupulous TV corporations bombard the public with a diet of murder and mayhem. Most American children spend more time watching TV than they do with their parents or in school. "By the age of 18 the average teenager has witnessed 15,000 murders and hundreds of thousands of other acts of violence on television. The primary goal of the television industry is not to develop children's character but to expand the market for fast food, toys, and other unnecessary goods."²⁶¹

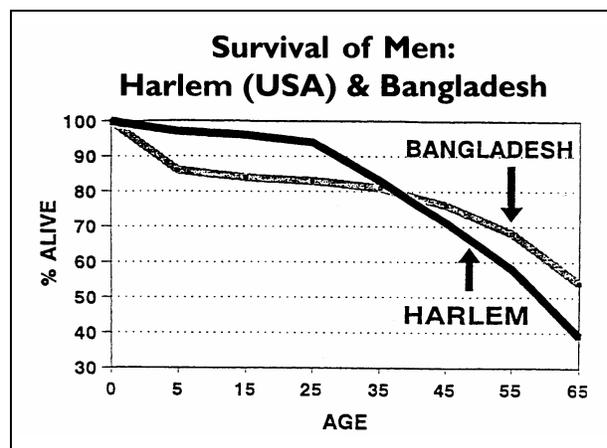


Fig. 3-18

The embers of racism and xenophobia in the US—never far below the surface—are currently being fanned into flames by the increasing polarization of opportunity and income. A wave of hate-crimes and terror has been spearheaded by self-seeking groups of the radical right (skin-heads, white-supremacists, neo-Nazis, Ku-Klux Klan, and self-styled paramilitary “militia”). There is little doubt that some of these militia—or at least the doctrine of terrorism and cold-blooded violence that they espouse—are linked to the 1995 bombing of the Federal Building in Oklahoma City in which nearly 200 persons, including many children, were killed.

At the same time as hate crimes by the radical right have escalated, vindictive legislation has been promoted by the conservative right. As an example, the recent passage of Proposition 187 in California, if ruled constitutional, would deny education and health care to undocumented children. Mexicans and progressive North Americans have labeled this action racist and even fascist. Through such legislation, decades of social progress are being reversed. Health care and education cease to be basic human rights.

Blacks clearly, on the average, have fewer opportunities than whites; far more are unemployed or paid impoverishing wages. An African-American man in Harlem is less likely to reach age 65 than a man in Bangladesh (see figure 3–18).²⁶² Such social violence against one sector of the population breeds violent repercussions. The budget cuts proposed through the “Contract with America” will inevitably cause greater hardship for Blacks, Latinos, and other minority groups.

As a reflection of the unhealthiness of our inequitable consumer society and the psychosocial strain which it imposes on young people, the rates of attempted suicide in the United States are shockingly high. Similarly, the use of alcohol and illicit drugs among older children and teenagers is disturbingly elevated. A study conducted by a 37-member commission including former Surgeon General C. Everett Koop and pollster George Gallup in 1990 reports that:

- Never before has one generation of American teenagers been less healthy, less cared for, or less prepared for life than their parents were at the same age.
- Hundreds of thousands of adolescents [suffer from] excessive drug use, unplanned pregnancies, sexually transmitted diseases and social and emotional problems that can lead to academic failure or suicide.
- The suicide rate for teens has doubled since 1968, and 10% of adolescent boys and 20% of girls have attempted suicide.

- Violence is part of many young people’s daily lives ... Every day 135,000 students bring guns to school, and homicide is the leading cause of death among 15 to 19-year old African-Americans.
- More than half of all high school seniors became drunk [at least] once a month, and alcohol-related accidents are the leading cause of death among teen-agers.
- 30% of tenth graders have experimented with drugs (as compared to 5% in the 1950s). Half a million 12- to 17-year olds have tried cocaine.

The study concluded that:

- Many of America’s young people, both rich and poor, from all racial and ethnic backgrounds, have serious social, emotional, and health problems that have potentially disastrous consequences not only for the individual teen, but for society as a whole.

During its first years in the White House in the early 1990s the Clinton Administration called loudly for social reform. It talked of more jobs, benefits, and services for working people, especially the poor, and for a national health system to meet all people’s needs. But actions speak louder than words. So far, Clinton—like his predecessors—has made many decisions in the interests of powerful lobbies (whose support he seeks for re-election) rather than the interests of the majority of the population. With the current shift to the conservative right in Congress—backed by the powerful lobbies of big business and the American Medical Association—the situation is likely to keep on deteriorating. Although Americans spend far more on medical care than any other nation, the American model based on private, exorbitant, inequitable services is definitely an example of *poor health at high cost*.

