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**Health Policy Reforms and the Poor in the Global South**

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## **Health Policy Reforms and the Poor in the Global South**

The developing countries in the Global South have been implementing health care reforms for over a decade. Beginning with the 1993 *World Development Report: Investing in Health*, health care in the developing countries, like its counterpart in the United States, began to be accepted as a private good rather than a basic human right. The policy approach to health reforms is largely determined by the suggestions contained in the structural adjustment programs of the 1980s that facilitated the prevalence of the market model over the state model of development across the Global South as well as the former communist bloc. The basic postulates of the market model of health care prescribe that developing countries play limited role in financing health care, privatize health care except most basic services, cut down the size of the public health sector and reduce public spending on health, introduce private insurance and facilitate foreign investment in the health sector. The World Bank-prescribed health reforms package now constitutes an integral part of health policies in most developing countries, particularly the aid and loan recipients.

This paper explores the factors, internal as well as external, that played significant role in the introduction of health care reforms in the Global South and the impacts the reforms are making on the poor in terms of access to health care services and their health conditions. It builds on the argument that health care reforms cost the poor dearly and violate their basic human rights to stay disease-free and lead a healthy life. The denial to poor people's health rights are perpetuated by a host of factors, including growing income inequalities, elimination of health equities, dismantling of public health systems and the expansionary grip of private sector health services.

### **The Developing Countries and Health Care Reforms**

Traditionally, health care was a public responsibility in most developing countries. After independence in the 1950s and 1960s, the post-colonial states in the

Global South undertook the responsibility to build and maintain health care infrastructures including hospitals, clinics and laboratories, managed health services personnel and imparted medical education in the society. Their health service systems which were obviously shaped by colonial rulers were not definitely efficient or equitable but the poor had better access to health services (Gish, 2004: 22-25). The curative care-oriented colonial model was allowed to continue; governments in various parts of the Global South at the same time adopted health development plans and financed health care services to include the poor people. Programs to fight malaria and tuberculosis received special significance and funds were more or less diverted to such high priority areas.

The post-independence health care systems faced a series of economic challenges in the 1980s, including declining commodity prices, collapsing fiscal regimes and most notably structural adjustment programs (SAPs) initiated by the World Bank in 1980. The SAPs, which anchor on the three basic elements of downsizing the government, deregulation, and privatization of the economy, contributed most to the destabilization of the public health systems. The World Bank-prescribed health policy reforms are but a part of the overall structural adjustment program. A brief look at the basic components of the health reforms package would confirm this contention. The reforms package rests on four basic elements – the introduction of health insurance, user fees for health services, decentralization of health services management, and a role for private service providers and the NGOs in service provisions. Certain internal developments also set the stage right for a reorientation in health policy and objectives. Declining commodity prices created many fiscal difficulties for the developing countries in the 1980s. Governments, in some cases, failed to pay health staff regularly, hospital began to charge patients for drugs and surgical supplies, nursing care was becoming unavailable. Rich people began to take advantage of private health services; the poor started to suffer as they lacked the resources to pay for rising health care costs (Standing, 1999; Standing and Bloom, 2001).

Responses to the health challenges by different governments varied until the World Bank came up with its own mega health reform proposal in 1993. The Bank made its intention of intervening in the health sector of the developing countries as early as

1987 with the publication of the report *Financing Health Services in Developing Countries: An Agenda for Reform* (The World Bank, 1987). The 1993 report *Investing in Health* further builds on the basic objectives outlined in the 1987 report. The two reports are premised on achieving two sets of objectives: to transfer health policy and services to the private domain, and streamline health policies to the priorities of fiscal adjustments. The first objective required that except limited public undertakings health would be primarily a private responsibility while the second objective required reductions in public expenditures, especially in the health sector.

