TURNING HEALTH INTO AN INVESTMENT:
THE LATEST HIGH-POWER ASSAULTS ON THIRD WORLD HEALTH CARE

Keynote address by David Werner
Seminar of Health Communications
Xavier Institute of Communications
25th Anniversary
17 November, 1994.

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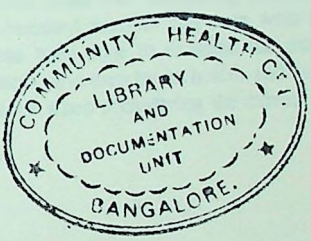

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— David Werner —

The topic I have been asked to address is "Health in Developing Countries: an Overview of Emerging Issues." Current trends in health and health care are, of course, part of a conservative, distressingly regressive, global trend and must be examined within this broader context.

In spite of the acclaimed goal of Health for All, in recent years formal health services have become increasingly inaccessible for the growing numbers of destitute people. The reason largely economic. At the same time that poverty is deepening in many nations, rich and poor, the costs for basic health care are being systematically shifted from the public sector to the individual consumer.

Since the early 1980s the income gap between rich and poor has been widening between countries and within them. Today over one billion persons—one in five of the world's people—try to survive on less than one dollar per day.[1] In many countries, minimum wages have fallen so low that they do not cover the family's basic food needs. On a recent visit to Bolivia, I was told it now takes seven official minimum wages to adequately feed a family of five. No wonder a lot of Bolivians grow coca—or chew it to stave off hunger! And no wonder over half of Bolivia's children show signs of stunting![2]

Too often high-level health and development planners get so absorbed in macro issues of health economics that they lose sight of the micro (or human) issues. They focus on how health ministries faced with increasing demands and shrinking budgets can function "cost effectively," rather than on how impoverished families can cope with falling wages and rising costs of both food and health services. Little research has been done to examine the extent to which the money poor families spend on health care affects the nutritional status, and thereby on health and survival, especially of women and children. Yet such questions are of crucial importance when considering the current trends toward privatization and cost recovery.

The colonial and neocolonial medical model

Ever since the Western Medical Model was introduced into Southern countries in colonial times, it has been a two edged sword. Its urban-based, doctor controlled, expensively equipped "disease palaces" have always catered to the privileged.[3] The few health services directed at the *'natives'* were mainly designed to keep them productively working in plantations and/or factories owned by the rich. Thus in the colonial era, health for the poor was not seen as a right, but as a requirement for well-managed performance of labor. (As we shall discuss, the World Bank's new mandate for *Investing in Health*, with its emphasis on *cost effectiveness* for productive contribution to the global economy, is a regression to this colonial mind-set.)

In the post-World War II era, there was an evolving social consciousness that *all people are entitled to the same basic rights* and that *society has a responsibility to make sure the basic needs of all people are met*, regardless of gender, race, class, and relative ability or disability. As a part of this new *basic needs approach*, development planners sought ways to make Western medical and health services more widely accessible to underserved Third World communities. Thus *rural dispensaries* were set up and staffed by modestly-trained *health auxiliaries*. While this "rural penetration" of Western medicine brought some benefits, it also created new problems. One was *added costs to consumers*. Even where services were subsidized, travel to the dispensaries, which were few and far between,

involved time and expense. Medicines, when available, were often costly; or sick persons were referred to a distant hospital at still greater costs to the poor family. Under the influence of new *wonder drugs*, people's faith in low-cost home remedies began to decline. "A pill for every ill" became standard treatment and injections acquired a magical ethos. Budding multinational pharmaceutical companies capitalized on this growing drug dependency. The medicalization and commercialization of health care, together with an erosion of traditional forms of self-care, became a growing obstacle to health.

Health care as an obstacle to health: an example from the Philippines

Several years ago a group of village health workers from Mexico and Central America went to the Philippines to exchange ideas. Near Tacloban we visited the Makapawa community-based health program. Among other innovations, local health workers had organized neighborhood groups to make their own herbal medicines for common ailments. These combined traditional lore with modern science. Cough and cold syrups contained bitter orange, high in Vitamin C. An 'ABC drink' for diarrhea was an oral rehydration mix with tasty herbs added. In festive gatherings, men, women, and children took part in preparing these handy home remedies.
Preparing these handy home remedies.