The United States and the Globalization of Poverty

The United States, as the only remaining superpower, continues to have an overarching influence on economic and social policies worldwide, both directly through economic and military strength, and indirectly through the international financial institutions (the World Bank, IMF, the World Trade Organization, etc.). Foreign aid, conditional loans, trade accords, and heavy-handed adjustment policies have tied most nations to a profit-before-people global market system largely structured and directed by the US. Those few countries bold enough to resist this greedy, myopic development paradigm, or that have pursued a path of more equitable social

development, have been beleaguered by US-led embargoes, destabilization strategies, and either overt aggression or covert mercenary-conducted terrorism. The result has been growing disparity of wealth and health and the globalization of poverty.

The dominant development model based on unbridled economic growth for the rich has led to an intensification of inequality and underdevelopment worldwide. In a meager attempt to justify this state-sanctioned economic terrorism, the US Senate–House Joint Economic Committee flatly stated in a recent report that “all societies have unequal wealth and income dispersion, and there is no positive basis for criticizing any degree of market determined inequality.”²⁶³ The resulting unjust and unsustainable social order is held precariously in place by providing strategic economic and military aid to the *burgeoning low-intensity democracies* which are fiercely controlled by wealthy elites in alliance with the powerful monied interests in the North.

The parallels between the domestic policies pursued by the US government since the early 1980s and the development policies imposed on Third World countries are inescapable. Likewise, the Third World debt crisis parallels the US national debt: the largest in the world. In the United States, as in the Third World, the same powerful interest groups have both engendered and benefitted from the neoliberal policies that have deepened poverty,

Despite all its wealth and power, the US is surely not a undermined democratic process, and precipitated environmental demise. healthy nation. Still less healthy are the inequitable policies it imposes on the rest of the world.

The Socioeconomics of Health in the Third World

In the Third World, generally speaking, national wealth (GNP per capita) tends to correlate with child mortality rates and other health indicators. Of the 35 countries that UNICEF lists as having “very high” under-five mortality rates (U5MRs) all but five have GNPs per capita of \$500 or less.²⁶⁴

However, as mentioned earlier, how a country’s wealth is distributed appears to be a more important determinant of health than is aggregate national wealth or average income. Let us compare Brazil with Costa Rica. Brazil has a relatively high GNP per capita of \$2,770 and a U5MR of 63.²⁶⁵ In comparison, Costa Rica has a GNP per capita of \$1,960 and a U5MR of 16—one fourth that of Brazil.²⁶⁶ Similarly, the maternal mortality rate in Brazil is 200 per 100,000 live births, in contrast to Costa Rica’s 36.²⁶⁷ And the average Brazilian dies at age 66, ten years younger than the average Costa Rican.²⁶⁸

