APPLYING THE LEECH

THE WORLD BANK AND THE POSSIBILITY OF HEALTH-PROMOTING STRUCTURAL ADJUSTMENT[i]

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1. Introduction

The World Bank's 1993 World Development Report[ii], *Investing in health*, is beautifully presented, well illustrated and highly readable, but yet it is dangerous. It is innovative methodologically and is peppered with studies undertaken by Bank staff or consultants working on the huge data bases held by the Bank. It reviews a number of the key issues in health and development and makes some sensible suggestions. And yet it is a dangerous document.

The report comprises:

- an overview of the health status of different populations around the world;
- an analysis of the conditions for better health, focussing on 'the household'; and
- policy recommendations, pitched at the country level, for achieving better health.

The report is a danger to the health of poor people in developing countries. The immediate danger is that it will mute criticism of structural adjustment programs (as presently imposed by the IMF) by creating the illusion that if such programs were complemented by the health policies recommended in this report they could actually enhance people's health ('health-promoting structural adjustment'). Perhaps more real is the danger that the report will sustain the perception that the only pathway to better health in developing countries is through economic growth and that this can only be achieved on the Bank's terms ('suffer now for better health later'). A longer term danger is that the report will shore up the illusion among people in the North that health advancement for poor people in the South is compatible with the way in which the global economy presently operates (the possibility of 'healthier poverty').

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2. Method of Critique

I have approached this evaluation of *Investing in health* in two stages, corresponding to two basic questions; first, "does it make sense?" and second, "what effects will it have?"

Does it make sense?

In my first reading of the report I have assessed the report in the terms of its own discourse. I have accepted the stated objectives at their face value and sought to evaluate the information presented, the methods used, the logic of the analysis and the practicability of the recommendations in the light of the stated objectives of the authors of the report. The basic question here is, "does it make sense?".

Applying this question to the report points to a number of anomalies in the policy recommendations which don't appear to be consistent with the stated purpose of the report. I shall describe these below in terms of individualism (the 'magic bullet'), reductionism and inconsistency. These are not trivial. They raise serious questions about whether the recommendations are practicable and whether the stated objectives are achievable. Having identified anomalies in the policy recommendations I then return to the information, the methods and the logic upon which these recommendations are based. Further examination of these inputs points towards issues of arbitrariness, selectivity and bias. The main instances of arbitrariness which I shall discuss arise in the conception and calculations of disability-adjusted life years (DALYs). The three main areas where selectivity and bias arise concern the information presented in the report, the use of DALYs to calculate cost-effectiveness, and the logic of the analysis underpinning the report.

In this review I discuss instances from all three classes of bias. I illustrate bias in presentation by discussing the optimistic gloss that the report casts on the improvements in health status around the world over the last four decades and the very negative depiction of 'government' as opposed to 'the market' in terms of delivering health programs. I illustrate methodological bias in the use of the DALY for measuring disease burden and in calculating cost-effectiveness. I suggest that two important 'conclusions' of the report were actually embedded in the methodology; first, that caring is essentially discretionary and ineffective; and second, that infrastructure development is not a cost-effective strategy for better health. The DALY method also greatly underestimates the burden of disability. I illustrate bias in the logic of the report by working through the very one-sided account provided of the relationship between economics and health. The report argues that economic growth is good for health and health development is good for economic growth. This presentation ignores the sacrifices of people's health that have been paid in order to achieve industrialisation in many different periods, places and political systems.

World view versus truth

It is apparent that I am really asking, "does it make sense to me?". In identifying and explicating these 'anomalies' (disjunctions between contents and stated objectives), I am relying on my own personal reaction to the report, my own sense of surprise or irritation. The anomalies are thus beacons which help to map the dissonances between the world view reflected in the report and my world view.

One important dissonance concerns the truth status of this report. The report presents its findings as the truth, or the closest so far attainable. I do not accept that there is a singular truth about these

issues. Rather there are many stories told by the many different players, to help to make sense of their realities, to help to inform their choices. These stories (and this report is one such story) themselves have a presence in the field of which they tell. The contentions between different disursive constructions of health and economics help to shape the processes and outcomes of which they speak.

What effects will it have?

In my second reading of the report I have sought to evaluate it as an event in the wider economic, political and social field. What effects will this event have?

In asking this question I have focussed firstly on the most optimistic promise of the report, the possibility of 'health-promoting structural adjustment'. Is this promise credible? The Bank's role in structural adjustment lending is by no means the only involvement of the Bank in health policy but it is the place where the report's prescriptions are most likely to be tried out and upon some of the world's most vulnerable populations. I shall conclude that, in view of the ambiguities and contradictions in the recommendations and the selectivity and bias in the methods and analysis, the promise of 'health-promoting structural adjustment' is not credible.

Evaluating the credibility of the fallback promise of "suffer now for better health later" requires that the report be located as an 'event' in North-South relations within the broader context of the global economy. Thus my conclusions about the credibility of this latter promise reflect a particular interpretation of what is presently happening in the world economy, which I shall refer to as the 'crisis deferred' scenario (outlined in more detail in Section 10 of this review). In this 'crisis deferred' story, structural adjustment programs (SAPs) are seen as helping to stabilise the global economy by maintaining the net flow of value from the South to the North. In these terms it may be concluded that the health policy recommendations of this report will do more to maintain the living standards of people in rich countries like Australia than to improve the health of people in severely indebted less developed countries.

Obviously there are other interpretations available about what is happening within the global economy including the more orthodox story which is told by the Bank, the Fund and modern neoclassical economics. Under this (the 'wealth through growth') scenario SAPs are unavoidable for heavily indebted out-of-credit economies and earlier rather than later. Without such adjustment these economies will inevitably deteriorate further in accordance with the inexorable laws of the new global market place. The constraints necessary for maintaining growth and achieving development place certain limitations on the framing of health policy. However, within these limitations the report's recommendations provide a practicable program for ameliorating the impact of structural adjustment, even using the opportunity to put in place more rational health systems and policies. Evaluated in terms of this scenario it is still unclear that the recommendations of this report could deliver 'health-promoting structural adjustment' but they might help to ameliorate the impact of such programs on health ('healthier poverty') and in due course they will (it is argued) lead to economic development and better health as a consequence of that ('suffer now for better health later').

My conclusion, on the basis of the 'crisis deferred' scenario, is that the promises of 'healthier poverty' and 'suffer now for better health later' are also unlikely to be redeemed for the vast majority of poor people in developing countries. However the report will create an appearance of the possibility of health-promoting structural adjustment and an appearance of the possibility of healthier poverty for people in developing countries and an appearance of countries being put on the right track

for economic development and better health. These appearances will help to shore up the legitimacy of the Bank and the Fund and the structural adjustment process generally.

The two scenarios mentioned are not to be regarded as scientific hypotheses, the truth of which will be determined by history. These are stories upon which people base their participation in the hurly burly world of politics and of policy-making. They are narratives that people draw upon in trying to make sense of economic change and in deciding how they shall act. These narratives are part of the political and economic contention which is presently shaping the future of the global economy. *Investing in health* is an intervention in this field of contention.

3. The Report's Argument

The report opens with an account of how better health contributes to economic growth. It reviews changing patterns of health globally over recent times.

The Bank's approach to measuring 'global disease burden' through the use of 'disability-adjusted life years' (DALYs) is then introduced: 'The global burden measures the present value of the future stream of disability-free life lost as a result of a death, disease or injury in 1990.' This is a central concept. An illness or injury taking place in 1990 will be represented in this measure in terms of the sum of (discounted and adjusted) years of life lost as a consequence of that event. Disabled life expectancy is represented in the measure as disability-free life years lost. The method starts with incidence data (or estimates) and passes these data through three processing steps. These are:

- an adjustment which converts levels of life expectancy with disability into disability-free life year equivalents (proportionately reduced according to the level of disability);
- an age weighting, with maximum value assigned to the 'productive years' (ages 15-40); and
- a discounting (3% per year) of the value of future years of life (expected or lost) according to how distant the year.

Thus a child who steps on a mine and dies at the age of 10 will be represented in this measure as the aggregate of expected life years lost (70 years being the shortfall from aged 10 to aged 80). Each of these years will be weighted with the relative values of each of the ages that he or she would have lived through (emphasising the value of the years from 15-40 and with diminishing weights placed on the older years). Each of the future years of life lost are then discounted according to how distant they are (their value, as a year of life, reducing by 3% per annum compounding).

If the child is permanently disabled rather than killed, the child's future years of disability are represented as years of disability-free life lost by adjusting the years of expected disabled life by a weighting factor (assigned by a group of experts to that 'class' of disability). Seventy years of disabled life expectancy might be judged to be equivalent to 20 years of disability-free life so the consequence of the original injury would be represented as 50 disability-adjusted life years lost. The aggregate of disability-free years of life lost so calculated is then adjusted with the age weights and discounted into the future as described above.

The DALY reduces the complexity of health status to one indicator, simplifying and rendering accessible what are otherwise very complicated data. The documentation of the global burden of disease in the text of the report and in the appendices provides a picture of where progress is being made and where people are being left behind. Some particular challenges are discussed in more detail, specifically AIDS/HIV and drug-resistant malaria and tuberculosis. Some of the reasons why mortality has declined are discussed, focussing on income growth, improvements in medical technology, the introduction of public health measures and the spread of knowledge about health.

This review of world health status is followed by an analysis of how health is created and the barriers to better health. This analysis is structured around 'the household' and focuses mainly on income and educational levels, in particular, women's education. It highlights also the interactions between these factors, in particular women's control over household buying power.