The Makapawa health workers proudly told us that after only two years child malnutrition and mortality had decreased. We asked why. They said it might be the nutrition training for mothers during 'under fives' clinics. But the mothers present said, "Not so! For years visiting nurses have lectured us on how to feed our children. If we don't feed them right, its for lack of money, not know-how." Yet the mothers confirmed that current wages were lower than before. So why, we asked, had their children's health improved? At first, no one had an answer.

We asked how much the mothers were spending on health care: herbal medicines, modern medicines, travel to doctors, etc. The average turned out to be 10 to 12% of family earnings. We said this was low compared to other lands we had visited, where some poor families spent 30% or more of their earnings on health-related expenses.

Then one mother said, "We don't spend nearly as much now as we used to." Others agreed. Before the program began some families had spent over 40% of their earnings on health-related costs. Their hungry children were constantly getting sick. A family would first spend on a witch doctor, then on modern tonics and cough syrups, and finally on costly trips to city doctors and hospitals. In emergencies they had to borrow from 'loan sharks,' and pay back for years. If their children recovered, little money was left to feed them, and soon they fell ill again.

"But now when our children have coughs or colds or diarrhea we give them our home-made medicines," explained one mother. "That leaves more money for food (and for medical help when really needed). So our children are fatter and get sick less often. We save even more on health expenses, so we can feed our children still better! And now they die less often!"

"You know what we're saying!" exclaimed one mother. "We're saying *it was what we were spending on health care that was killing our babies!*" Thus the mothers recognized that by avoiding some of the high costs of commercial medicine, and by rediscovering the value of certain traditional forms of healing, they could better protect their children's health. Another factor, they realized, was that their health workers had helped them organize and share in times of need, to avoid falling prey to the loan sharks.[4]

The birth and death of Primary Health Care

By the late 1970s, wide recognition that the Western medical model was still failing to adequately improve Third World health levels led to growing demand for reform. In 1978 the World Health Organization (WHO) and UNICEF convened the famed global conference endorsing the Alma Ata Declaration. To advance toward *Health for All by the Year 2000*, the Declaration called for a potentially revolutionary approach. *Primary Health Care* (PHC) was

conceived as a comprehensive strategy that would not only include an equitable, consumer-centered approach to health services, but would address the underlying social and political determinants of health. It called for accountability of health workers and health ministries to the common people, and for social guarantees to make sure that the basic needs—including food needs—of all people are met. In recognition that socially progressive change only comes from organized demand, it called for strong popular participation.

Unhappily, these high expectations of Alma Ata have not been met. Today, 17 years later, it is painfully evident that the goal of *Health for All* is growing more distant, not just for the poor, but for humanity. Some critics say that Primary Health Care has failed. Others protest that it has never really been tried.

Strategically, there have been *three major events* that have sabotaged the revolutionary essence of Primary Health Care: 1) the introduction of *Selective Primary Health Care* at the end of the 1970s, 2) *Structural Adjustment Programs* and the push for *User-financed Health Services*, introduced in 1980s, and 3) the *take over of Third World health care policy-making by the World Bank* in the 1990s. All three of these monumental assaults on Primary Health Care are a reflection of the prevailing regressive sociopolitical and economic trends.

1. Selective Primary Health Care

No sooner had the dust settled from the Alma Ata Conference in 1978, than top-ranking health experts in the North began to trim the wings of Primary Health Care. They asserted that, in view of the global recession and shrinking health budgets, such a comprehensive approach would be too costly. If any health statistics were to be improved, they argued, high risk groups must be "targeted" with a few cost-effective interventions. This new politically-sanitized version of PHC was dubbed *Selective Primary Health Care*.