The Bank's shift in policy approach from the public to the private sector is based on three arguments: (a) the poverty of the state, that is, scarcity of resources would make the state incapable of providing health services to the people; (b) the inefficiency of the public sector to respond to people's health needs and resource management that, in effect, justifies privatization of health services; and lastly, (c) the need to ensure equity in access to health services. The Bank argues that state resources allocated to the public health sector benefit the rich people and that the introduction of health insurance coverage would make justice to the poor (Laurell and Arellano, 2002: 199-200). What is missing from the health reforms package is a discussion on the possible sources of money the poor people can capitalize on to buy health insurance coverage. There was also a lack of sound thinking about the possible consequences health reforms would produce in the resource-poor developing countries. The current crisis in the public health sector in the Global South is largely viewed by many analysts as an outcome of the adjustment policies that led to under-funding of public health services.

In line with its proposed approach to health policy, the World Bank continued to put more faith in private health management to improve cost control, promote efficiency and provide quality service to all people. Governments were expected to make health interventions in few areas, including programs of immunization, anti-tobacco and alcohol programs, distribution of low-cost drugs to combat intestinal worms, AIDS prevention educational programs etc. All health services, other than the abovementioned most basic ones, are to be managed by private sector actors. The Bank identified three sets of actors

to efficiently execute private health services: the individual and the family, non-profit organizations, and private economic forces in the market place (see Laurell and Arellano, 2002: 198-199). A combined operation of the three sets of actors, the Bank opined, would produce better medical services available to rich and poor people.

The individual persons, according to the Bank, should be responsible for their health and satisfy their health needs based on service availability in the market. The question of financial capability of individual persons or the family to purchase market-based medical services was bypassed. The non-profit organizations, more specifically the non-governmental organizations (NGOs), were assigned a special role to provide medical care to the too poor who are likely to be lost out in the new system. The Bank recommended that the NGOs should get fund from the government and handle health problems previously managed by the public health sector. Additionally, the participation of private medical care providers in the health market would promote competition in extending health insurance coverage and making health supplies available at competitive price.

There are two major objections to the World Bank's policy approach for an expanded role for the private sector actors in health services management. Critics point out that the Bank developed its health reforms package based on the American model of private managed care. Health services in America are managed by three sets of actors – private care organizations, insurance companies and the pharmaceutical companies. All three sets of actors are driven by profit motives and operate from a biomedical perspective. A series of economic and organizational issues like reductions in health costs, promotion of efficiency and health equity, and consumers' satisfaction dominate the American health system. The government also plays a significant role by extending generous financial support to the health management system. The total allocation of resources to the health sector in America far exceeds the allocation of any other country in the world; the American per capita expenditure on health is more than five thousand dollars per year. Still, in terms of access to health care services and facilities, America fares badly in the community of nations. As of today, around 40 million Americans,

including 10 million children, have no health insurance (Fort, 2002: 4; Rylko-Bauer and Farmer, 2002: 476-506). Despite visible defects of the American model, which is also labeled as “one size fits all” approach, the World Bank decided to implement the private managed care model across the Global South.

More importantly, the World Bank’s “one size fits all” approach came as an assault on the primary health care systems designed and promoted by the Alma-Ata Declaration of 1978. Drafted and endorsed by countries world over, the Alma-Ata Declaration recognized health as a fundamental human right, addressed the root social, political and economic causes of illness and poor health and recommended solution to the health problems of the general people within the broader framework of social development and the spirit of social justice. The Declaration emphasized primary health care through community organizing dominated by a concern for the poor. The basic areas governments were advised to take actions included provision of food and nutrition for the people, education about disease and health problems, safe water and basic sanitation, immunization against major diseases, maternal and child care, appropriate treatment of common diseases and injuries, and provision of essential drugs (Hong, 2002: 28-29).