A recurring theme throughout the report concerns the role of governments in health care as compared with private providers. The report suggests three rationales only for government involvement in subsidising or delivering health care. These are:

- the alleviation of poverty through the provision of subsidised health care;
- the delivery of 'public goods' (eg area-wide control of disease vectors) or services with high positive externalities (eg treatment of STDs); and
- correcting failures in markets for health care and health insurance.

Having identified the principles which it suggests ought to determine decisions about government involvement, the report proceeds to the setting of priorities in relation to particular health programs. For this purpose some 47 public health and clinical interventions have been studied with a view to estimating their cost effectiveness. The benefits are expressed in terms of loss of DALYs averted. The cost data (per intervention or intervention-year) range from leukemia treatment (10 DALYs achieved for $10,000) to Vitamin A supplementation (1 DALY for just $1).

The report argues for priority in public sector spending to be assigned to interventions which address conditions which are responsible for high disease burdens (measured in DALYs) and which are cost-effective (in terms of the cost of reducing the loss of DALYs). On the basis of the proposed principles about the role of government and the estimates of disease burden and cost-effectiveness the report constructs a package of public health interventions and a minimal package of clinical interventions appropriate for government subsidy, preferably to be targeted to the poor.

The public health package includes: augmentation of the Expanded Programme on Immunisation, including micronutrient supplementation; school health programs to treat worm infections and micronutrient deficiencies and to provide health education; programs to increase public knowledge about family planning and nutrition, about self-care or indications for seeking care, and about vector control and disease surveillance activities; programs to reduce consumption of tobacco, alcohol and other drugs; and AIDS prevention programs with a strong STD component. The clinical package includes: tuberculosis treatment; management of the sick child; prenatal and delivery care; family planning; STD treatment; treatment of infection and minor trauma; assessment, advice and pain alleviation.

It is intended that governments should subsidise the minimal essential package for the poor; the provision of the minimal package to the non-poor would be provided through the private sector (supported by health insurance) or on a cost recovery basis if through the public sector.

The report claims that reallocation of government health spending on the basis of these principles would yield dramatic benefits in terms of DALYs. However, most developing countries would need to direct considerably more resources to public health (from $3-6 per capita per annum) and more resources to the basic clinical package (from $5-15 per capita per annum) under this regime. Assuming no expansion of government health budgets, many governments would have to reduce current public sector spending on what the report describes as 'discretionary clinical services' and 'subsidies to the non-poor' under this plan[iii].

The report reviews the various kinds of health care delivery systems operating in developing countries and then considers how the package might be financed. Public financing is recognised as desirable for the poor and the benefits, in terms of public acceptance, of having a universalist delivery system are also recognised. However the drawback of a universalist system, it is argued, is that it might involve subsidising benefits to the non-poor; for governments with very limited resources this might necessitate the introduction of means-tested user charges. In some cases a more targeted delivery system may be appropriate, especially where there is a separate private sector system for the non-poor. Another alternative is for services to be delivered through private providers funded (at least partly) through health insurance, with essential services to the poor subsidised through the insurance system.

There is a recognition of some of the problems associated with health insurance, including regressive subsidies, selection bias and cost escalation. The need to regulate health insurance is emphasised if it is not to reproduce inequities in access and lead to cost escalation. A number of options for the regulation of health insurance are discussed and suggestions are made for the more efficient delivery of publicly sponsored clinical services. Decentralised planning and administration and improved hospital management are highlighted in particular.

The final chapter pulls together three packages of recommendations to be directed respectively to low income countries, middle income countries and formerly socialist countries. The package for the low income countries comprises:

- increased schooling (especially for girls),
- investment in public health (the basic public health package outlined above),
- redirection of government funds to the essential clinical package (as above), and
- community financing (a combination of user charges and prepaid insurance).

The package for middle income countries comprises:

- phasing out of subsidies to better off groups (eg tax deductions for insurance premiums), and
- the extension of insurance (within defined regulatory constraints).

The package for formerly socialist countries comprises:

- improving the efficiency of government services,
- finding new ways of financing health care, and
- exploring competitive provision and changing the government role from provision to nurturing and regulation of markets.

These packages might be implemented simply because of the persuasive power of this report but the sharp point comes when countries seek World Bank aid, particularly in the context of IMF structural adjustment programs. The report acknowledges that structural adjustment usually involves cuts in public spending and price increases and that, at least, during the adjustment phase there have been health costs particularly among the poor[iv]. The report suggests that in 'early cases' structural adjustment was handled badly but argues that it was necessary to deal with 'severe economic imbalances' and was 'clearly needed for long-run health gains'. The report claims that the harm done to the health of the poor was actually the consequence of the "necessity for the country to curb its consumption; without adjustment loans, even greater decreases on consumption would probably have been necessary."

The report claims that economic growth following adjustment has generally led to improved health. It claims that public sector spending on health by 'adjusted' governments recovered within a few years to levels greater than that for non-adjusted countries. (The basis for these comparisons (see Fig 2.6) is not demonstrated.) The report acknowledges that:

> *[M]uch is still to be learned about more efficient ways of carrying out stabilisation and adjustment programs while protecting the poor.*[v]

The report considers the role of the 'donor community' in developing health care systems; it identifies a number of steps towards improving the effectiveness of aid for health:

> *The productivity of aid would increase substantially if donors were to direct more of their assistance to public health measures and essential clinical services, especially in low-income countries. They might also usefully focus on capacity-building, research, and reform of health policy.*

The report foreshadows the need for greater coordination of aid at the country level and for it to be informed by stronger national health planning capabilities. The Bank sees itself as well placed to take a lead in this coordination.

4. The 'Magic Bullet'

The public health package recommended in this report is strongly oriented to 'magic bullets' (vaccines, dietary supplements and antibiotics). The report claims that:

> *.. in many ways the Intensified Smallpox Eradication Program exemplifies the potential of today's medicine.*[vi]

This claim is not sustainable. The eradication of smallpox was a great achievement. It was achievable because smallpox as a disease was so well suited to a strategy of case finding, isolation and vaccination. Tuberculosis illustrates a very different disease ecology. The spread of tuberculosis is closely associated with social and economic circumstances; its successful treatment requires continued clinical supervision, social support and care in drug choice. The example of tuberculosis might point towards the need to consider change in social structures as part of a public health program.

Mass worm treatment for school children but leave water supply and sanitation to the private sector

The assumption that small pox eradication is an appropriate model for modern public health is reflected in the preoccupation with magic bullets in the Bank's public health package. This is well illustrated in the recommendations regarding mass treatment for round worm, hook worm and whip worm with albendazole and praziquantel.

> *Treatment usually cures the current infection, but in endemic areas children will inevitably become reinfected. A return to pretreatment levels of infection typically takes about twelve months for roundworm and twenty-four months or more for hookworm. Rates of reinfection can be reduced by environmental improvements, especially sanitation, but where this is impractical or unaffordable, it is cost-effective to repeat the therapy at regular intervals.*
>
> *The benefits of individual treatment can be significantly enhanced by community-wide treatment which, by lowering the overall levels of contamination of the environment with infective stages of the worms, slows the rate of reinfection.*[vii]

This enthusiasm for treating the worms stands in sharp contrast to the report's strictures against public sector financing of water supply, sanitation, garbage collection, housing, and sewerage connection all of which should be delivered through the private sector (an exception is made for trunk sewers and treatment plants). The government role should be to provide the regulatory and administrative framework within which "efficient and accountable providers (often in the private sector) have an incentive to offer" such services.[viii]

> *Health benefits alone do not generally provide a rationale for public subsidy of water and sanitation.*[ix]

The report argues for a 'demand driven approach'. It argues that: "[s]upply side failures are largely caused by inefficiency and unresponsive public sector monopolies"[x]. It cites Lima where poor people pay (an unsubsidised) $3 per cubic metre for water in a dirty bucket compared with middle class consumers paying 30c per cubic metre for tap water via a publicly subsidised water company. The report suggests that such problems are intrinsically related to public sector subsidy or provision. Another analysis might point to the greater efficiency of the public sector provider compared with the private sector and would assign greater importance to the economic structures which reflect and reproduce gross inequalities (of opportunity, access and of power) in such societies.

There is no analysis in the report of the failures of private supply in the newly industrialising countries of the 19th century and the successful experience of publicly provided water and sanitation[xi]. More recently the privatisation of water in the UK has been associated with increasing rates of disconnection for debt and an increasing incidence of dysentery and hepatitis A, particularly in those areas where the disconnection rates are highest[xii].

Micronutrient supplementation but no land reform

The report displays comparable enthusiasm for micronutrient dietary supplementation as a cost-effective strategy for malnutrition. The prevalence of iron deficiency (88% of pregnant women in India are iron deficient); iodine deficiency (responsible for 20 million cases of mental retardation)

and Vitamin A deficiency (13.8 million children with eye damage) are reviewed and strategies are suggested for delivering supplementation to appropriate target groups in a cost-effective manner (including adding Vitamin A and iodine to the 'EPI plus' schedule).

The report also estimates that 780 million people world wide suffer from an energy deficient diet; many are protein deficient also. Macro nutrient malnutrition is attributed to household income, female income and seasonal access. The dumping of cheap wheat and butter and the overcommitment to export crops with the discounting of food security are not considered. The main strategy suggested for addressing macro nutrient malnutrition is greater household buying power, associated with economic growth.

The report is scathing about the use of food subsidies. They are inefficient, hard to target appropriately and interfere with the orderly working of food markets.