UNICEF had been a strong advocate of *Comprehensive Primary Health Care* as declared at Alma Ata. But frustrated by the unwillingness of major donor agencies and health ministries to seriously promote such a radical model, and pressured by the socially retrograde political climate of the 80s, UNICEF soon compromised. It began to advocate Selective PHC as being more "realistic." Through its so-called *Child Survival Revolution*—which some critics called a counter-revolution—UNICEF prioritized four interventions known as GOBI (Growth monitoring, Oral rehydration therapy (ORT), Breast feeding, and Immunization). UNICEF later attempted to broaden its limited package of health technologies to GOBI-FFF (adding Food supplements, Female education, and Family planning). But in practice, in most countries PHC became even more selectively reduced to the *twin engines of Child Survival:* ORT and Immunization.

The global Child Survival Campaign quickly won high-level support. For those in positions of privilege and power, it was safe and politically useful. It promised to improve a widely accepted health indicator, namely child mortality, while it prudently skirted (except in rhetoric) the social and economic inequities underlying poor health. Not surprisingly, many health professionals, governments, and USAID quickly jumped on the Child Survival bandwagon. Even the World Bank—which had previously not put much *investment in health*—began to lend its support.

But technological solutions can only go so far in combating health problems whose roots are social and political. Predictably, the Child Survival initiative has had less impact than was hoped. Over 13 million children still die each year (roughly the same number as 15 years ago, although the percentage is somewhat reduced). Most of these deaths still are related to poverty and undernutrition.

It has become increasingly clear that reducing child mortality through selected technological interventions does not necessarily improve children's health or quality of life, especially if they do little to combat poverty or improve living standards. During the 1980s a disturbing pattern began to emerge in the health indicators of some poor countries: while child mortality rates dropped, undernutrition and morbidity rates increased. Such a pattern bodes an ominous

forecast. And sure enough, in the late 80s and early 90s, in many countries the decline in child mortality rates has now slowed or halted, and in several countries (especially in sub-Saharan Africa) child mortality is increasing.[5]

Equally disturbing, the two most heavily promoted technologies for reducing child mortality are proving difficult to sustain. Since the start of the 90s, there has been a backslide both in Oral Rehydration Therapy usage and Immunization coverage.[6] The recent decline in immunization and corresponding increase in polio cases are shown on the two graphs from UNICEF's *State of the World's Children Report, 1994*. As for oral rehydration, even Egypt's national program—long upheld as the great success story—has in the 90s experienced a precipitous decline in ORS usage rates: from more than 50%, down to 23%.[7]

[Include here graphs from UNICEF's SWCR 94, with appropriate captions and refs.]

The disappointing and in some countries diminishing impact of Oral Rehydration Therapy can in part be explained by structural adjustment policies, which have methodically shifted the costs of health services and products onto the poor. But it is partly due to the dependency-creating, disempowering way the technology was introduced.
As we all know, there are two basic approaches to ORT: (1) manufactured packets of Oral Rehydration Salts (ORS), and (2) "home fluids." Strong encouragement of appropriate home fluids promotes greater self-reliance and control over diarrheal disease at the family and community level. Home fluids are less costly, more rapidly and reliably available, when prepared with cereals or starches can be safer and more effective than the sugar-based ORS formula.

But from the start, WHO, UNICEF, and USAID put their biggest investment into factory-made packets, thus pharmaceuticalizing a "simple solution" and creating dependency on a product whose price and availability lie outside family and community control. At first ORS packets were distributed free. But when health budgets were slashed by adjustment policies, health ministries were pressured to privatize both production and distribution. This commercialization of a potentially "life saving technology," means that today many poor families spend up to one fourth of their day's wage for one packet of ORS. Since undernutrition is the predisposing cause of death from diarrhea, it is easy to see how social marketing that induces poor families to spend their limited food money on ORS packets may be counterproductive in terms of lowering child mortality. However, virtually no studies have been done to determine how family expenditure on ORS may negatively affect child nutrition and survival.
may negatively effect child nutrition + survival.