Opposition to the Alma-Ata Declaration soon began to unfold. A number of American organizations, particularly the Rockefeller Foundation, the Ford Foundation, and the Population Council found the community-based health initiatives too radical, expensive and unfeasible. These organizations proposed selective primary health care, avoided the emphasis on socioeconomic development and assigned a special role to health experts to determine health priorities based on a cost-effective approach. They argued for selective interventions in areas like child and adult mortality reduction and discouraged governments from adopting ambitious health programs. Community involvement in health policy-making and implementation was largely avoided (Hong, 2004: 29-30). The World Bank’s approach to health reforms can be viewed as the culmination of this long American position on health problems and related issues in the developing world.

Needless to say, the private actors-centered health reforms package created tremendous reactions around the world. The Bank, however, successfully overcame the opposition due to a host of factors at its disposal. Although the Bank is primarily a credit institution mandated to extend loans and technical services to the developing countries, it began to take active interests in the formulation of social policies at the start of the 1990s. The *1990 Report on Poverty* signaled a milestone in such intervention. Accordingly, it used its credit instruments to impose the proposed health policy reforms on the debtor nations (Laurell and Arellano, 2002: 191). The Bank particularly made use of its influence in the ministries of finance and health to make its health package acceptable to different governments. The International Monetary Fund (IMF) is also known for the use of its lending capacity to influence policy-making processes in the Global South and joined hands with the World Bank by the late 1980s to bring about important policy changes in various developing countries. Loans, granted under the new program “Enhanced Structural Adjustment Facility” (ESAF), put into effect in 1987, are an effective IMF weapon against the low-income developing countries. Governments receiving ESAF loans must satisfy a number of IMF set criteria, including reduction in government spending and involvement in the economy, deregulation and privatization of the economy, elimination of price subsidies, trade liberalization and imposition of consumption taxes (Kolko, 2002: 174).

The World Bank’s aggressive stance on the health reform issues since the mid-1990s has turned it into the most influential global health actor. It has already effectively outmatched the World Health Organization (WHO), the traditional international health actor, in terms of credits for the health, nutrition and population sectors of the developing countries. By the mid-1990s, the Bank’s total volume of health lending reached 13.5 billion dollars; the lending jumped from \$1160 million in 1995 to \$2350 million in 1996. The WHO health grants, in contrast, reached a staggering \$900 million per year throughout the 1990s (Abbasi, 1999a: 866).

While the World Bank made best use of the credit instruments to pressure the developing countries to accept its health reforms package, a number of other global

economic developments stripped the developing countries of their capacities to design and implement independent economic policies including health. The most destabilizing development was the debt crisis of the 1980s. The oil crisis of 1973 resulted in a drastic increase in oil prices per barrel from \$7 in 1973 to \$35 by 1981 and a corresponding boom in bilateral and multilateral lending. This unexpected windfall of money led the oil producing countries to invest oil dollars into Western banks that, in turn, extended loans to non-oil producing developing countries. Initially, interest rates were low and loan conditions were soft but the situation radically changed in the late 1970s and early 1980s when the developed countries raised interest rates, extended subsidies to their agricultural and industrial products. The result was a relative decline in the prices of developing countries' agricultural exports (Federal Deposit Insurance Corporation, 1997: 191-210) and a debt repayment crisis followed.

The total external debt of the developing countries was US \$59 billion in 1960; in 1990 debt servicing alone amounted to \$160 billion and by 1997 it jumped to \$270 billion. The highly indebted countries now spend \$13 on debt repayment for every dollar they receive from the creditors. Brazil as the highest indebted country had to pay \$30 million per day as interest payments and Mexico's minimum urban salaries fell by 50 percent as a result of continuous devaluation of its currency between 1980 and 1990 (Sen, 2001: 141). The anti-debt movement initiated by the NGOs, most notably Jubilee 2000, created moral pressures on the World Bank and the IMF to cancel debts of the poorest countries. The World Bank responded with its program of Heavily Indebted Poor Countries Debt Initiative and offered debt relief to the poorest countries provided they accept policy prescriptions of the Bank to improve their economic performances. Only 20 out of 52 heavily indebted countries were identified as eligible for debt relief; Uganda was the first country to receive debt relief benefits in 1998 (Abbasi, 1999a: 867). Despite temporary relief in debt burden, some heavily indebted countries still continue to pay more on debt servicing than spend on public health. For example, Mozambique that qualified for debt relief pays \$55 million on debt service while allocates only \$42 million to the public health sector on an annual basis (Gloyd, 2004: 53).