> *There is a strong case for government intervention to improve health by improving nutrition, but not for interfering generally in food markets, except in extraordinary conditions such as famine. ... Reductions in mortality, blindness, mental impairment, and anaemia can make fortification and supplementation extremely cost-effective, comparable to the best control measures for other diseases. .. A year of healthy life can be bought for less than $10 with some micronutrient interventions and for less than $100 with programs that provide food supplements sparingly and combine them with behavioural change and health care.*[xiii]

Land reform is recognised as one strategy for feeding the poor but it is judged to be generally not practicable.

> *[I]n most societies providing health and education for the poor commands a degree of political assent that is altogether lacking for transfers of income or of assets such as land. Investing in the health of the poor is an economically efficient and politically acceptable strategy for reducing poverty and alleviating its consequences.*[xiv]

(The report's reluctance to address land reform may be related to the role of large land holdings in export agriculture and their links with the transnational economy. In this sense addressing the problem of hunger, through land reform, would be in conflict with the Bank's economic objectives.)

Education as a 'magic bullet'

The report's discussion of education is strikingly reductionist. In explaining why health standards improve across time the report points to the enabling role of general educational levels. As populations have become more educated new medical understandings have been more quickly converted into popular practice. This is a useful insight and well supported historically. However, this historical insight is then recast as an explanation of inequalities in health within contemporaneous populations.

> *Because educated people tend to make choices that are better for their health, there is often a strong relation between schooling and health.*[xv]

Data from a number of developing and industrialised countries are cited as demonstrating the links between educational levels on the one hand and morbidity, mortality and risk behaviour. However, it is unfortunate that the well known 'knowledge action gap' is not discussed in this context. Health differentials between people with different educational levels may be attributed to lack of knowledge

in some degree. Educational standards can also be a surrogate for income and wealth and this also helps to explain differing health chances. However, in many cases, the poorer health chances of less educated people are not explained by either knowledge or income.

In the industrialised countries 'life-style' diseases, such as those linked to obesity, smoking, alcohol and drug use and lack of exercise, are not entirely attributable to poverty nor to lack of knowledge. The possibility exists that the social relations of oppression and marginalisation (eg in the US ghettos) are more fundamental contributors to poor health than failure to take up 'good health messages'. In this view the experience of oppression, exclusion and marginalisation must be seen as part of the dynamic; poverty and lack of education may be consequences of such marginalisation as well as contributing to reproducing it.

The reductionist discourse of simple cause and effect is also evident in the discussion of the health consequences of alcohol and illegal drugs.

> *Within households, drinking often leads to assault and injury ..*[xvi].

> *As with alcohol, abuse of illegal drugs causes serious health and social problems.*[xvii]

There is no reference to the social exclusions that often underlie alcohol and drug use. Notwithstanding the reference to drug problems in the US there is no reference to its prevalence in the ghettos of US cities and its association with marginalisation and exclusion. There is no reference to the strategic alliances and covert operations which have been involved in sustaining drug suppliers. There is no reference to the social and economic factors which contribute to sustaining the drug trade in Asia and Latin America[xviii].

The reductionist discourse of cause and effect, of primary and secondary factors[xix] is too simple. It would be more useful to recognise a constellation of interrelated factors within a complex social and cultural system. The social relations of inequality, gender relations, economic and political relations would all warrant policy attention as part of such a constellation of factors.

It is paradoxical that the Bank should be so keen to defend structural adjustment programs which can be so far reaching in their effects but should be so coy about the kinds of structural change which might advance health, in particular, the redressing of social and economic inequalities.

Female education and health

> *[W]ell educated mothers reduce the damage that poverty does to health.*[xx]

Maternal education is a prominent theme in this report. Educated women, it appears, start their families later, make greater use of prenatal and delivery support services, practise better domestic hygiene and ensure better nutrition, immunisation, the wiser use of medical services and the procurement of safe water.

> *Education greatly strengthens women's ability to perform their vital role in creating healthy households.*[xxi]

The report argues for increased commitment to female education, not because of the oppressions and restrictions that women suffer in highly patriarchal societies but because increased female education will lead to better child survival rates. Many will see a paradox here, arguing for female autonomy on basically instrumental grounds.

The report reduces to simple cause and effect the complex links between female autonomy and health status. Caldwell has argued that the achievement of better health at lower cost by Sri Lanka, Kerala, Costa Rica, Cuba and China are linked, not just to female education and female autonomy but to a complex of historical and cultural factors which also includes a more equal spread of income and wealth and a political culture of populism and egalitarianism[xxii].

Patriarchy is more than girls not going to school; it is about how whole cultures work: the ways in which decisions are made, the ways in which people relate to each other. It is constituted by the norms which prevent men from participating more actively in child rearing and which limit women's participation beyond the household; the laws and customs which deny women the right to own land. The report does not consider barriers to achieving cultural and political change in deeply patriarchal societies, barriers such as: wide inequalities in household income which divide women from each other and weaken their solidarity; the denial of human rights which limit the scope of political action; patriarchal property rights (including dowry obligations) which tie wives and daughters to fathers and husbands; the absence of welfare provisions which might otherwise allow women to live independently; and barriers to the development of democratic institutions through which social change might be negotiated[xxiii].

The report is particularly unreflexive about the impact of structural adjustment and the preferred path towards economic development recommended by the Bank and the Fund on gender roles and relations. For example, the refusal of this report to countenance public sector expenditure on water supply has profound implications for the work of women in many countries. An Indian planner has commented that, "If men had to fetch drinking water, then 230,000 villages would not have remained without drinking water after 30 years of planned development."[xxiv] Similarly, the impact of commercial mechanised agriculture has had particular effects on domestic food production and on women's employment. "Among small family producers of a cash crop for the market, women are having to intensify their workload as unpaid family labour in order to compete with larger capitalist enterprises."[xxv]

Instances such as these, of the New World Order at work, are treated as invisible while the report recommends increasing expenditure on female schooling!

5. Policy Contradictions

There is a tangle of contradictions in the recommendations for the development of health services which are not reconciled in the report. There are contradictions between the targeted delivery of a sharply defined minimal essential package and the development of decentralised integrated district level services. There are contradictions between increasing competition between primary care providers and the possibility of developing public health leadership at the primary health care level. There are contradictions between the commitment to health insurance and the barriers to effective regulation of health insurance.

Delivering the essential health care package through integrated district health systems

The minimal essential package of clinical services, derived on the basis of DALY-based cost effectiveness, is central to the logic of this report. This might be taken as heralding a new set of

targeted, tightly controlled vertical programs but this does not appear to be the intention of the report. Speaking of the minimum package the report emphasises:

> *Efficient delivery of these essential services requires a well-functioning district health system consisting of health posts and health centres as the first point of patient contact and district hospitals as referral facilities, with the two levels linked by emergency transport.*[xxvi]

The report comments in various places about the inefficiencies associated with bureaucratically delivered vertical programs[xxvii] and the need to decentralise health service administration is emphasised repeatedly.

> *Government hospitals and clinics provide the bulk of modern medical care, but they suffer from highly centralised decision-making, wide fluctuations in annual budget allocations, and poor motivation of both facility managers and health care workers. Ministries of health and other government agencies often have only limited capacity to formulate health policy, implement health plans and regulate the private sector.*[xxviii]

> *In Ghana, until recently, decisions on health spending were highly centralised, with inflexible expenditure levels set by the Ministry of Health for specific 'vertical' programs such as immunisation, control of tuberculosis and leprosy, and family planning.*[xxix]

The report describes approvingly how in Botswana the government has devolved responsibility for primary care to local district councils with district health teams and the management of the primary care centres run by the councils. The report argues strongly for the development of district health services.

> *Governments should invest in district health infrastructure by ... expanding training programs for primary care providers, particularly nurses and midwives; targeting construction funds to improve health posts, health centres, and district hospitals; financing ambulances and other vehicles needed for effective emergency transport, together with the necessary radio and telephone networks and building the capacity to plan and manage health services at the district level and in individual facilities.*[xxx]

Notwithstanding the emphasis on the minimal package the health service administration recommendations do not point to the kind of managerial control that would be needed to restrict providers to the cost-effective delivery of the approved items in the package[xxxi].

Competition, community involvement and public health leadership at the primary health care level

There is little recognition, in the discussion of public health interventions, of the potential role of primary health care providers in advocacy and leadership for public health. In view of the tightly defined interventions included in the public health package this is not too surprising.

However, the report acknowledges the inefficiencies associated with campaign-based strategies for delivering immunisation as compared with including immunisation in an integrated program of 'routine services'.[xxxii] Perhaps there is an expectation that primary health care providers will be involved in delivering public health initiatives but again it is not clear that the decentralisation referred to above would be consistent with the delivery of tightly defined public health interventions determined on the basis of DALY cost effectiveness.

An integral part of the primary health care model advanced at Alma Ata was community involvement, in determining priorities, in advocacy and in mounting various programs. The report is notable for the lack of the rhetoric of community involvement which has characterised such reports produced through the World Health Organisation but it is nevertheless equivocal as to whether it is arguing for top down control versus community ownership. The warm approval of the Bamako Initiative (a community-based financing scheme) leaves the place of community control open[xxxiii]. There could be contradictions between local autonomy and the controllability essential to the 'efficiency' of selective programs.

The report argues strongly for the recruitment and training of community health workers. Among the necessary prerequisites for successful community health worker programs is that the community health workers are 'well supervised'[xxxiv]. This echos another long running debate in primary health care as to whether the community health worker should be conceived as a physician extender or a local public health leader[xxxv]. This has important implications in terms of organisational and power relationships. The reference to supervision implies hierarchical centre-periphery relationships which elsewhere in the report are criticised.

Further ambiguity centres around the place of competition in health service development. There are repeated endorsements for the wonders of competition in health care delivery, generally not matched by evidence or logic.