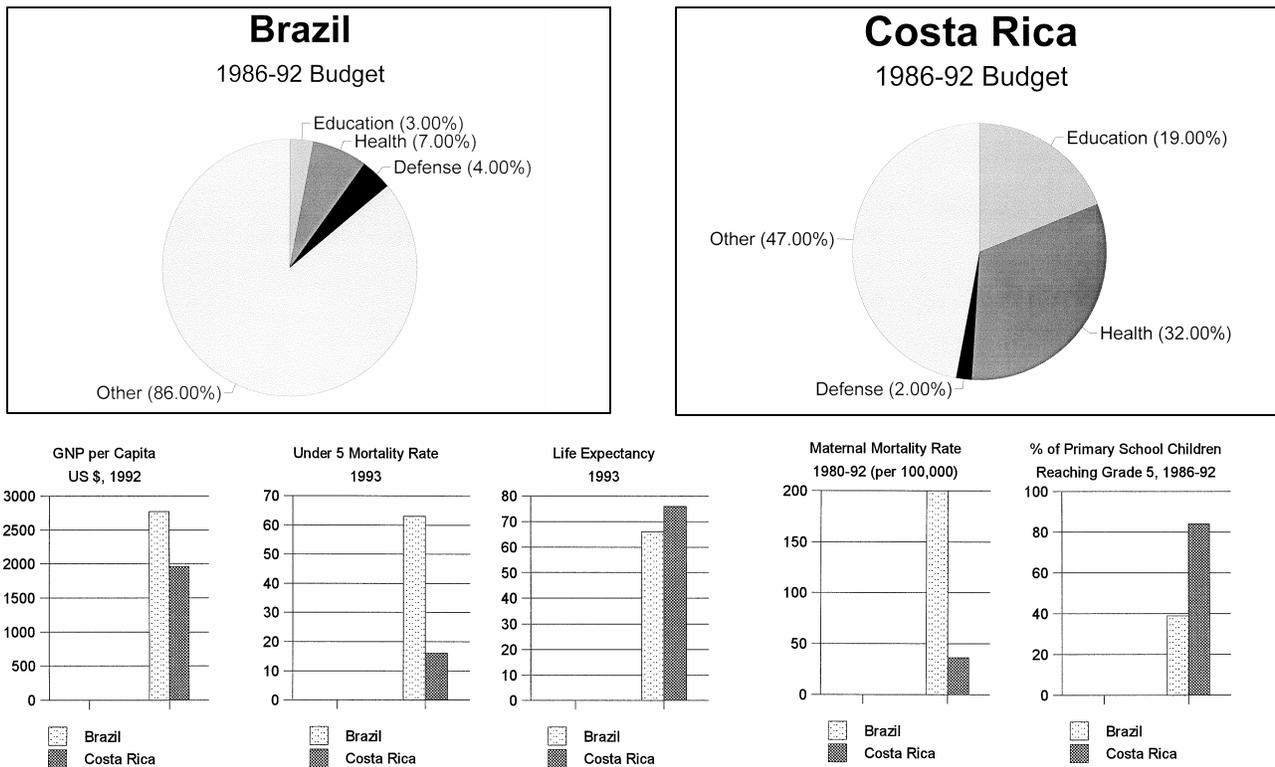


Figure 3-19 Comparison of economic, health and education indicators ²⁷⁶

Costa Rica's superior health indices may be due in part to its emphasis on health, and also may partly be explained by the fact that the gap between rich and poor is smaller there, while in Brazil it is enormous and continues to widen.²⁶⁹ Today, one percent of Brazil's population owns 48% of the country's arable land.²⁷⁰ The poorest 40% of Brazil's population receives only 7% of the country's total income²⁷¹ (as compared with 8% three years earlier).²⁷² In contrast, the poorest 20% of Costa Rica's population receives 13% of their country's total income.²⁷³

The inequity of Brazilian society is also reflected in the government's low spending on social services. Brazil spends 7% of its budget on health care and 3% on education.²⁷⁴ Costa Rica, in contrast, spends 32% of its budget on health and 19% on education.²⁷⁵ Correspondingly, only 39% of Brazilian children are in primary school, as compared with 84% of Costa Rican children.²⁷⁶ (See figure 3–18.)

As we have already mentioned, there is a close correlation between women's education and child mortality. Thus, the fact that Brazil's primary school enrollment fell yet further during the 1980s does not bode well for the health of its children. (In 50 other Third World countries, school enrollment also fell during the 1980s, partly as a result of structural adjustment.)²⁷⁷

In the Third World as in the USA, income disparity among families correlates with disparities in child mortality. A recent study of 28 countries found that in lower income families neonatal mortality is 2 to 4 times as high as that of higher income families; post-neonatal mortality is 2 to 5 times as high; while child mortality is 4 to 30 times higher.²⁷⁸ The effect that a wide disparity in wealth has on children's health is graphically expressed by a hospital official in El Salvador:

It is a vicious cycle. We don't cure children, we simply revive them so that they can go out and starve once more. Sometimes they get sick from simple infections that become serious for children without any resistance, children who don't get enough to eat. Three-quarters of Salvadoran children under five suffer from some grade of malnutrition.

There is food in the country but the poor cannot afford it. We have a twelve-year-old girl now, dying of malnutrition. Her father has a cow and chickens and grows beans and corn. He owes all of it to the man who owns his land, so his daughter and the rest of the family are starving. If he didn't hand over the milk, the eggs, and his crops, someone would come and take them, so

what could the man do? It is a social and economic problem, not a medical one. We just bandage the wound; we don't cure anybody here.²⁷⁹

Good Health at Low Cost

Despite the dismal and deteriorating living conditions and health situation in many poor countries, a few poor states have succeeded in making impressive strides in improving their people's health. In 1985 the Rockefeller Foundation sponsored a study titled *Good Health at Low Cost*.²⁸⁰ Its purpose was to explore "the reasons why certain poor countries have achieved acceptable health statistics in spite of very low national incomes." Specifically, the study sought to "verify whether China, the state of Kerala in India, Sri Lanka, and Costa Rica did indeed attain life expectancies of 65–70 years with gross national products per capita of only \$300–\$1,300," and, if so, to discover why.*

On completing the study, its authors concluded that "the four states did achieve good health at low cost." Specifically, the states had dramatically reduced their infant and child mortality rates, and as a result increased their life expectancies to near-First World levels. The reductions in mortality attained by the four states were substantially greater than those registered by Third World countries that pursued conventional child survival strategies. Moreover, these reductions were accompanied by declines in malnutrition and, in some cases, the incidence of disease.