A related economic development that further worsened the debt situation and greatly paved the way for health reforms package was the steep decline in development assistance in the 1990s. The shift in geopolitical interests of the Western powers in the wake of the collapse of the communist bloc in the former Soviet Union and Eastern Europe was the principal reason for this decline in assistance. Development assistance, as a percentage of GNP, fell by more than 50 percent between the period 1965 and 1998. Whatever aid and assistance the developing countries received in the 1990s and beyond were channeled through the NGOs which were considered more efficient in aid distribution and running development projects (Randel, German and Ewing, 2000: 3).

A group of powerful social forces from within the developing countries support structural economic adjustment and health reform policies. The support and collaboration of this powerful group is vital to the programs of the World Bank and the IMF. Strong support for the deregulation and privatization of the economy and trade liberalization came from the business and industrialist classes in many developing countries. This group buys privatized factories and state enterprises, benefits from relaxed trade regimes by importing and flooding domestic markets with quality foreign goods the middle class prefer to buy (Nuruzzaman, 2005: 122). The health sector of the developing countries is dominated by a different group of powerful actors who maintain close relations with the business and industrial sector elites. Included in this powerful group are the medical and nursing establishment, government decision-makers, and financial magnets who are ready to invest in health infrastructures, operate health insurance companies and import medical supplies. Market provisions in the medical sector mean a window of business opportunity for this group.

It may be mentioned that this powerful group opposed the community needs-based primary health care systems envisioned by the 1978 Alma-Ata Declaration. The Declaration's emphasis on digging out the socio-economic and political causes of ill-health of the poor posed threats to their vested interests; keeping health services in their hands was considered a vital step to protect their interests (Werner and Sanders, 1997:

16). The privatization of health services would bring for this group new opportunities to enhance their control over the health market and make handsome profits.

### **Health Reforms and the Poor: the Multiple Impacts**

It is important to note that health policy reforms do not affect all societal groups equally. The better-off sections are rather benefited; market provisions allow them to approach private sector service providers and buy required health services in the market place. The situation of the poor people who mostly depend on subsidized public sector health services is quite different. Lack of resources effectively prevents them from access to private medical care and this is a common problem in many developing countries. The impact on Southern African countries has been particularly devastating. As early as 1989 the Economic Commission for Africa (ECA) mentioned that the cuts in public social spending resulted in a 50% decline in health expenditure and 25% decline in education expenditure in the Southern African countries that were undergoing structural adjustment programs (ECA, 1989).

In South Asia, India and Pakistan were exhorted by the World Bank and the IMF to reduce government social spending, including health. Before India submitted to the World Bank/IMF structural adjustment programs in 1991, the union government financed 23% of public expenditure for health. In 1992, the government reduced its health spending by 20% and the reduction hit hard the health programs critical to the poor. Budgets for public malaria control and eradication of tuberculosis programs were cut by 40% (Banerji, 2001: 47). Similarly, Pakistan that started implementing structural economic reforms in the late 1980s reduced its social expenditure from 3.4% in 1987-88 to 2.8% in 1990-91. There was a marginal increase in social expenditure to 3.3 percent by 1996-97 but still low compared to 1987-88 level (Bennett, 2001: 55). In general, health spending in the low and medium-income countries either remained constant or dropped in the 1990s while allocations for education in the low-income countries decreased considerably, from 3.43% to 3.25% in the period from 1990 to 1996 (Cornia, 2001: 837).