Apart from promoting needless spending by poor families, privatization of ORS has made teaching about oral rehydration more problematic. As you know, here in India there is an array of ORS products on the market, designed for mixing with quantities of water ranging from 1 liter to 1/3, 1/4 and 1/5 of a liter. This wide variation makes it impossible to teach families how to mix a safe an effective ORS drink. All the health worker can tell mothers is, "Follow the instructions on each packet." But in a land where most women cannot read, following such instructions is not easy. The probability of preparing dangerously concentrated ORS drinks has increased.

Wisely, in the last few years, UNICEF and WHO have begun to place more emphasis on *increased home fluids and continued feeding* (including breast feeding) rather than such disproportionate emphasis on ORS packets. But after a decade of marketing the packets as a wonder drug, it is proving difficult to reeducate people (and especially health practitioners) that they can save both money and lives by using appropriate home drinks. Some health activists draw a parallel between the misdirected promotion of ORS packets and that of bottle feeding. Both involve commercial products which are more costly, more nutritionally counterproductive, more dependency-creating, and more exploitative of the poor, than are the corresponding home drinks.

Zimbabwe is one country that has taken a courageous stand in favor of home solutions and has refused to use ORS packets. The Zimbabwe Health Ministry firmly refuses to let ORS packets be used even in health centers, on the grounds that this would make people think home drinks are a second best substitute. Instead, nurses teach mothers how to prepare and give the same rehydration drinks they are encouraged to use at home.

2. Structural Adjustment Programs and cost-recovery plans

The next big set-back to Primary Health Care has been the introduction, during the 1980s, of Structural Adjustment programs (SAPs).

Structural adjustment programs (SAPs)—engineered by the World Bank and IMF—are, in essence, a way of making poor people pay for the irresponsible lending by the rich in the North to the rich in the South. By the beginning of the 80s, the "development" strategies imposed by the North on the South had begun to backfire. The Big is Beautiful development paradigm—pushed in the 60s and 70s by huge loans from Northern banks—made poor countries more dependent on the global market with its ruthless ups and downs. With the introduction of large scale, machinery-intensive agribusiness and industry, land and wealth concentrated into fewer hands. Landlessness, unemployment, poverty, and hunger increased. Growing unrest brought more repressive measures of social control. Even in countries that experienced "economic miracles," like Brazil, real earnings of workers drastically declined. More trickled up than trickled down. In sum, for vast numbers of people *development* really meant *underdevelopment*. It brought deteriorating living conditions and denial of basic rights.

But troubles were just beginning. By the start of the 80s poor countries were faced with staggering foreign debt. Huge interest payments offset any benefits from economic growth. As Third World economies began to falter, Northern banks withheld new loans, and scores of countries went into a fiscal tailspin. Some—beginning with

Mexico in 1982—announced they simply could not pay. The banks, with billions of dollars in loans to poor countries, feared economic collapse if debtor countries defaulted on their loans.

Then the World Bank and IMF came to the rescue (primarily of the Northern banks). They gave countries in crisis bail-out loans to keep servicing their huge debts and hopefully to restore economic growth. But strings were attached to these loans, mainly in the form of Structural Adjustment Programs. SAPs were designed to *stream-line* poor country economies so as to free up money for servicing foreign debt, and to bind poor countries into international trade accords that favor big business and "free market" interests in the North. SAPs have usually included the following components:

- cutbacks in public spending
- privatization of government enterprises
- freezing of wages and freeing of prices
- increase of production for export rather than for local consumption
- reducing tariffs and regulations and creating incentives to attract foreign capital and trade
- reducing government deficits by charging user fees for social services, including health

In sum, such policies add up to "transferring resources to investors and lowering payments to laborers."[8] Inevitably, they hit the poor hardest. Budgets for so-called "non-productive" government initiatives such as health, education, and food subsidies were ruthlessly slashed, while bloated military expenditures were mostly left untouched. Public hospitals and health centers were sold to the private sector, pricing their services out of reach of the poor. Falling real wages, food scarcity, and growing unemployment due to government layoffs all joined to push low-income families into worsening destitution.[9]
families into worsening

The overall impact of adjustment has been hotly debated. At first the World Bank denied that structural adjustment has hurt the poor. (This is like the tobacco industry saying there is no proof that smoking causes lung cancer.) More recently, the Bank has conceded that adjustment may have caused *temporary hardships* for low income families, but that such *austerity* (starvation of children?) is necessary to restore economic growth. Ignoring the historical record, the Bank still seems to think that by helping the rich get richer, the benefits will somehow trickle down to the poor.