The authors of the study attributed these remarkable improvements in the health of entire populations to four key factors. These factors are:

1. Political and social commitment to equity (i.e. to meeting all people's basic needs).
2. Education for all with emphasis on the primary level.
3. Equitable distribution throughout the urban and rural populations of public health measures and primary health care.
4. Assurance of adequate caloric intake [enough food] at all levels of society in a manner that does not inhibit indigenous agricultural activity.²⁸¹

*Ironically, the authors of this study—which provides a strong argument for Comprehensive Primary Health Care in the broadest sense—included Kenneth Warren and Julia Walsh, two of the earliest and strongest advocates of Selective Primary Health Care (see page 23).

The importance of a strong “political and social commitment to equity”—although pursued in different ways—cannot be over-emphasized. Henry Mosley, director of Johns Hopkins University’s International Institute of Health and Population, points to the social and political factors underlying the improvements in health achieved in these four states:

[To] guarantee access [to services] there must be an aggressive effort to break down the social and economic barriers that can exist between the disadvantaged subgroup and the medical services. This may be approached with a top-down strategy as illustrated by Costa Rica, or it may be gained through a bottom-up strategy where demand is generated by the organized poor as in Kerala . . . A passive approach of only making services available will not succeed in most situations unless the population has a heightened consciousness of their political rights.²⁸²

Mosley further notes that:

The fundamental underpinnings of any mortality reduction effort involve the political commitment to equity as well as policies and strategies to provide essential services to all. Judging by the historical experiences of the case studies, this stage may be reached through a long history of egalitarian principles and democracy (Costa Rica), through agitation by disadvantaged political groups (Kerala), or through social revolution (China).²⁸³

Although in the Rockefeller investigation *mortality* and *life expectancy* were used as the primary indicators of relative health levels, a number of *quality of life* and *equity* factors were also considered. The *Gini coefficient* (GE) is an index that looks at relative equality in a population in terms of such factors as total income per household, land distribution, and food consumption. Lower readings of the coefficient indicate a greater degree of equality. All the countries in the *Good Health* study had relatively low (more equitable) GEs compared to neighboring states. However, among the four states studied some differences and trends were observed which may throw light on the probability of sustaining the health improvements achieved. In Sri Lanka, for example, there was a decline in the GE for total household income (i.e. income disparities narrowed) from 0.46 in 1953 to 0.35 in 1973, but climbed again to 0.43 by 1981, reflecting the reversal of the egalitarian trend after 1977. (In response to an economic crisis in the late 1970s including an economic adjustment program in 1977, eligibility for food subsidies was greatly reduced.²⁸⁴ In the late 1970s the caloric intake of the poorest 30% of Sri Lankans steadily declined, while that of the top 50% increased.)²⁸⁵ Thus Sri

Lanka has experienced some reversals in its earlier social gains. Obviously, the ongoing civil war in the north of the country has not helped.

Of the 4 countries investigated, China proved by far the most “. . . exceptional in terms of equality. . . It has been reported that for some regions of China, the Gini coefficient (GE) for the distribution of wealth (mostly land) declined from 0.80 [at the time of the Revolution] to as low as 0.22.” Whereas decline in infant mortality rate (IMR) in the other three countries was largely accredited to remedial services (improved coverage of health care, immunization, water and sanitation, food subsidies, and education), China’s improvements were rooted in fairer distribution of land use and food production. In other words, the population was encouraged to become more self-sufficient, rather than to become dependent on government assistance. The harvests of the cooperative production units [communes] were taxed by the government. This provided a reserve so that the government could assist communities at times of crisis and, where necessary, redistribute some of the surplus from more prosperous communities to those in difficulty.

How sustainable is “good health at low cost?” Trends since the Rockefeller study

In the years that have passed since the Rockefeller study, it is interesting to compare how the four states investigated have succeeded in sustaining their respective advances toward ‘good health at low cost.’ According to a number of indicators, China appears to come closest. By contrast, in Kerala, Sri Lanka, and Costa Rica, the gains in reducing malnutrition and disease have in the last few years been somewhat eroded, most notably (and predictably) in the case of Sri Lanka. In these 3 countries equity was less deep-rooted and institutionalized; also they have been hit hard by economic recession and by structural adjustment and, in the case of Sri Lanka, by civil war.