Cuts in public health spending simply mean the shrinking of poor people's access to health care facilities. Withdrawal of medical subsidies resulted in huge shortages of medicines and vital basic supplies like gauze, bed sheets, IV tubes, surgical tools and hospital food. The poor depend on public health supplies but the transfer of the costs to the poor in the form of user's fees and purchase of medicines from the private markets have created new health concerns for them (Gloyd, 2004: 50). In some countries, poor patients must pay before they can have access to medical care. Ghana may be cited as a terrible example. The hospital authorities in Ghana hold the poor patients hostage and refuse to release the patients until their family members or relatives bring money to pay the medical costs incurred (Grusky, 2002).

The state of declining health situation of the poor cannot be explained by the single factor of reduced spending in the public health sector. A number of external and internal factors are active behind it. The problem started with a rise in global income inequalities between and within the rich and poor countries. It is a common wisdom that income inequalities between the rich and the poor greatly widened in the last two decades of economic globalization. Until the year 2003, the per capital income in the 50 least developed countries was US \$295 while per capita income in the industrialized countries rose to US \$ 28,210 (UNICEF, 2004). The income gap between the top 20 percent richest and the bottom 20 percent poorest people rose from 30 to 1 in 1960 to 74 to 1 in 1997 (UNDP, 1999). A number of proponents of globalization, however, find the distributive impacts of economic reforms neutral and the level of income inequality within countries stable (Dollar, 2001; Li, Squire and Zou, 1998). Said differently, economic globalization, according to the proponents, did not promote economic disparities between and within nations and that the introduction of economic reforms may not explain rising global and national inequalities in income and resource distribution. Other studies, however, refute this claim of the proponents of globalization.

Cornia and Kiiski (2001) conducted a comprehensive study on the domestic trends in income distribution in 73 countries between the period 1950s and 1990s. Their study found that in the last two decades income inequality rose in 48 countries, a decline

in income concentration in nine small and medium-sized countries (such as Honduras, Jamaica, Tunisia, France, Malaysia etc.) and constant income concentration in 16 countries (such as Bangladesh, India). L. Taylor (2000) carried out a similar study on the impacts of economic reforms in 18 developing and transitional countries covering the last two decades of the 20<sup>th</sup> century. Taylor divided the study period into 21 reform episodes and found rising income inequality in 13 cases, constant inequality in 6 cases and a reduction in income inequality in only 2 cases.

Naturally, the rise in income inequality has seen a corresponding rise in the number of poor people exactly because rising income inequality results in extreme polarization in wealth and poverty. Poverty alleviation programs adopted in the 1990s failed to keep pace with greater income polarization, despite an increase in average per capita income. The situation is particularly acute in rural areas where majority people in the developing countries live (Ravallion, 2001). The rise in global poverty from 1 billion in 1977 to 1.3 billion by the end of the 1990s forced a rethinking of the poverty issues by the World Bank and the G-7 Group. The World Bank, in its 2001 report, mentioned that although there was a decline in the incidence of poverty in the developing countries from 28.3% in 1987 to 24% in 1997 (based on US \$1/day), 40 developing countries with a total population of 400 million did fail to register any increase in their per capita income growth from 1970 to 2000 (The World Bank, 2001: 3).

Obviously, poverty and health of the poor became an area of major concern at the dawn of the 21<sup>st</sup> century and the emphasis on the multiple links between poverty and poor health became common. The World Health Organization (WHO) set up the Commission on Macro-Economics and Health in 2001. The Commission, in its report *Macro-Economics and Health: Investing in Health for Development*, recommended US \$27 billion international investment in health per annum over the next five years (WHO, 2001). International response, particularly from the western wealthy countries, was not that much promising. There was no call for redistributive justice to promote the economic capability of the poor either.