But the evidence is overwhelming that structural adjustment, linked with other conservative trends in recent years, has caused a major set-back to Third World health.[10] The World Bank defends its strategies with reports and graphs showing that over the past 30 years Third World health has steadily improved. However, these reports shrewdly downplay the fact that *in many countries improvements in health have slowed down or stopped since the mid-80s, and more so in the 90s.*[11] In some countries rates of under-nutrition, tuberculosis, cholera, STDs, plague, malaria, and other indicators of deteriorating conditions, have been drastically increasing.

In spite of a modicum of development aid from the North, in the 1990s more than $60 billion net flows each year from the poor countries to the rich. GATT and recent "free trade" agreement, as currently drafted, are more likely to increase than decrease this inequity. Today, the income of the richest 20% of the world's inhabitants is 140 times as great as that of the poorest 20%. And worldwide the gap between rich and poor has grown 30% in the last 10 years. Although enough food is produced in the world to feed all people adequately, according to the UNDP nearly one quarter of the world's people do not get enough to eat.

User-financing or cost recovery schemes, together with privatization of public health services are among the adjustment policies mandated by the World Bank and IMF. UNICEF has also promoted user-financing of village health posts through the so-called Bamako Initiative, now functioning in many African countries and elsewhere.

While UNICEF has some reservations about the Initiative, it argues that in today's hard times it sees no better alternative. Cutbacks in health budgets during the 80s resulted in closure of many rural health posts, largely for lack

of medicines. UNICEF knows that people want medicines and are willing to pay for them. So through Bamako, consumers are charged enough for drugs to keep the health posts stocked and functioning.

UNICEF has tried to make the Bamako Initiative user-friendly and community controlled (c.f. UNICEF's *Adjustment with a Human Face*).[12] Indeed, the program does have a number of positive features. For one, only essential drugs are used (although, perhaps counterproductively, ORS packets are sold as an 'essential drug' for home use). Also, in some of the Bamako community-run health posts I have visited, local participation has been active and enthusiastic.

But many cost-recovery schemes have serious—and perhaps life-threatening—drawbacks. Just because poor families are *willing* to pay for medicines does not mean they can *afford* to pay for them. As we saw in the Philippines, poor families often spend for medicine the last pennies they need to feed their sick children. And when health posts are financed through sale of drugs, the temptation to over-prescribe is great. Also, because the poorest families get sick most often and tend to require more medication, they may carry more than their share of costs for the health post. While Bamako has provisions to charge less to *the poorest of the poor*, such safety nets work better on paper than in practice.

Studies in some countries have shown that *when cost-recovery has been introduced, utilization of health centers by high risk groups has dropped.* For example, in Kenya the introduction of user fees at a center for sexually transmitted diseases caused a sharp decline in attendance and an increase in untreated STDs.[13]

Whatever their short-term impact, the introduction of these so-called *cost-sharing* schemes has disturbing long-term social and ethical implications. It represents a retreat from progressive taxation, where society takes from the prosperous to benefit the least fortunate, in a sense of fairness and sharing. Placed in historical perspective, *when decision makers begin to inflict destitute and undernourished people with an increased portion of health-related costs, this is a great step backwards.* It means that for those in greatest need, health care is no longer a human right.

3. *Investing in Health:* The World Bank takeover of health policy planning

The World Bank's 1993 World Development Report, *Investing in Health*, has put the last nail in the coffin of the Alma Ata Declaration.[14] *Turning Health into Investment* would be a better title, for the Bank takes a dehumanizingly mechanistic marketplace view of both health and health care. When stripped of its humanitarian rhetoric, its chilling thesis is that *the purpose of keeping people healthy is to promote economic growth.* Were this growth to serve the well-being of all, the Bank's intrusion into health care might be more palatable. But the 'economic growth' which the Bank invariably promotes as the goal and measure of "development" has invariably benefitted large multinational corporations, often at great human and environmental cost.