The trends in Costa Rica are especially revealing. Evidence suggests that its impressive decline in Under Fives Mortality Rate (from 112 in 1960 down to 29 in 1980, and 16 in 1992)²⁸⁶ has mostly been due to reductions in diarrheal disease and respiratory infections. These are attributed mainly to health interventions: early treatment, expanded immunization coverage, water and sanitation, food supplements to young children and pregnant mothers, and later, wider access to hospitals (secondary care) and to family planning services.²⁸⁷ In the Rockefeller study, “socioeconomic progress” was credited for only 25% of the total decline in infant mortality.²⁸⁸

However, with the growing debt crisis in Costa Rica in the early 1980s, as socioeconomic progress stagnated and

began to reverse, the drop in infant mortality halted.²⁸⁹ Rapid inflation and a fall in real wages “brought a deterioration in purchasing power and may have resulted in higher rates of malnutrition and mortality.”²⁹⁰ The percentage of the population who could not afford “the basic food basket” increased from 18% in 1980, to 37% in 1982. Nutritional levels, especially of children, began to decline; more than 1 in 3 children were not getting enough to eat. This situation improved somewhat in 1983 “because the inflationary process was slowed down and government increased the minimum wage.”²⁹¹ Today health levels in Costa Rica remain fairly good. (For example, its percentage of low birth weight babies is lower than that in the United States.)²⁹² However, progress in most areas has come to a standstill, and in many ways quality of life for a large segment of the population is deteriorating.

Much of this deterioration appears to be related to structural adjustment policies imposed by the World Bank and the IMF, and they are generally implemented through USAID.²⁹³ Rather than helping Costa Rica recover from its debt crisis, its debts have grown even bigger (through new bans tied to adjustment policies) and the earlier positive trends toward greater equality have been reversed.

Costa Rica’s adjustment program calls for increasing export earnings to service foreign debt. It does this, in part, by “forcing farmers who have traditionally grown beans, rice, and corn [maize] to plant *nontraditional agricultural exports* (NTAEs) such as ornamental plants, flowers, melons, strawberries and red peppers.” Incentives and tax/tariff breaks are given to larger growers for converting their farms by growing these NTAEs. According to Alicia Korten “Small farmers say that these policies are forcing them off the land and that the small farmer is disappearing as a productive social class.”²⁹⁴ Even the World Bank admitted in its 1988 *Costa Rica: Country Economic Memorandum* that “small holders unable to move into the new (nontraditional crop) activities might have to sell their land and become landless workers.”²⁹⁵

As more people in Costa Rica become marginalized, to maintain stability the government relies increasingly on its civil police, whose numbers have increased dramatically since the early 1980s. The rise in police brutality, eviction at gunpoint, and mass burning of squatters’ homes is a sad turn of events for a country that abolished its army in 1948 and has prided itself on a nonviolent tradition.²⁹⁶ Even USAID official Arturo Villalobos agrees that the concentration of land into fewer hands and the creation of vast numbers of landless peasants “has been a terrible blow to Costa Rican democracy, social harmony and the environment.”²⁹⁷

As Costa Rica has become more dependent on export crops and the fluctuation (mostly downward) of the international market, its economic difficulties have deepened. Money spent on the import of luxury goods for the rich outweighs the export income. The lifting of tariffs on basic grains from subsidized Northern agribusiness has undermined local production and driven even more farmers off the land. USAID economist Miguel Sagot suggests that “structural adjustment has increased the income gap in Costa Rica.” He notes that “Social services ... have also been deteriorating in the last years. Many people believe that this is because the government has switched its budget priorities from social services toward export promotion.”²⁹⁸ In reality, the Costa Rican government has little choice. If it does not comply with the adjustment dictates of the World Bank and IMF it will be locked out of North American free trade agreements and will lose its access to further loans. As Alicia Korten concludes, “Costa Rica’s leaders seem willing to sacrifice social equity, environmental sustainability and long-term economic stability for a place in the global market.” By following such a course, it appears that they may also be on the road to sacrificing ‘good health at low cost.’²⁹⁹

Kerala is one of the poorest states in India, but because its popular government for the past 30 years has given high priority to basic needs, this state far out-paces the rest of the country in terms of health and education. In Kerala over 90% of adults are literate compared to 52% for India as a whole. Kerala’s infant mortality rate is about 10 per 1000 live births (one of the lowest rates in the Third World) compared to 81 for India as a whole. A vigorous program of land reform has benefitted millions of Kerala farmers, who no longer toil on feudal estates. Kerala also has some of the best transportation, electricity, and water supply systems in India.