The inequalities in income or consumption between the rich and the poor across the developing countries, presented in Table – 1, gradually reduced the poor people’s capacity to buy essential items, including food, health care, education etc. Many countries in the Global South, particularly in Africa (such as, Botswana, Burundi, Central African Republic, Ethiopia, Kenya, Malawi etc.), South-East Asia (Bangladesh, Bhutan, India, Myanmar, North Korea etc.), South America (Bolivia, Ecuador, Guatemala, Haiti,

**Table - 1**

Inequality in income or consumption in some selected developing countries

Countries	Survey year	Share of income or consumption (%)			
		poorest (10%)	poorest (20%)	Richest (10%)	Richest (20%)
Bangladesh	1995-96	3.9	8.7	42.8	28.6
China	1998	2.4	5.9	46.6	30.4
India	1997	3.5	8.1	46.1	33.5
Malaysia	1997	1.7	4.4	54.3	38.4
Mozambique	1996-97	2.5	6.5	46.5	31.7
Nepal	1995-96	3.2	7.6	44.8	29.8
Nigeria	1996-97	1.6	4.4	55.7	40.8
Pakistan	1996-97	4.1	9.4	41.1	27.6
Philippines	1997	2.3	5.4	52.3	36.6
Sri Lanka	1995	3.5	8.0	42.8	28.0
Uganda	1996	3.0	7.1	44.9	29.8
Zimbabwe	1995	2.0	4.7	55.7	40.4

Source: UNDP (2002), Human Development Report 2002 (New York and Oxford: Oxford University Press).

Nicaragua, and Peru) are faced with high child and adult mortality rates (WHO, 2004: 157). The reduced public health expenditure and the decline in poor men’s income largely explain high rate of child and adult mortality.

Unbridled expansion of private medical services also contributes to the decline in health condition of the poor. In some developing countries, most notably Bangladesh

and Pakistan, private medical sector outperforms the public medical sector. Access to medical care is determined not by need but the ability to pay. Pakistan's tryst with private initiatives in the health sector started specifically in the second half of the 1990s. The government adopted a national health policy in 1997 and finalized a social action program in 1998. Prior to the adoption of these two programs, the government slowed down the pace of economic reforms in the mid-1990s that made the World Bank and the IMF unhappy and these two institutions soon cancelled all loans to Pakistan. There was an impending economic crisis and the government negotiated a stabilization package with the IMF, finally agreeing to implement structural reforms. The national health policy of 1997 was premised on decentralization of health management, community-based health initiatives, introduction of the use of health insurance, NGOs involvement providing health services and so on (Abbasi, 1999b: 1135). Since 1997, private sector has been the principal medical service provider in Pakistan. Private health sector that has extended its grip up to the remote rural areas accounts for 75% of the total expenditure by patients. Government appointed doctors obsessed with profit-making motives often set up private clinics while leaving the public sector health facility to a medical auxiliary or technician (Zaidi, 2001: 280).

In Bangladesh, private medical service provisions also came as a component of World Bank/IMF loan package, although private doctors have been providing services on a limited scale since erstwhile United Pakistan days. Some changes that were introduced in the health sector following the World Bank health policy recommendations include introduction of user's fee for access to medical care, reduction in primary health care expenditure and a corresponding increase in family planning expenses, and provisions of public investment in private sector (Khan, 2001: 307-308). The rich people usually prefer high quality private medical care while the poor in urban areas use the public medical services and the rural poor are continuously deprived of medical facilities.

Both in Pakistan and Bangladesh, medical education through private colleges and institutes is a booming industry. A section of wealthy people in these two countries are deeply involved in private medical education. Private medical colleges take advantage of

high demand for medical education and usually charge tuition fees forty to fifty times higher than the tuition charged by government medical colleges. Parents who send their children to private medical colleges invest huge amounts of money and naturally expect a quick return from their children after graduation. The private medical graduates soon start their own clinics or hospitals equipped with latest medical supplies and charge patients high consultation fees (Zaidi, 2001: 287). Government medical colleges, in the face of subsidy withdrawal, continue to use old equipment and the wealthy people rarely visit publicly under-funded hospitals for treatment. Poor patients who lack the resources to buy private market services usually visit government hospitals and that access has also been trimmed by the introduction of user's fees.