The World Bank tells us it has turned over a new leaf: it now recognizes that *sustainable development* must take direct measures to eliminate poverty. Yet the Bank has so consistently financed projects and policies which worsen the situation of disadvantaged people that we must question its ability to change its course. A growing number of critics suggest that *perhaps the most effective step the World Bank could take to eliminate poverty would be to eliminate itself.*

On first reading, the Bank's strategy for improving health status worldwide sounds comprehensive, even modestly progressive. It acknowledges the economic roots of ill health, and states that improvements in health are likely to result primarily from advances in non-health sectors. It calls for increased family income, better education (especially for girls), greater access to health care, and a focus on basic health services rather than tertiary and specialist care. It quite rightly criticizes the persistent inequity and inefficiency of current Third World health systems. Ironically, in view of its track record of slashing health budgets, it even calls for increased health spending. . . . So far so good.

But on reading further, we discover that under the guise of promoting an equitable, cost-effective, decentralized, and country-appropriate health system, the World Bank's key recommendations spring from the same sort of structural adjustment paradigm that has worsened poverty and lowered levels of health.

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

1. Foster an enabling environment for households to improve health.
2. Improve government spending in health.
3. Promote diversity and competition in the promotion of health services."

These recommendations are said to reflect *new thinking*. But stripped of their Good Samaritan face lift, and reading the Report's *fine print*, we can restate these three prongs more revealingly:

1. "Foster an enabling environment for households to improve health" means requiring disadvantaged families to cover the costs of their own health care . . . in other words, *fee for service* and *cost recovery through user financing*: putting the burden of health costs back on the shoulders of the poor.

2. "Improve government spending in health" means trimming government spending by reducing services from comprehensive coverage to a computerized selection of cost-effective measures . . . in other words, a new brand of *Selective Primary Health Care*.

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

So we find the Bank's new health policy is old wine in new bottles: a rehash of the conservative strategies that have systematically derailed Comprehensive Primary Health Care—but with the added shackles of structural adjustment. In essence, it is a market-friendly version of Selective Primary Health Care, which includes privatization of medical services and user-financed cost recovery.[15] As with other Selective PHC schemes, it focuses on technological interventions and glosses over the social and legislative determinants of health: issues such as legalization of abortion and abandoned children. One reviewer (David Legge) observes that the World Bank Report is "primarily oriented around the technical fix rather than any focus on structural causes of poor health; it is about *healthier poverty*."[16]

The Bank prioritize health interventions by calculating their relative *cost effectiveness*. This is measured by the number of *Disability Adjusted Life Years* (DALYs) saved through each intervention. The cost of each intervention is weighed against the person's potential 'productivity' (i.e., contribution to economic growth). Each disease and ailment is classified according to how many years of productive (disability free) life the individual loses as a result. The Bank has studied and prioritized 47 different public health and clinical interventions, expressing their benefits in DALYs achieved. For example, leukaemia treatment is not cost effective, only 10 DALYs being saved for $10,000, while Vitamin A supplementation achieves nearly 1 DALY for $1.

In calculating DALYs, years of productive life lost are weighted according to age and work potential. Hence children and the elderly have lower value than young adults, and presumably disabled persons who are unable to work are awarded zero value and therefore have little or no entitlement to health services at public expense. The very term *Disability Adjusted Life Years* is an affront to disabled persons. (The DALY prioritization method which authoritatively deprecates disability has the stench of eugenics. Disabled activists need to join with health rights activists to protest this potentially neo-fascist policy.)

The *Investing in Health* Report advocates that governments should favor an environment that enables households to improve health. But to do this it does not call loudly for fairer wages or stronger labor unions. Instead, as always, it recommends economic growth policies backed by structural adjustment programs which, it claims, will eventually raise income per capita. In making this recommendation, the Bank ignores the fact that in many countries with SAPs average per capita income has plummeted. Even in countries whose economies have partially recovered, most gains have been pocketed by the wealthy; poor people's real income has tended to decline.