Yet rising costs and unfavorable terms of trade in the late 1980s and 1990s have made it increasingly difficult for Kerala to maintain its welfare-state model. Unemployment has swelled and inflation is eroding living standards.³⁰⁰ Like Sri Lanka and (to a lesser extent) Costa Rica, Kerala shows a divergence between its relatively low child mortality rates and quality-of-life indicators. Although child nutrition is better than in neighboring (wealthier) states, high rates of growth stunting and low birth-weight babies suggest that significant and widespread undernutrition persists in Kerala. (The Rockefeller study noted that rates of illness appear to have declined only in those causes related to immunization.)³⁰¹ Two local highly qualified researchers conclude: “The health status of Kerala presents an interesting picture of a low overall mortality coexisting with considerable morbidity, mostly caused by diseases linked to underdevelopment and poverty.”³⁰²

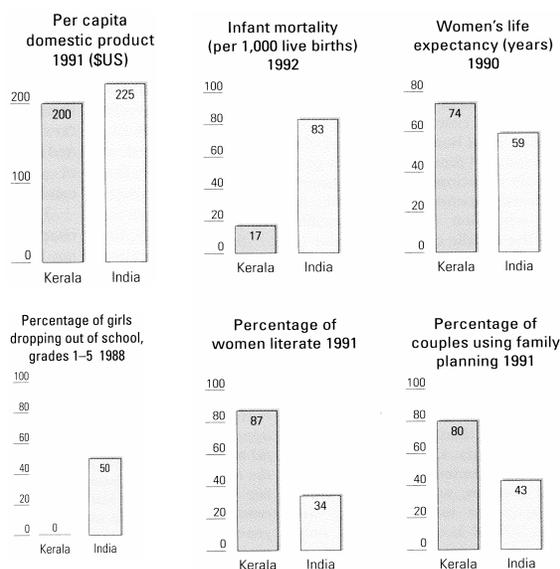


Fig. 3-20 A comparison of Kerala to the rest of India: economy, health, education and family planning³⁰³

This divergence between mortality and morbidity suggests that *health gains achieved through fundamental socio-economic change in the direction of overall equity, as was the case in China, are more secure against economic downturns than are health gains achieved through relatively superficial and more easily reversible welfare and health care policies, as in the other three examples.* In China, overall improvements in health—which included simultaneous mortality, malnutrition, and morbidity reductions—occurred as a result of improved socioeconomic conditions rather than of health care and public services alone. These improvements have therefore been more resilient.

However, in the present conservative global climate it remains to be seen whether even China's improvements will endure. With the country's steady shift toward a market economy, the barefoot doctors who were chosen by and accountable to their own communes are largely a thing of the past. With the introduction of private farms, the gap between rich and poor is again growing. As China falls more in line with the mainstream development model, its political commitment to equity appears to be slipping. Revealingly, during the early 1980s the number of underweight children in China rose by 10%; by 1990 one in five Chinese children was underweight.³⁰⁴ Will it be possible for China—with one fifth of the world's population—to sustain its achievements of *good health at low cost*?

Lessons to be learned from the "good health at low cost" countries

Despite the difficulties encountered by the four countries studied in *Good Health at Low Cost*, they illustrate that even very poor countries can achieve profound improvements in the health of their populations. They did this by following development strategies that gave top priority to making sure the basic needs of all people were met. None of the countries—at least during the period of greatest improvements—followed the prevailing *growth-at-all-costs* development model which promotes unbridled expansion of private large scale industry, in the hope that some of the aggregate wealth will trickle down to the poor. Rather they followed a *basic needs* approach to development that focused on equitable forms of service and/or production aimed at involving as large a sector of the population as possible. In agriculture, in order to make sure that all people's (especially children's) food needs were met, these countries reinforced traditional, small scale farming methods to grow local, low-cost food staples. Production was mostly for local consumption, not export. Depending on the country, property ownership ranged from private (Costa Rica) to communal (China). But in all four countries a cooperative, community approach to resolving problems and meeting mutual needs was encouraged. A spirit of sharing and working together for the common good was an underlying motif. In their own ways, these four countries offer strong arguments for a comprehensive, equity-oriented approach to meeting national health needs.