The World Bank's health reforms package instructs the loan recipients to privatize health services and withdraw health subsidies but the Bank itself neither invests in health infrastructure development nor emphasizes the need for equity-oriented policies to ensure access to health facilities for all societal groups. The budgetary allocations to the public health sector in most developing countries are abysmally low and the Bank's policy prescription to reduce the already small financial allocations for public health forecloses any possibility of expanded public health programs beneficial to the poor (see Table – 2).

Equity-oriented health policy is also a rare commodity in most developing countries; a few countries like Sri Lanka and the Indian state of Kerala remain the exceptions. The post-independence central and provincial governments in Sri Lanka and Kerala were committed to socialist goals. Government leaders in a short period of ten to fifteen years after independence in the late 1940s carried out a series of revolutionary measures, the most important being free universal primary education, land reforms to benefit the poor, and basic curative and preventive health services for their respective people (Gunatilleke, 1984; Parayil, 2000).

**Table - 2**

Levels of total and per capita government expenditure on health in some selected developing countries:

Countries	Total expenditure on health as % of GDP			Per capita government expenditure on health at average exchange rate (US\$)		
	1997	1999	2001	1997	1999	2001
Bangladesh	2.9	3.1	3.5	3	4	5
China	4.6	5.1	5.5	13	15	18
India	5.3	5.2	5.1	4	4	
Malaysia	2.8	3.1	3.8	69	58	77
Mozambique	5.0	5.0	5.9	6	7	8
Nepal	5.4	5.3	5.2	4	3	3
Nigeria	2.8	3.0	3.4	4	2	3
Pakistan	3.8	4.0	3.9	5	5	4
Philippines	3.6	3.5	3.3	18	16	14
Sri Lanka	3.2	3.5	3.6	13	15	15
Uganda	3.9	4.1	5.9	3	5	8
Zimbabwe	9.3	7.9	6.2	39	17	20

Source: World Health Organization (2004), The World Health Report 2004 (Geneva: The World Health Organization)

The case of Kerala, which is one of the poorest states in India, is more interesting. With only US \$28 per capita expenditure on health by the end of the 20<sup>th</sup> century, Kerala achieved tremendous progress in health comparable to highly developed countries. Infant mortality rate in Kerala is 14 per 1000 live births and life expectancy at birth is 70 for men and 76 for women. In the United States the corresponding figures are 7 per 1000 live births and life expectancy at birth for men and women are 74 and 80 respectively. However, the impact of globalization is also landing on Kerala gradually. The reduction in social spending by the union government since 1992 has meant a decline in resource allocation from the centre to the state government. The incapacity of the Kerala state government to meet the rising demand for medical care has facilitated the introduction of private health services but despite new challenges the Kerala health model serves the interest of its people best (Thankappan, 2001).



A good number of other developing countries started with socialist regimes right after independence but the record of equity-promoting health policies are hardly known. And in this age of globalization, almost all developing countries are run by governments who prefer to align with the neoliberal governments and institutions in the west and who are also tied by aid and loan conditionality. The possibility for equity-oriented health programs aimed at promoting the health interest of the poor people appears to be slim. The lack of a good number of important variables, including pro-poor regimes (such as Kerala and Sri Lanka in South Asia, the African state of Zimbabwe that vigorously pursued redistributive efforts in health in the 1980s and 1990s, and Costa Rica in Latin America that extended health policy coverage to all its citizens by the 1980s) and nationally planned and supported health fund (such as, Chile where payroll deductions and public revenue subsidy finance the health care of all people) or introduction of universal health insurance (such as, Korea where the government created a national health insurance system in the 1980s and decided to subsidize the insurance funds for the bottom 8 to 10% of the people) point to a less promising pro-poor health system in most developing countries.