With its call for "greater diversity and competition in the provision of health services, promoting competitive procurement practices, fostering greater involvement by non-government and other private organizations, and regulating insurance markets," the Bank's new policy for the Third World sounds suspiciously like the health care model of the United States. It argues that private health care for individuals gives more choice and satisfaction and is more efficient. But there is little evidence to support this claim. The US health system, dominated by a strong profit-hungry private sector, is by far the most expensive in the world, yet US health statistics are the worst among the Northern industrialized nations. Indeed, some US health indicators are worse than those of certain Third World countries. Most striking is the extreme inequity of the US health system: Washington DC, with its large low-income population, has poorer child and maternal mortality rates than Jamaica.[17] Several US inner cities have immunization rates as low as 10%, and for the last several years deaths from measles in the US have been increasing.[18]

The commercial medical establishment and some large NGOs have celebrated the World Bank's *Investment in Health* strategy as a 'breakthrough' toward universal, more *cost-efficient* health care. But most health rights activists see the report as a masterpiece of disinformation, with dangerous implications. They fear the Bank will impose its recommendations on those poor countries that can least afford them. With its enormous money-lending capacity, the Bank can force poor countries to accept its blueprint by tying it to loans, as it has done with structural adjustment. In addition, the Bank states that it will encourage the donor community "to assist by financing the transition costs, especially in low-income countries." So beware!

A call for organized protest of the World Bank's intrusion into health policy making

It is an ominous sign when a giant financial institution with such strong ties to big government and big business bullies its way into the field of health care. Yet according to the British medical journal, *Lancet*, the World Bank is now moving into first place as the global agency most influencing health policy, leaving the World Health Organization in a weaker second place.[19]

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

In various parts of the world, concerned groups are attempting to engender a broad-based protest of the pernicious policies of the World Bank and IMF. Health Action International has put together a packet of writings from a wide variety of sources, criticizing the 1993 World Development Report and alerting health activists to oppose it.[1]

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[1] To become better informed about the full range of objections to the Report and the World Bank's controversial prescription for health, you can write to: Health Action International– Europe, Jacob van Lennepkade 334 T, 1053 NJ Amsterdam, The Netherlands.

For more information on the "50 Years is Enough" campaign, the groups involved, and a calendar of events, you can contact: The Bank Information Center, 2025 I Street, NW, Suite 522, Washington, DC 20006. tel. (202) 466-

Covering a broader critical analysis, "50 Years Is Enough" is an international coalition organized around the 50th anniversary of the World Bank and IMF. Involving scores of environment, development, religious, labor, student, and health groups, it represents an unprecedented worldwide movement to reform these International Financial Institutions. At the same time, many groups and networks around the globe are working on health and development issues from a grassroots perspective, trying to listen and respond to what people want. They are attempting to create broad public awareness of our current global crises, and to organize a groundswell of pressure from below on the world's policy making bodies. Two such grassroots coalitions based in the South are the Third World Network based in Malaysia, and the International People's Health Council, based in Nicaragua.

It is urgent that all of us concerned with the health and rights of disadvantaged people become familiar with the World Bank's *Investing in Health* Report. We must speak out clearly about the harm its policies are likely to do, and clarify whose interests those policies serve. New communications methods are needed to alert ordinary people to far-reaching concerns, and to counter massive disinformation, which has become the most effective strategy of social control. Never has the need been greater for a coordinated global effort to demand that world leaders and policy makers be accountable to humanity.

8191; fax. (202) 466-8189.

For a comprehensive list of groups around the world working on development issues from a grassroots perspective, you can consult the International Directory of Non-Government Organizations, compiled by WorldWise, 401 San Miguel Way, Sacramento, CA 95819, USA.

Endnotes

1. Brown LR, editor. *State of the World, 1994.* New York; London W. W. Norton. Foreword.

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3. The term "disease palaces" was first used by primary health care pioneer David Morley in his classic book "Paediatric Priorities in Developing Countries."

4. Werner D, Bower B, *Helping Health Workers Learn.* Hesperian Foundation, 1982. p. 18-7.

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