> *The private health sector typically serves a diverse clientele, and it typically delivers services that are perceived to be high in quality and more responsive to consumer demand than the government's.*[xxxvi]

> *The existence of alternative suppliers, both public and private, creates pressure for improved performance. In developing countries where the public system has a near-monopoly on health care delivery, a mixed system is likely to be more efficient and to improve quality of care.*[xxxvii]

Prepayment for a defined package of services through 'managed competition' is seen as a strategy for efficiency-promoting competition (although it is recognised that it carries a heavy administrative overload). On the other hand the report acknowledges that more coherent health care delivery systems can work.

> *But there are also examples of highly efficient public sector health centers and district hospitals ... and there are circumstances in which it is impossible or too costly to persuade the private sector to deliver care - particularly in geographically remote or extremely poor areas.*[xxxviii]

> *One way to eliminate these disparities would be to put all health facilities under a single administration and open them to all. Few countries have taken on this politically and administratively difficult task. Costa Rica, in which the social security agency manages all government hospitals, is a rare exception. Another solution is for the government to focus spending on the poor by investing heavily in the infrastructure (facilities, equipment, and transport) needed to improve essential clinical care for the poor and spending substantially more on the associated personnel and drugs. By focussing investments in peripheral health units (health centres, subcentres, and health posts) and on staff for these facilities, Malaysia and Zimbabwe have successfully upgraded separate clinical services targeted to the poor.*[xxxix]

There is no mention in the report of the importance of cooperation among primary health care providers and the developing of collaborative relations between primary health care providers and local communities, networks and organisations. The efficient delivery of programs (making pregnancy and delivery safe, the integrated management of the sick child and treatment of TB and STDs) all depend on cooperation among providers, on collaboration among primary health care practitioners, with informal carers, local community networks and with local institutions. This is necessary also in mounting public health interventions at the local and community level. Encouraging the development of competition at the primary health care level would seriously impair the delivery of the essential clinical and public health programs.

Health care financing

The report argues that government expenditure ought to be restricted to subsidising essential clinical services for the poor and public health interventions that are public goods or have high positive externalities. The third 'acceptable' role for government is in regulating health insurance.

Having discounted the possibility of a universal health care delivery system as a general solution the report is committed to some form of universal health insurance. It is not totally prescriptive with respect to the kind of health insurance it favours but it should be: universal, regulated so as to mandate community rating, based on prepayment principles rather than third party reimbursement of fee for service charges, not subsidised (except for the essential package for the poor), and perhaps based on employment-related contributions[xl].

The endorsement of employment-based insurance systems for countries with large informal economies and with widespread unemployment is surprising. It is clearly not based on considerations of efficiency with respect to the collection of premiums. It would seem a very direct way of establishing a two tier health care system, with private providers and employment related contributions for those in permanent employment and a publicly subsidised safety net (with user charges) for the rest.

Although the report suggests wider exploration of pre-payment systems and various forms of budget-holding by providers it acknowledges that there are no perfect models.

> *Surprisingly, emerging managed care institutions in developing countries often fail to cover benefits that would be in such an essential package. In the 1980s in Brazil, for example, many health maintenance organisations failed to include immunisations and family planning in the basic benefits package for their clienteles.*

The report notes the market failures commonly associated with health insurance: unfair subsidies; selection bias; cost escalations associated with fee for service compensation and third party reimbursement; and imperfect competition between providers, associated with monopolies and economies of scale. Regulated universal coverage is seen as necessary for ameliorating the effects of these market failures although the report recognises difficulties in establishing effective regulation of private sector insurers in developing countries.

> *Most governments also perform poorly in regulating markets for private services, including insurance. As recent research in Brazil has shown, the quality of medical care could be substantially improved at low cost if government discharged this role better. The rapid growth and almost total lack of regulation of private insurance in such*

> *countries as Brazil and Korea present another challenge for which governments are ill prepared.*[xli]

Nonetheless, the report would settle for self-regulation if necessary, "where the government's ability to regulate is particularly weak"[xlii]. Even where governments have a capacity for regulating the private health insurance industry, the report acknowledges that there are no clear policy models for regulation which guarantee both equity and cost effectiveness. When in doubt encourage competition:

> *In most cases, however, the primary objective of public policy should be to promote competition among providers - including between the public and private sectors (when there are public providers) as well as among private providers whether non-profit or for-profit. Competition should increase consumer choice and satisfaction and drive down costs by increasing efficiency. Government supply in a competitive setting may improve quality or control costs, but non-competitive public provision of health services is likely to be inefficient or of poor quality.*

In its recommendations for middle income countries the report urges the extension of insurance, for example, extending pay-roll based insurance to the whole population (likely to be difficult where there is a large informal economy) and wider competition among insurers:

> *...multiple semi-independent insurance institutions may still have advantages over a single large parastatal agency. Local insurance funds managed by boards composed of representatives of workers, employers and local government as in Germany, tend to be more accountable to their members. In a number of Latin American countries monolithic social security institutes are already heavily discredited because of past inefficiencies and corruption.*[xliii]

There are counter-arguments regarding the benefits of competition in health care markets and health insurance markets. In Australia, having a single national health insurance agency linked to the tax system has had huge pay-offs in terms of efficiency and reduced costs of administration. The publicly delivered tax funded National Health Service in the UK has maintained very tight cost control over many years whilst maintaining high quality care. It is intriguing that the achievements of the NHS in the UK in terms of cost containment and of the Australian Medicare scheme carry less weight than the untried 'managed markets' presently being developed in the USA. It is especially intriguing given the better health outcomes in the UK and Australia for much less in terms of outlays. Health service efficiency is perhaps not as important as creating opportunities for private business activity and private capital formation.

There must be health insurance; health insurance must be regulated; effective regulation is unlikely; there must be health insurance. The weaknesses of the report in the area of health care financing suggest again that policy constraints from beyond the health sector may have limited the options with which the authors of the report were able to work.

6. Selectivity and Bias in Presentation

The 'great advances' claim

The report offers a very optimistic account of developments in world health over the last four decades. The glass is very definitely 'half full'.

Countries at all levels of income have achieved great advances in health.[xliv]

This claim is based on the fact that only 10% of children die before the age of five years now; this is less than half what it was in 1950 (9.6% in 1990 cf 25% in 1950[xlv]). But this is indeed only half the story. In Sub-Saharan Africa, the absolute number of children dying before the age of five increased from 2.3m in 1950 to 4.0m in 1990. The absolute numbers dying in the age groups 5-14, 15-59 and 60+ have all increased also[xlvi]. In India there has been a 30% drop in the number of deaths before the age of five (from 4.4m to 'only' 3.2m) but over the forty years, 1950-1990, there has been no change in the numbers of deaths in the 5-14 group (static at 0.6m pa)[xlvii].

The report does not direct attention to the growing global health gap, the increasing inequalities between countries. In the following table the relative probability of dying before different ages is expressed as rate ratios, comparing the rates for developing countries to those for the industrialised countries. Expressed in these terms the global gap has more than doubled.

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

Table 1. The widening global health gap[xlviii]. Age-specific death rates expressed as the ratio DDC/(FSE+EME); the ratio of the age specific death rates in the demographically developing countries (DDC) to the combined rates of the formerly socialist economies (FSE) and the established market economies (EME).

Here are two different ways of interpreting the same data; they differ in their choice of unit of comparison, rates versus absolute numbers, and in their choice of reference framework, the same region across time versus contemporary standards prevailing elsewhere in the world. What is the proper unit of comparison? What is the proper frame of reference for the comparison? The choice of rates as the unit of comparison makes it appear that even in Africa there have been great advances (which is a bizarre way of interpreting a massive increase in the number of children dying each year). The kinds of assumptions which might justify the use of rates rather than absolute numbers would perhaps hold that changes in population health status are properly separated from population trends. "Sure, if you look at absolute numbers there may have been increasing numbers of deaths but that is because of population growth". The conditions for better health cannot be so simply separated from the conditions for population stabilisation.

The choice of an historical reference point only as the basis for the comparison recalls Rostow's linear model of development, conceiving the processes of economic development as unrelated to that

country's place in the system of global relations[xlix]. Improvements in health are accordingly matters for each country to attend to. On the other hand, relating health status improvements in developing countries to concurrent improvements in other parts of the world might reflect a judgement that the people of developing countries have a moral claim to a fair share of the technical and economic gains which have been achieved over the last four decades.

Governments and private enterprise

There are passages throughout the report condemning government for a wide range of failings.

> *In every developing country decisive steps are needed to correct the pervasive inefficiency of clinical health programs and facilities and especially of government services. Clinics and outreach programs operate poorly because of shortages of drugs, transport and maintenance. Hospitals keep patients longer than necessary and are poorly organised and managed.*[l]

The underlying message is reiterated that governments per se cannot deliver health services and that the main policy task is one of getting governments out and markets in. Failings of particular governments are cited as failures of the institution of government in general with no reference to the particular circumstances such as gross income inequalities, military dictatorships, the arms trades, strategic interference by great powers, etc. A typical passage:

> *Any potential benefits from greater public sector involvement in health must be weighed against the risk that governments will in fact make matters worse. ... Even when they choose correct policies, they may fail to implement them properly.*[li]

Inappropriate investment in two large donor-financed public hospitals is cited as illustrating the general theme that governments generally are incompetent. The story as told[lii] does not exclude the possibility that it was the donors' conditions which led to the unwise investments. Donors have been instrumental in setting up and financing Western style medical schools in many developing countries. If doctors whose expectations reflect western patterns of medical practice are part of the problem it might be fair to note the influence of such previous interventions from the industrialised world.