The Health Achievements of Cuba

China, Sri Lanka, Kerala, and Costa Rica are, of course, not the only countries or states that have made progress toward good health at low cost. Cuba, with a per capita income (GNP) only two thirds that of Costa Rica, has a significantly lower U5MR (11 as compared to 16). Not only are Cuba's levels of health, education, and overall social welfare superior to any other 'Third World' country, but in many ways they are equal, if not superior, to many of the Northern 'developed' countries. For example, Cuba has an U5MR equal to that of Israel, whose GNP is 10 times as high. And Cuba has a much higher child immunization rate than the United States, whose GNP is 20 times as high. Indeed, for immunization of children against measles and of pregnant women against neonatal tetanus, Cuba has the highest coverage rates in the world (98%). Cuba has also placed strong emphasis on equal rights of women, and has a higher enrollment ratio of girls to boys in high school than does the United States. Even with its increasing economic difficulties due to loss of Soviet support and a stiffer US embargo under the Clinton Administration, Cuba

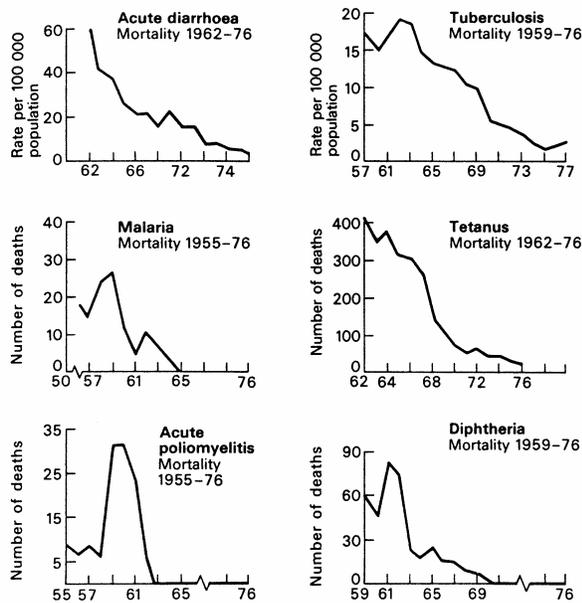


Fig. 3-21 Cuba's significant health gains³⁰⁵

has succeeded in making sure the basic needs of all people—and especially the nutritional needs of children—continue to be met.

However, Cuba was not included in the Rockefeller study. Nor are its spectacular child health achievements given any prominence in UNICEF's annual reports. The reason is clear: Cuba has followed a path of development radically outside that of the prevailing market system. By the United States it has been violently attacked, boycotted, refused development loans (until recently), and suffered repeated assassination attempts of its leadership. All this has been done in the name of US *national security*. But the most worrisome threat little Cuba poses to such a giant superpower is a development model that puts the needs of people before the profits of big business. Such a model—if permitted to succeed—could be dangerous to the *status quo*.

Cuba has managed, to date, to sustain the high levels of health of its children in spite of a 50 percent decline in its economy since the start of the 1990s. As with China, this may in part be because its comprehensive approach to health and well-being is rooted in revolutionary social change built on strong popular involvement.

Cuba has long used the slogan of "Power by the people!" (*¡Poder Popular!*). In some ways this citizen's power exists. But decision-making participation has been weakened, as in China, by a strongly centralized, authoritarian government. Unless Cuba and China succeed in making *poder popular* more of a practical reality, internal difficulties and outside pressures for free market modernization may undermine the enormous achievements of both these exceptional states.

Guyana's experiment with an equity-based alternative to structural adjustment*

Guyana, though rich in minerals and rainforests, is the poorest country in the Western Hemisphere. This small Caribbean country was once prosperous. But following independence from Britain in 1966 it was ravaged by a corrupt dictatorship that controlled most of the country's economic activity for its own benefit and that of the Northern powers that supported it.

In the 1980s Guyana became the most heavily indebted country in the world. Since 1988, 80% of government revenues have gone to service foreign debt. Under IMF-supervised adjustment policies, the value of the Guyanese dollar fell from 10 to one US dollar in 1988 to 144 Guyanese dollars to one US dollar in 1995. As part of adjustment, the country has subordinated the needs of the domestic economy to those of the international market place. Subsistence agriculture has largely been replaced by export crops. Forests have been cut and minerals mined for export to bring in short-term profit for servicing the debt. Budgets for health, education, and clean water have been slashed to pay for loans to finance the development of exports.

A few local elites benefit, but most of the people gain little and lose much. Throughout the 1980s and into the 1990s, malnutrition, child death rates, disease, unemployment, and overall poverty rose dramatically, as did crime, drug trafficking, street children, and prostitution.