The array of internal social forces within the developing countries also works against the health interests of the poor people. These forces resist government efforts to reallocate public resources for the health benefits of the mass people. It is possible to identify two such powerful groups of social forces in every developing country. First, the group of political and bureaucratic elites. Politicians and high and medium-ranking bureaucrats usually enjoy free medical services and hospital facilities in many developing countries, including the South Asian states of Bangladesh, India and Pakistan. Public medical services at national and local levels are available for them at short notice. Since the existing medical service systems meet most of their health needs they have little interests in expanding health facilities to the poor people. This factor also explains why the World Bank proposed health policy reforms package did not meet any significant resistance from this powerful group. In contrast, the poor people are powerless and they continue to suffer.

Rural poor are the worst sufferers. Rural health facilities in all South Asian countries are extremely poor, especially in Bangladesh. Since independence in 1971, various Bangladeshi governments undertook ambitious programs, including the establishment of rural health centers and village doctors training scheme, to bridge the gaps between rural and urban health services but none of the programs was implemented firmly (Khan, 2001: 294-295). Consequently, a small percentage of rural wealthy people have access to quality medical care while the vast majority of poor people continue to use the services of unqualified private practitioners and traditional healers.

The second group that poses additional challenges to the health of the poor includes the doctors, nurses and their respective trade unions. Major government hospitals in the developing world are located in major urban centers and most doctors and nurses who work in the urban-based medical centers and hospitals oppose redeployment to smaller peripheral towns in rural areas. Most civic amenities in remote rural areas are lacking; doctors and other health workers make every attempt to ensure that the health service system remains centralized. The World Bank has added the component of decentralization in health policy reforms but the resultant outcomes of decentralization are not very much pleasant. Many experienced doctors have switched to the private medical market and those who are still working in the public health sector are neglecting their duties and responsibilities. Practical experience tells that many doctors transferred to the rural health centers become the usual absentees and the urban-based doctors who visit the rural health centers on a daily basis stay there for a few hours and return to their urban residences quickly. In the ultimate analysis, the poor people's health is not protected.

## **Conclusion**

The introduction of the market-based health model in the Global South is one of World Bank's most significant policy undertakings in the 1990s. The rationale of the health model rests on the basic premises of the structural adjustment programs the World Bank and its sister organization – the IMF formulated and gradually imposed on the developing countries in the 1980s. The acceptance of the model was not a free choice

made by governments across the Global South, rather an outcome shaped by the Bank's effective use of its financial leverage. The deteriorating macro-economic conditions in the 1980s, particularly the debt crisis, fall in commodity prices, and a decline in development assistance by the early 1990s largely paved the way for the emergence of the market-based health model. The support of internal social forces, primarily the business and industrialist classes, from within the developing countries further facilitated the introduction of the market-based health model.

The different societal groups in the developing countries are affected by pro-market health reforms differently. The wealthy people can buy quality medical services from the market place at competitive price and they have good reasons to view the private managed care system positively. But for the poor the new health model, in terms of costs and access to market-based services, has proved less beneficial. A number of adverse global and national developments largely shrank the poor majority's access to health facilities. The worldwide rise in inequalities in income and wealth distribution and a corresponding increase in poverty hit hard the poor people and also made them incapable of addressing their health needs. Reductions in social spending on health on the one hand and the continuous expansion of high cost private health services on the other greatly compromised the health care provisions of the poor people. The lack of equity-oriented health policies in almost all developing countries has dealt another serious blow to the health situation of the poor.

Access to health care services is a fundamental human right. The Alma-Ata Declaration of 1978 affirmed this right of all people some twenty-seven years ago; the United Nations Millennium Declaration, adopted in 2000, further reaffirmed this fundamental right by placing health at the heart of development. Inequalities in income and wealth distribution and lack of commitment to equity and social justice already led to an erosion of the health right of many people. The large-scale health interventions by the World Bank since the mid-1990s in the name of cost-cutting and efficiency promotion have made access to health services extremely difficult for millions of poor people. Whatever might be the rationale and arguments behind it, the World Bank's health reforms package has contributed to the violation of health rights in many countries of the Global South.

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