> *Health will also be served if governments do less in a number of areas - if they avoid intervening in food markets, cut indiscriminate subsidies for water and sanitation, remove most restrictions on contraceptive services, and abolish subsidies on fuels.*[liii]

Having already agreed that market failure constitutes a proper rationale for government involvement we must assume that the report regards food markets in developing countries as examples of perfectly operating markets. Such a judgement would be ignoring the dumping by industrialised countries of surplus agricultural products on the food markets of developing countries, the impact of agricultural protectionism in world markets, and widely fluctuating and, in the long term, falling commodity prices.

One of the major causes of ‘market failure’ in developing countries is the existence of massive inequalities in income, wealth and power. Whilst massive inequality is not a necessary condition for industrialisation (compare the rapidly growing East Asian economies with those of Latin America) the authors do not see it as warranting a policy focus in this report[liv].

The pall which is cast over public sector service delivery is only matched by the gloss which is projected onto the private sector.

> *The private sector already serves a large and diverse clientele in developing countries and often delivers service of higher quality without the long lines and inadequate supplies frequently found in government facilities.*[lv]

The clear implication of passages like this is that public sector providers and private providers are otherwise working in comparable settings, servicing comparable clients; that the only difference is that one is delivered through government and the other is delivered privately. Promoting competition in the delivery of services ... "will improve health outcomes, contain costs and enhance consumer satisfaction"[lvi].

> *Other promising approaches are to allow government hospitals to compete with one another as semi autonomous enterprises...*[lvii]

> *Greater reliance on the private sector to deliver clinical services, both those that are included by a country in its essential package and those that are discretionary can help to raise efficiency.*[lviii]

The arguments for privatising health care are not based on any balanced evaluation of the empirical evidence from around the world. The condemnation of government and special pleading on behalf of private enterprise appears to have more to do with reducing welfare expenditure and creating private business opportunities rather than any intrinsic differences in efficiency[lix].

7. Methodological Bias

The report recommends that priority in health expenditure should be directed towards conditions which cause a high disease burden and for which cost-effective interventions are available. It is necessary therefore to look closely at the methods underpinning the calculation of 'disease burden' and for estimating 'cost-effectiveness'.

Arbitrary and subjective judgements

It is clear that the calculation of disease burden in terms of DALYs involves quite arbitrary decisions, in the choice of the age weightings and the discount rate, the assignment of disability conditions to weighting categories and the use of expert judgement to fill in for missing information. It is worth noting the reliance of the DALY methodology on these kinds of subjective judgements, if only because of the claims to objectivity which the report makes.

The use of arbitrary guestimates in calculating disease burden may be justifiable at the global level. However, in applying the DALY methodology within individual countries the reliance of the method on these kinds of arbitrary and subjective judgements could become politically very significant. There is considerable scope, within the DALY method, for fiddling with the parameters which determine the pattern of 'national disease burden' and the 'cost-effectiveness' of particular interventions.

Downplaying disability

The DALY method used in the report has the effect of underestimating the burden of chronic disability and obscuring the policy challenge of rehabilitation.

Disease burden is calculated on an incidence rather than prevalence basis. The burden of disease in 1990 is the sum of DALYs attributable to diseases (or injuries) occurring in 1990. The backlog of chronic disability (incurred prior to 1990) is not included in this figure. It presumably has no claim on health service expenditure.

The report also obscures the social and financial challenge of rehabilitation programs and policies by ignoring the distinction between disability and handicap. The International Classification of Impairment, Disability and Handicap (ICIDH) distinguishes between bio-mechanical 'impairment' (developmental or following disease or injury), functional 'disability' (consequent upon the impairment) and the social 'handicap' which remains after appropriate aids and appliances and access policies have been put in place[lx].

The distinction between disability and handicap thus raises the possibility of cost-effectiveness calculations, along the DALY lines, to compare the cost-effectiveness of interventions which reduce the handicap associated with particular disabilities. Such calculations would require data which are largely unavailable and which would be very expensive to obtain. It would also point to significant additional expenditures on rehabilitation, aids and appliances and new social policies directed to facilitating access and participation. By basing DALYs on incidence rather than prevalence and by conflating disability and handicap the report greatly understates the magnitude and challenge of impairment and handicap.

On representing caring as discretionary

DALY-based cost-effectiveness has the effect of privileging interventions that cure or prevent illness and marginalising the caring function of sick care services.

The disease burden in 1990 is a measure of the present value of the future stream of disability-free life years which are lost as a consequence of death, disease or injury occurring in 1990. The calculation of cost-effectiveness of clinical or public health interventions is based on estimates of DALYs which are averted by particular interventions. Interventions which do not alter the future stream of disability free life years are accordingly represented as being not effective. Caring activity which does not contribute to cure or prevention is rendered infinitely expensive or infinitely ineffective by this methodology.

> *Insisting on value for money is not only fully consistent with compassion for the victims of disease, it is the only way to avert needless suffering.*[lxi]

The caring activities which express human compassion in health services are at risk of being discounted by policies based on the assumption that value for money is defined solely in terms of cure or prevention. Caring for people with AIDS would be defined as 'discretionary' by the logic of this methodology. Caring for people with disabilities, in particular older people with disabilities (eg stroke), is rendered an even greater waste of money in this schema.

The discounting of caring in the DALY-based cost effectiveness calculations has implications also for the practicability of other recommendations in the report. In many cultures popular attitudes to health care value the trust and empathy which is part of caring. The trust which is necessary to achieve instrumental outcomes (such as cure or prevention) depends often on human relationships (at the clinical and community levels) which have been fostered by caring.

The focus on interventions which buy the greatest number of cures and preventions for the least outlay could, if fully implemented, lead to some improvements in health status statistics. However,

the cutting edge of these recommendations is likely to be in the context of structural adjustment and in the processes of mobilising funds for the essential public health and clinical packages. In many countries the public health and clinical packages would both require additional funds, to be found largely through the redirection of existing health finances. The report runs a strong line about reallocating public resources away from tertiary care that provides "little gain for the money spent" towards more cost-effective programs (as defined on the cost per DALY basis)[lxii]. Since many clinical services would be represented as ineffective by DALY-based cost effectiveness calculations we may anticipate strong pressure to transfer public funds from hospitals (identified as 'discretionary clinical services'). The report foreshadows greater involvement of private entrepreneurs and non-government organisations in running health services and the development of greater competition. The privatisation of public hospitals followed by increased user charges would clearly be high on the agenda.

In support of these changes the report cites examples of grotesque misallocations of expenditure on hospitals but there are also large hospitals which constitute the only health care for large concentrations of marginalised urban people. The claim that this is a waste of presently available recurrent resources is arguable; it may in fact be a very efficient, albeit not very desirable way of providing much needed services.

Infrastructure expenditure not cost-effective

I have commented earlier on the report's enthusiasm for treating worms in contrast to its strictures against public sector financing of water supply, sanitation, garbage collection, housing, and sewerage connection all of which should all be delivered through the private sector. The government role should be to provide the regulatory and administrative framework within which "efficient and accountable providers (often in the private sector) have an incentive to offer" such services[lxiii].

The authors of the report choose their words very carefully in pronouncing that investment in water supply and sanitation is not cost-effective:

> *If households pay the total cost of water and sanitation services because of the productivity and amenity benefits, substantial health gains are an added bonus achieved at no cost per DALY gained. When willingness to pay is much less than costs, it is usually a mistake to justify subsidies on the basis of health benefits alone. First, such subsidies compromise the demand-driven approach to service provision (that is, provision of services that people want and are willing to pay for); lack of accountability and inefficiency are the inevitable consequences. And second, if publicly financed investments in these services are being considered for health reasons it should be noted that such investments generally cost more per DALY gained than other health interventions recommended in this report.*[lxiv]

Restated more simply, if the costs of an investment in water supply and sanitation are to be justified only in terms of improved health then it would be cheaper to the pay for recurrent mass drug administration. As the above quote acknowledges this comparison ignores the productivity and amenity benefits in other sectors of social activity. It also ignores the differential impact on 'women's work' as compared with 'men's work'. If the costs of the investment were allocated across a range of other beneficial outcomes the result would be different.

If cost-effectiveness calculations are to assign the total cost of measures which have intersectoral benefit to the health sector alone it is inevitable that health service interventions will be rendered relatively more cost-effective. The alternative is to undertake full intersectoral cost accounting analyses for all public health infrastructure measures. This would probably be impractical. Thus the report uses and advocates a method which is only practical if it is implemented in a way that privileges health service interventions vis a vis infrastructure (intersectoral) interventions.

8. Economics and Health

The report presents an extraordinarily positive account of the relations between health and economics. Economic growth is good for health; health is good for economic growth. Poverty is acknowledged as a barrier to health. Ignored are: the role of social and economic inequality; the degree to which (in various historical circumstances) capital formation has been based on destroying people's health; and the ways in which the economic disadvantages of developing countries are structured into the way the global economic regime operates.

The report directs considerable attention to the relations between poverty and health. It demonstrates that poverty is a health hazard and as a general rule low public expenditure on health is bad for population health. The effects of poverty are attributed to poor living conditions, occupational exposures (malaria in Turkey, pesticides in Sri Lanka) and the distribution of household income within the household (ie the proportion disposed of by women). It is estimated that the growth slow down of the 1980s led to 350,000 deaths that would have been averted if pre-existing growth rates had persisted. Latin America's recession of 1983 is estimated to have caused 12,000 infant deaths (2% of all infant deaths in that year)[lxv].

One of the leading themes of the report is that economic growth ('that benefits the poor') is a condition for health improvement "including, where necessary, adjustment policies that preserve cost-effective health expenditures"[lxvi]. Income growth leads to better health through better nutrition, access to safe water and living conditions, access to doctors, etc.