An alternative path based on people's needs.

Then in 1992, in the first free election in 30 years, the people of Guyana elected Cheddi Jagan of the People's Progressive Party as their new president. Jagan had been overthrown 30 years earlier in a US-assisted coup.

At first, IMF policies kept Jagan from implementing social and economic reforms that could effectively combat poverty. But in August, 1993, the citizens of Guyana joined forces with the Bretton Woods Reform Organization (BWRO) to create the first concrete alternative to SAPs, called the Alternative Structural Adjustment

*This account of Guyana's alternative development strategy is adapted from "Guyana Takes on the IMF" by Susan Meeker-Lowry in the summer 1995 issue of *In Context*. Susan is the author of *Economics as if the Earth Really Mattered* (1988) and *Investing in the Common Good* (1995)—both published by New Society Publishers.



Program (ASAP). Heading the BWRO is Davison Budhoo who, after 12 years of working for the IMF designing SAPs, resigned in disgust. In his open letter of resignation, titled “Enough is Enough,” he said that he hoped to “wash my hands of ... the blood of millions of poor and starving people.”³⁰⁶ For two years Budhoo had been the IMF resident representative to Guyana, which is now the base for the BWRO.

Guyana’s new alternative to structural adjustment goes far beyond UNICEF’s rather cautious *Adjustment with a Human Face*. According to Budhoo it “involves democratically designing a comprehensive ... economic policy to meet the basic needs of the entire population.” The first step is to form a national committee which is responsible for getting input from all affected sectors and groups.

Through a series of seminars and symposiums, a core group of people eager for an alternative development strategy brought together representatives from labor, women, educators, farmers, business people, and indigenous peoples. Together they discussed and formulated an economic development plan aimed at meeting the needs of the people of Guyana. According to Susan Meeker-Lowry,

The result is an approach in marked contrast to that of the IMF and World Bank. It is based on

the principle that a healthy economy does not rely on exports for income and on imports for daily needs. Rather, a healthy economy provides for the needs of the people in a sustainable and egalitarian way that fosters self reliance.

Sustainable agriculture is a key component of the Guyana alternative. Exporting raw materials and importing processed products is no longer encouraged. Instead, domestic food production and domestic consumption receive priority. Crops are diversified, and nontraditional crops—which both lower the cost of food and increase employment—are encouraged.

This approach also promotes a broad economic base with priority given to small-scale, labor-intensive enterprises. Appropriate rural infrastructure is emphasized, including roads, communications, and affordable energy and technology. Friendly credit promotes local business development through Grameen-type banks, which make small loans at low or no interest, using a peer group lending process.

The Guyana [alternative] rejects the IMF freeze on social sector spending, asserting that “increasing the standard of living of the majority must be the first and foremost objective.”³⁰⁷

Deforestation has been a major issue; Guyana has one of the largest remaining rainforest areas in the world. However, most of it has been leased for exploitation by transnationals, which, under terms of the IMF’s SAP, were offered a 10-year exemption from taxation. The resultant heavy timbering was rapidly destroying the environment of Guyana’s indigenous forest dwellers.

As part of the new alternative to adjustment, an International Rainforest Tribunal was appointed to review the government’s agreement with logging and mining TNCs. The tribunal will declassify and renegotiate the secret contracts between the government and the TNCs and facilitate the reformation of the currently nonfunctioning Guyanese Natural Resources Agency. It will also ensure the indigenous people that their land titles will be honored and that they will have a strong voice in all development affecting them.

In 1994, President Jagan declared the IMF program for Guyana “massively flawed and inappropriate” and agreed “to cancel the IMF SAP and renegotiate with that institution on the basis of the conclusions and recommendations of the people’s ASAP.” The Guyanese do not expect the IMF to agree easily to the alternative plan

because of its emphasis on self-reliance rather than on serving the world market. But Budhoo and other social activists see this new approach as the beginning of a global movement for more people-friendly alternatives. A “big splash” is predicted when India and the Philippines stand up to the international financial institutions to push through their alternative, equity-oriented approaches to development. Already, in 1993 in India, half a million people, mostly farmers, protested against

the IMF/World Bank agricultural policy and GATT (General Agreement on Tarriffs and Trade).³⁰⁸

Budhoo asserts that “Guyana is important because we need to show it can be done ... We are not speaking about technical problems in international finance, we’re speaking about our role in shaping the destiny of human-kind and about the legacy that we will leave to generation upon generation yet unborn.”³⁰⁹