> *Economic policies conducive to sustained growth are thus among the most important measures that governments can take to improve their citizen's health.*[lxvii]

The report estimates that the effect of economic growth on life expectancy is two thirds due to increasing public expenditure on health and one third due to the alleviation of poverty.

> *... but spending on health can also be justified on purely economic grounds.*
>
> *Improved health contributes to economic growth in four ways: it reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrollment of children in school and makes them better able to learn and it frees for alternative uses resources that would have otherwise have to be spent on treating illness.*[lxviii]

It is scarcely credible that an account of the relations between economics and health should fail to acknowledge that the creation of capital from healthy lives sacrificed was an integral part of the industrial revolution in Europe and in the USA and during Soviet industrialisation under Stalin. In the increasingly globalised economy of today the competitive advantage of many developing countries is tied to their achieving lower costs of production through paying subsistence wages (or

lower) and observing minimal occupational and environmental standards. It would be a suitable challenge for the Bank's economists to devise a method for determining a DALY/$ index which quantifies the relationship between health sacrificed and capital created under various policy regimes.

The report skirts around the relations between economic inequality and health. Rapid economic growth has in many countries been associated with the emergence of gross inequalities and widening health differentials. On the other hand, in those countries where inequalities have been reduced, health improvements have been amongst the fastest. In some cases this has been associated with rapid economic growth also. The relatively good health outcomes of Japan and the rapidly growing East Asian economies appears to be related to their achievement of industrialisation with relative equity. (Wilkinson has suggested (on the basis of OECD data[lxix]) that inequity in income distribution has an effect on national mortality rates that is independent of the direct effects of low income at the family and community levels.)

The policy assumptions of this report might be paraphrased as "growth, disregarding equity, but with a safety net". An alternative policy, "growth with equity (and with less need for a safety net)" could, on the East Asian experience, deliver rapid economic growth and rapid improvement in health outcomes. Why is this policy so studiously avoided in this report? It is perhaps because rich people save a higher proportion of their incomes than poor people. There may be a contradiction here between the economic objective of promoting private capital formation and the objective of improving health.

No doubt the Bank's economists would be pleased if their policies could deliver better health outcomes as well as economic growth. However, in regions such as Latin America, so long as its clients deliver economic growth (even with increasing inequalities) it appears that the Bank would not be willing to constrain their social policies through any kind of 'health through equity' conditionality.

The rules of the global regime

The government-blaming of this report is underpinned by the assumption that economic growth and social development simply require that governments adopt the right policies. This helps to divert the attention of the reader away from the dynamics of global economic relations and the barriers to development and health which arise from the way this global regime operates.

The Bank argues for a free trade regime globally and asserts that this is in the best interest of developing countries and that they should actively open themselves to it. There are many countries who have been urged to adopt export oriented agricultural policies who have been caught by falling commodity prices and increasing reliance on imported inputs. Falling terms of trade have meant that export earnings are increasingly inadequate to cover the cost of imports and debt servicing; continually deferring the promised capital formation. Meanwhile subsistence farming and the marketing of locally produced foods have been neglected and run down. Similarly damaged are the countries whose indigenous food production has been undercut by dumped grain surpluses from the US, unloaded cheaply at the ports of large cities at lower prices than foods which are 'less efficiently' produced in the rural areas and 'less efficiently' transported to the cities. The US has been dumping subsidised grain on developing country markets for over 30 years[lxx] and the European Community dumping likewise its butter.

Free trade is usually represented as harnessing the efficiency of market forces for the greater benefit of all. It is well to note that the parameters of those markets (and hence the way they define 'efficiency') are structured under the influence of financial and military power. In 1971 the US was able to unilaterally abrogate the Bretton Woods Agreement in order to internationalise its problems with inflation. In the 1980s high interest rate policies in the US were used to maintain the value of the dollar despite the massive trade and budget deficits. It was this interest rate spiral which triggered the debt trap for developing countries. Was this simply the effect of the 'free' market or was it the projection of power? The US embargo on trade with Cuba is illegal under the rules of the WTO but this is hollow vindication for Cubans since the only sanctions available to them under the WTO would be authorised retaliation. 'Free trade' is the operation of a market regime which is structured by unequal power relations.

The World Bank's analysis of the causes of poverty in developing countries and its prescriptions for economic growth are not the only ways of understanding poverty nor the only credible pathways to development. The assumptions informing this report represent only one pole in much more complex debates about economic development; other poles (such as those associated with UNCTAD for example) are unsurprisingly absent[lxxi].

Export of toxic waste

The competitive pressure on developing countries to accept lower environmental standards, lower occupational and health standards and to deliver low cost labour is accepted as a constraint within which this report is crafted rather than being a problem for the Bank to address.

The report's failure to discuss the global pressures on developing countries to accept lower regulatory standards must have been an explicit policy decision because the matter was raised notoriously during the period of this report's preparation. The Bank's chief economist pointed out in 1991[lxxii] that for the Bank to encourage the migration of dirty industries, such as heavy manufacturing and toxic waste, to developing countries is fully consistent with the economic policy directions of the Bank.

> *The measurement of the costs of health-impairing pollution, depends on the foregone earnings from increased morbidity and mortality. From this point of view a given amount of health-impairing pollution should be done in the country with the lowest cost, which will be the country with the lowest wages.*

Mr Summers subsequently explained that he was not proposing an explicit Bank policy on the toxic waste trade. He was simply pointing out the logical implications of the wider economic policy framework of neoclassical free trade orthodoxy within which the Bank works.

> *I think the economic logic behind dumping a load of toxic waste in the lowest-wage country is impeccable and we should face up to that.*

9. The Promise of Health-promoting Structural Adjustment

My approach so far in evaluating *Investing in health* has been structured around the question, "Does it make sense?". Indeed some of it does make sense but major anomalies emerge when the substance

of the report is measured against its stated objectives. These anomalies include contradictions in the recommendations and bias in the presentation, methods and analysis.

The second stage of my analysis is to ask, "What effect will it have?", more specifically, can it deliver on its promise of 'health-promoting structural adjustment'? One of the key implementation pathways for the recommendations of this report is in the context of structural adjustment lending and the 'health care reform conditionality' proposed in the report. The report may have persuasive authority in many other settings but in the context of negotiating structural adjustment loans it will have the authority of law.

Structural adjustment packages are the policy conditions imposed by the IMF as a condition for bailing out heavily indebted less developed countries who have run out of credit. Their indebtedness is understood (by the Bank and the Fund) as being due to failed import substitution policies, grandiose development projects, capricious borrowing, inefficiency and corruption, military adventurism, and a range of other irresponsibilities. SAPs usually comprise cuts in public sector programs, devaluation, export development, priority to payment of overseas debts and the dismantling of national economic controls. Since the mid 1980s the World Bank has participated more actively with the IMF in structural adjustment by providing identified structural adjustment loans.

The Fund and the Bank have been widely criticised for the health-damaging consequences of many structural adjustment programs and for redirecting development lending to bailing out the private banks. A group of health and social scientists from various African countries meeting in 1990 declared that:

> *Advocacy initiatives such as UNICEF's 'Adjustment with a human face and the World Bank's 'Social dimensions of adjustment' have manifestly failed to address the underlying structural causes and have not even succeeded in their ojectives of mitigating the effects of SAPs. Worse still, these initiatives have contributed to obscuring the fundamental bases of this crisis, thus further disempowering the most vulnerable.*[lxxiii]

Investing in health provides further guidelines for 'health-promoting structural adjustment'. The report finds:

- it is possible to target funding to heavy disease burden conditions for which there are cost-effective interventions;
- public subsidy for water supply, sanitation and garbage removal is not cost-effective;
- much hospital care is not cost-effective and hospital funding can be (and should be) redirected to the basic clinical and public health packages;
- cutting public expenditure is not necessarily bad for people's health;
- governments are notoriously and inevitably inefficient; and that
- structural adjustment lending can be consistent with health improvement if implemented in association with the recommended health policy packages.

These claims can be re-evaluated in the light of the anomalies identified earlier in this paper. I have identified important unresolved contradictions in the policy recommendations: between the objective of tightly controlled vertical programs and decentralised integrated local services; between

competition in the primary health care sector and cooperative public health programs; between health insurance and barriers to effective regulation. The ambiguities and contradictions in these recommendations are likely to be operationalised by in-country Bank officers with no health background but heavy training in neoclassical economics. Under these circumstances the economic policy agenda will determine how the ambiguities are interpreted. It is likely that many of the more sensible propositions in the report will disappear from view at this point.

The policy analysis upon which the recommendations are based are strikingly individualistic and reductionist. The magic bullet emerges as the preferred approach to most problems but further excavation reveals that this 'finding' was embedded in the methods of analysis which were selected. Central to this report's analysis is a particular story about the relations between economic growth, health and equity; a story which is basically not credible.

It is possible that the recommendations of this report could lead to some improvements in certain health indicators, in particular, by reducing those conditions which are amenable to more organised vertical public health strategies operating on relatively passive populations. Immunisation is the archetypal case. However, it is likely that the health status indicators would remain poor generally and that the gaps between rich and poor would widen.

'Suffer now for better health later'

Whilst the leading message of *Investing in health* is about the possibility of 'health promoting structural adjustment' there is a fall-back position which is the underlying message of the report. This message is essentially that people living in debt-burdened, out-of-credit countries have no alternative but to 'suffer now for better health later'.

10. 'Wealth through growth'

Is this directive, 'suffer now for better health later' credible? It depends on how you understand the world economy.

There are numerous stories which are told about the dynamics of development and the directions of the global economy. I shall present two accounts. The first I shall call 'wealth through growth', which corresponds broadly to the assumptions of the Bank, the Fund and orthodox neoclassical economics. (In the next section I shall outline an alternative story which I shall refer to as 'crisis deferred'.)

'Wealth through growth' refers to a story which is told by the Bank, the Fund and orthodox neoclassical economics. It is a story of rapid and dramatic change in the world economy: the internationalisation of trade and finance; new technologies affecting production and employment. There are risks associated with these changes, including risks of social, political or financial instability. The key strategy to contain such risks and to achieve global well-being must be economic growth. This is most efficiently achieved through free play of market forces and the winding back of government regulation.

There are three more specific scenarios which illustrate the realisation of this story. The first is the 'opening up of China' (or Eastern Europe or any other underdeveloped country or region); the second

is ‘the wealth creating impact of new technology’ and the third is ‘wealth creation through exploiting natural resources’.

The ‘opening up of China’ scenario involves finding hungry people who are used to working hard and providing them with new technologies which will multiply their productivity. Increased food production per farmer will release other (ex-)farmers to make things which the newly wealthy farmer will be able to buy, thereby allowing the workers to buy food. In due course indigenous capitalists emerge who are able to underwrite the next round of investment in farming or manufacturing technologies. The role of outside investors in these processes are essentially facilitatory; introducing new technologies or inputs, assisting new producers to find markets. Obviously the outside investors are also laying a claim to a continuing percentage of the increasing turnover.

The classical case of ‘the wealth creating impact of new technology’ in the Twentieth Century is the internal combustion engine: new technology (including cheap oil) multiplies the productivity of enterprises and workers and leads to massive increases in aggregate wealth. This scenario is closely tied to the third, namely ‘wealth creation through exploiting natural resources’. Whether it be consuming stored energy, exploiting living resources or using up the absorption capacity of the environment wealth creation through the exploitation of natural resources is a core element of the ‘wealth through growth’ scenario.

The ‘wealth through growth’ story has considerable descriptive and explanatory power. There have been many periods of history in many parts of the world which can be interpreted very plausibly in the terms of this story. ‘Wealth through growth’ corresponds to the way many people experience the global economy, particularly people whose world view is oriented around the experience of the industrialised world or the wealthy strata of the developing world.

In the terms of this ‘wealth through growth’ scenario the ‘anomalies’ which I have identified in *Investing in health* are simply constraints imposed on health policy-making by the economic circumstances. In the terms of this story, SAPs, following the IMF formula, are unavoidable for severely indebted, out-of-credit economies. Cuts in public sector programs reduce the tax burden on business and free up limited resources for debt repayment and infrastructure for export oriented growth. Devaluation decreases the price of commodities in the export markets (and discourages imports through higher prices). The dismantling of national economic controls encourages foreign investment.

Whilst structural adjustment may not actually improve health, structural adjustment packages which incorporate the policy recommendations of this report would be expected (when projected within the ‘wealth through growth’ scenario) to ameliorate the health damaging impact of adjustment and put those countries on the road to economic growth and in due course to better health. ‘Suffer now for better health later.’

11. ‘Crisis deferred’ - Structural Crisis in the Global Economy

‘Wealth through growth’ is a very useful story for thinking about the local histories of many places and periods. It helps to make sense of different experiences and it has proved useful as a basis for policy making in many situations. However, these strengths do not mean that it is ‘true’ in the sense of presenting an accurate picture of ‘what is really happening’ in the world economy.

The world economy is not open to being 'known'; it is impossibly complicated. In the tradition of the Enlightenment, we create 'models' which reflect what might be happening and we see how useful these models are in terms of making sense of our experience or as frameworks for our planning. The 'wealth through growth' is one very useful model for making sense of the world economy.

However, there are many places and periods which have histories which do not fit the 'wealth through growth' model. There are many people who do not find 'wealth through growth' to be very useful in explaining the trends and changes that they are concerned about. There are policy makers in many countries who have not found 'wealth through growth' to be a useful basis for policy-making.

'Wealth through growth' is one story which corresponds to certain trends and certain dynamics. However, there are other trends and other dynamics which it does not explain; there are other objectives of policy which it does not help to achieve.

'Crisis deferred' is a story of structural crisis in the global economy[lxxiv]. It is cast at a larger scale and longer time frame than 'wealth through growth' and in that sense helps to contextualise the dynamics on which 'wealth through growth' relies. 'Crisis deferred' provides a framework for explaining many of the trends and dynamics which are not well explained by 'wealth through growth'.

Growth rates globally have trended downwards over the last two decades. During this time there have been dramatic structural changes in economic and financial relations and in production methods and markets. A new feature from the 1970s was the lack of responsiveness of national economies to Keynesian strategies. Monetarist strategies controlled inflation but did not lead to increased rates of economic growth. During the last two decades there has also been an increasing awareness of the environmental limits to growth although effective action to achieve ecological sustainability is still a way off.

Clearly there are structural changes taking place. The notion that these changes constitute a crisis hinges on the argument that they are tending towards systemic instability which is held off at the cost of the continuing impoverishment of a large slice of humanity and by continuing environmental degradation.

At the centre of this 'crisis deferred' story is a dynamic of increasingly 'efficient' production for increasingly global markets which contributes to a tendency to a decline in aggregate employment (high wage employment in particular) which leads to a tendency to a decline in aggregate demand. This is perceived at the level of the corporation as declining profits, the response to which is to cut costs and to seek new markets. The pressure to cut costs accelerates the replacement of labour with technology, particularly in mass employment industries, and impels the move of production to low wage countries where labour and environmental standards are looser. The replacement of labour with technology, and of high wage labour with low wage labour, contributes further to the decline in aggregate demand and further constrains profits. The contraction of demand limits the development of new markets and points corporate policy towards maintaining profits through increasing share of established markets through take-overs and mergers. These have the added benefits of asset stripping, as a means of boosting the bottom line, and lead to a greater control over prices.

The tendency to falling aggregate demand has been obscured by two major mechanisms over the last two decades; by inflation during the 1970s and by the expansion of debt from the 1980s.

During the early 1970s there was a massive creation of new money, in part as an outcome of Keynesian policy strategies around the world responding to the early decline in growth rates. A

component of this global inflation was driven by military Keynesianism during the Vietnam war which was nominally paid for in dollars but in reality paid for through price increases distributed world wide because of the international status of the dollar. By the late 1970s Keynesianism was rejected (seen as the 'cause' of inflation) and was replaced by monetarism as the new economic policy orthodoxy.

With monetarism came the debt explosion; the increasing reliance on debt to pay for current consumption including the massive trade and budget deficits of the US. During the 1980s the US borrowed heavily to pay for Star Wars (whilst cutting taxes) and to maintain the value of the dollar, despite a huge trade deficit. Increased reliance on debt (in the financing of households, corporations and government) was the hallmark of the 1980s and was associated with a rapid expansion of the financial sector (institutions, employment and power).

Underlying the debt explosion has been the conversion of financial capital into consumption expenditure without generating new productive assets. This is a process which feeds upon itself as the increasing burden of debt is refinanced through more borrowings and is serviced through drawing on an increasing proportion of household, corporate and government revenues. Consumption expenditure in the economies of the North is thus supported through the destruction of human capital in the South (the health consequences of the demand for debt repayment, unequal trading relationships, lax environmental and labour standards and the effects of 'structural adjustment'). Consumption in the North is supported also through the run down of natural capital because market prices of diverse goods and services are subsidised by the continuing non-sustainable exploitation of natural resources.

Global financial relations are presently in a particularly vulnerable state. Salient features include: the US budget and trade deficits: the burden of corporate debt following the take-overs of the 1980s; the vulnerability of the US banking industry and the reinsurance industry world wide; the collapse of European monetary union and the rise of new round of euro-speculation and, most recently, the speculation against South East Asian currencies. The possibility of a financial crisis is widely recognised. The crises of the US Savings and Loans and of Lloyds of London both hint at the possible fallout of a financial collapse. Commentators periodically cast worried glances at the Tokyo property market.

The power and vulnerability of the international financial sector have implications also for the possibility of national and international policies directed towards restructuring the global economy on a more sustainable basis. The power of the nation state has been reduced by the rise of the transnational financial sector. This is symbolised by the sanctions held by 'international financial markets' over national policy through their power over the value of the domestic currency and credit ratings.

In summary, the crisis story turns upon a tendency towards declining growth rates due to declining demand associated with increasingly efficient production for global markets. The response of corporations has been focussed on cost cutting and the control of market share, both of which exacerbate the crisis. The diagnosis of crisis is justified by the instability of the system and the increasingly direct conversion of capital (financial, natural and human) into rich world consumption without creating new productive assets.

The proposition, 'suffer now for better health later', may be applicable for some groups but the crisis deferred story suggests that the continued imposition of structural adjustment according to the

IMF formula will simply exacerbate and prolong the suffering indefinitely for the majority of people in developing countries.

The World Bank does not stand apart from this system, as some kind of impartial and objective observer. It stands at the cross roads, mediating in crucial matters the relationships between North and South. The Bank blends a commitment to facilitating 'development' in the South with a close relationship with the transnational banking system and a structured accountability to its dominant shareholders, the large capitalist economies of the North (of which the largest is the USA). The Bank, as an institution, would wither and die if it alienated these constituencies. Necessarily therefore the Bank's conception of 'development' (including the conditions for health development) must conform in broad terms with the concerns of the private banks and of economic policy makers in the US, Japan and Europe. In this context it should not be surprising that that certain (otherwise arguable) propositions are elevated to the status of basic principles and truths, embedded in the language of the report. These truths include the propositions that: "Third World debt must be paid"; "economic growth is essential" and that "global integration is inevitable". The particular position that the Bank occupies in mediating the relationships between North and South clearly affects the policy positions developed in *Investing in health*.

The World Bank, through its structural adjustment loans, plays a central role in maintaining massive resource flows from South to North, in the first instance to the Northern banks. Notwithstanding the billions of dollars flowing from the poor countries to the rich world each year the world financial system remains vulnerable and the threat of default on developing country debt remains a risk to global financial stability. The continuing flow of resources (material and financial) from the indebted developing countries is a necessary condition for global financial stability. What might have been achieved in terms of health and social infrastructure in developing countries if this money had been invested locally?

Investing in health does not countenance the possibility that cancellation of debt might be a serious policy recommendation for health development in deeply-indebted Third World countries. The rose coloured spectacles, hostility to public administration and above all the imperative to reduce public spending on health care are all clearly shaped by the assumption that Third World debt must be paid.

Why does the report fail to acknowledge inequality as a cause of poor health standards, compared for example with its discussion of poverty? Why is structural adjustment reasonable but land reform beyond the pale? Are there functions which depend upon perpetuating inequalities that have constrained this analysis? Is inequality necessary to promote private capital formation, because rich people save a higher proportion of their income than poor people? There is no doubt that gross inequalities and abuses of human rights have characterised some regimes that have achieved rapid economic growth and rapid capital accumulation (for example, during the industrial revolution in England). It is incontrovertible that a high rate of exploitation of workers and the existence of a reserve army of unemployed and desperate people contributes to lower costs of production, greater returns on investment and accelerated economic growth.

Why does the report fail to acknowledge the sacrifice of health which has been a major dynamic underlying capital accumulation historically and remains so today, particularly, in unskilled and polluting industries? Is the continuing destruction of people's health for the purposes of capital accumulation invisible to the authors of this report because it is so firmly accepted as part the assumptions of this report?

12. Conclusions

I have argued that the policy recommendations of this report are individualist and contradictory and that the presentation, methods and analysis are biased and highly selective. Because of these contradictions and biases the promise of 'health-promoting structural adjustment' must be judged to be not credible.

However, evaluating the fallback promise, of 'suffer now for better health later', is more complicated. I have argued that the credibility of this promise depends on how you understand the global economy and the Bank's role in mediating North South relations. I have discussed two different ways of viewing the world economy which have very different implications for the usefulness or dangerousness of this report. It is evident that *Investing in health* is based on the 'wealth through growth' scenario; indeed this is presented as simply the fact. This scenario does indeed support the promise of 'suffer now for better health later.'

I think that the 'crisis deferred' scenario provides a more convincing account of many aspects of the world economy and the Bank's role in North South relations. Evaluated in terms of the 'crisis deferred' scenario it appears that the report's health policy recommendations will do more good for the legitimacy of the Bank, the stability of the world economy and the living standards of people in the rich countries like the US and Australia than for the health of people in severely indebted, out-of-credit less developed countries.

The slogan 'suffer now for better health later' might be better rendered as "suffer now, and into the foreseeable future, for the continuing stability of the global capitalist system".

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i. A review of the World Bank's 16th World Development report, *Investing in health*. Earlier drafts of this review were presented (i) to a workshop on the report held on Canberra, Tuesday 31st August, 1993 and co-sponsored by the Australian Development Assistance Bureau, the National Centre for Epidemiology and Population Health and the Public Health Association of Australia; (ii) at the September 1994 Annual Conference of the Public Health Association of Australia; and (iii) to the December 1994 meeting of the International People's Health Council.

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ii. Referred to as 'the report' for the rest of this review.

[iii]. "Furthermore, in countries where government health services are both overextended and excessively concentrated on discretionary care at the expense of essential services for the poor, the public system needs to be scaled back. This means reducing public investment in tertiary care facilities and specialist training and, in some cases, transferring discretionary care facilities to the private sector." Pages 125-126

[iv]. Pages 44-45

[v]. Page 8

[vi]. Page 17

[vii]. Page 74

[viii]. Pages 9 & 93

[ix]. Page 93

[x]. Page 93

[xi]. See for example Rosen G (1993 [1958]) A history of public health, Chapter VI, pp 168-269, Baltimore and London: Johns Hopkins University Press

[xii]. Ernst J (1994), Whose utility? The social impact of public utility privatisation and regulation in Britain, Buckingham: Open University Press

[xiii]. Page 81

[xiv]. Page 55

[xv]. Page 43

[xvi]. Page 8

[xvii]. Page 89

[xviii]. See for example, McCoy AW (1991) The politics of heroin: CIA complicity in the global drug trade, New York: Lawrence Hill Books

[xix]. Pages 43-44

[xx]. Page 43

[xxi]. Page 42

[xxii]. John C Caldwell (1986), "Routes to low mortality in poor countries", Population and Development Review, 12(2), 171-220

[xxiii]. See for an alternative view "The Dakar declaration on another development with women", Development Dialogue, 1982 (1-2), pages 11-16

[xxiv]. Swaminathan MS (1982), cited in Mazumdar V (1982) "Another development with women: a view from Asia", Development Dialogue, 1982 (1-2), pages 65-73

[xxv]. Arizpe L (1982) "Women and development in Latin America and the Caribbean", Development Dialogue, 1982 (1-2), pages 74-84

[xxvi]. Page 113

[xxvii]. Page 49

[xxviii]. Page 157

[xxix]. Page 129

[xxx]. Page 158

[xxxi]. The long standing debates between selective and comprehensive primary health care are relevant to this issue. See for example: Banerji D (1985) "Primary health care: selective or comprehensive?" World Health Forum, 5(4), 312-315; Smith RA (1982) "Primary health care: rhetoric or reality?" World Health Forum, 3(1), 30-37. This report does not progress the discussion.

[xxxii]. Page 33

[xxxiii]. Box 7.1, page 159

[xxxiv]. Page 143

[xxxv]. See for example, Werner D (1981) "The village health worker: lackey or liberator?" World Health Forum, 2(1), 46-68

[xxxvi]. Page 124-5

[xxxvii]. Page 125

[xxxviii]. Page 124-5

[xxxix]. Page 124

[xl]. Page 15

[xli]. Page 65

[xlii]. Page 13

[xliii]. Page 161

[xliv]. Page iii

[xlv]. Table A.5 page 203

[xlvi]. Table A.4 page 202

[xlvii]. Table A.4 page 202

[xlviii]. Calculated from Table A.5, p203

[xlix]. See Rostow W (1960) The stages of economic growth, Cambridge: Cambridge University Press. For a critique see Blomstrom M and B Hettne (1984) Development theory in transition. The dependency debate and beyond: Third World responses, pp 21-24, London: Zed Books

[l]. Page 12

[li]. Page 53

[lii]. Page 59

[liii]. Page 107

[liv]. On the possibility of growth with equity see Fei JCH, G Ranis and SWY Kuo (1979) Growth with equity: the Taiwan case, published for the World Bank by Oxford University Press. For a less optimistic account of the Asian miracle see Bello W and S Rosenfeld (1990) Dragons in distress; Asia's miracle economies in crisis, San Francisco: Institute for Food and Development Policy.

[lv]. Page 12

[lvi]. Page iii

[lvii]. Page 161

[lviii]. Page 12

[lix]. In the 1950s Eugene Black, then President of the World Bank, stated: "Our foreign aid programmes constitute a distinct benefit to American business; The three major benefits are: 1. foreign aid provides a substantial and immediate market for United States goods and services; 2. foreign aid stimulates the development of new overseas markets for United States companies; 3. foreign aid orients national economies towards a free enterprise system in which United States firms can prosper." Cited by Hayter T (1982) The creation of world poverty, New Delhi: Selectbook Service Syndicate, page 134

[lx]. Wood PHN (1989) "Measuring the consequences of illness", World Health Statistical Quarterly, 45,115-121

[lxi]. Page 61

[lxii]. Page iii

[lxiii]. Page 9 & 93

[lxiv]. Page 93

[lxv]. Page 42

[lxvi]. Box 1, page 6

[lxvii]. Page 7

[lxviii]. Pages 18-21

[lxix]. Wilkinson RG (1990) "Income distribution and mortality: an 'natural' experiment", Sociology of Health & Illness 12(4) 391-412

[lxx]. See Andrae G and B Beckman (1985), The wheat trap, London: Zed Books. See also Morgan D (1980) Merchants of grain, Harmondsworth: Penguin

[lxxi]. See for example Manley M and W Brandt (1985), Global challenge. From crisis to cooperation: breaking the North-South stalemate, London: Pan Books

[lxxii]. From a leaked and widely publicised World Bank internal memo of December 12 1991, Inter Press Service, 1992.

[lxxiii]. "The Ukanda Declaration on economic policy and health", produced at the first African regional conference of Social Science and Medicine (and published in Health Policy and Planning 6(2) 173-175 (1991)

[lxxiv]. The account provided draws upon a range of sources. Particularly important have been diverse writings by Sweezy and Magdoff in the pages of Monthly Review; the world systems theory of Wallerstein (Wallerstein I (1984), The politics of the world economy: the states, the movements and the civilisations, Cambridge: Cambridge University Press); the development writings of Andre Gunder Frank, and the writings by Amin on 'delinking' (see Amin S, G Arrighi, AG Frank, and I Wallerstein (1982) Dynamics of global crisis, New York: Monthly Review Press) and Stuart Holland (see Holland S (1987) The global economy: from meso to macro economics, London: Weidenfeld and Nicholson) among others.