

Healthcare – Who cares?

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The World Health Organization (WHO) has defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. According to the Director-General of WHO, more than half the world's population have no access to medicines¹, and health systems which should offer protection against disease have, in extreme cases, either collapsed or not even built in many countries. The result is a resurgence of diseases that were once under control and societies unable to get themselves back on their feet or afford healthcare they need.²

The World Health Report 1995 draws attention to the widening gap between the health of the privileged and under privileged groups and concluded that poverty is the world's deadliest disease. Using this indicator it can be estimated that 1.3 billion people are suffering from the deadliest disease. Poverty eradication should be given top priority at World Health Assemblies. The closest the WHA and WHO came near poverty and social development was soon after the Alma Ata Declaration in 1978. The Assembly resolution on Health for All (HFA) by the year 2000 identified primary health care (PHC) as the key to HFA. It was underscored that PHC should form an integral part of the overall social and economic development of a country.

The Alma Ata Declaration states that, “An acceptable level of healthcare for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which PHC, as an essential part, should be allotted its proper share”.

Wars, violence, arms and public health

A substantial amount of world's resources is spent on arms, armaments and military conflicts. In the mid 1990s the annual global expenditure on the military was over \$750 billion³ and since World War II, the world has spent about \$30 – 35 billion on arms.⁴ From 1972 to 1982, while the developing countries spending on health and education fell, their military expenditures soared from \$7 billion to over \$ 100 billion.⁵

By 1986, the 43 developing countries with the highest infant mortality rates spent three times as much on defence as on health. In the same year, the advanced industrial nations spent over 20 times as much on the military as on development assistance.⁶ By 1988, the annual military spending in developing countries totaled \$145 billion. This would have been sufficient to end poverty around the globe within a period of 10 years.⁷

Wars, violence and the arms industry are real public health problems. HFA can never be achieved as long as these problems continue. The international community needs to explore ways and means of ending wars, violence and arms production.

In 1987, the United Nations convened a conference to examine the theme of disarmament and development. All Member States participated except the United States, which argued that disarmament and development were unrelated issues and also claimed that the Soviet Block had been the prime mover to get the forum to attack US policy.⁸ The Soviet Block is now history and the cold war is over. The UN should consider convening the second UN Conference on Disarmament and Development.

Health for all, peace and security are very closely interconnected. Health for all the people is fundamental to the attainment of lasting peace and security.⁹ Peace and security are essential for the attainment of HFA.

Poverty and the World Bank

The World Development Report 2001 gives the incidence of poverty under national and international poverty lines. The national poverty line is set by individual countries, the international poverty line, estimated by the World Bank (WB), is based on income. Table 1 gives the incidence of poverty in seven selected African and Asian countries.

Table 1. Incidence of poverty, per capita GNP and the ratios of income of the poorest 10 percent and richest 10 percent of the population in seven selected African and Asian countries.

	Population below National poverty line (Percentage)	Population below International poverty line (Percentage)	Per capita GNP US\$	Ratio of the Poorest 10% to Riches 10 Percent
China	4.6	18.5	780	1:13
India	35.0	44.2	450	1:10
Morocco	19.0	<2.0	1200	1:12
Nigeria	34.0	70.2	310	1:26
Sri Lanka	35.3	6.6	820	1:8
Thailand	13.1	<2.0	1960	1:12
Tunisia	14.1	<2	2100	1:13

Source:World Development Report 2001

Based on the national poverty line, in India, Nigeria and Sri Lanka about a third of the population lives below the poverty line. However according to the World Bank measurement the percentages vary very widely and are 44.2, 70.2 and 6.6 respectively in these three countries.

Being a measurement based on income, the WB’s measurement seems to correlate with the GNP. However in China and Sri Lanka with approximately similar GNPs, the measurements seem contradictory. World Bank’s measurement is too simplistic. Poverty is too complex an issue to be reduced to a single parameter - consumption based income.

The World Development Report of 1990 on Poverty states that the cost of minimum adequate caloric intake and other necessities can be calculated by looking at the market prices of foods that make up the diets of the poor and prices of other basic necessities.

The market prices of whatever they buy are given for unit measures such as kilograms, pounds, gallons and litres.

Poor people can never buy in such unit measures. They buy their requirements daily (if they have the money) in small amounts just enough for one meal from the rural grocer who is not a philanthropist, but a businessman. The very small amounts the poor buy cannot be measured. The prices are estimates and never pro-rata based on market prices, which the World Bank uses to estimate poverty line. The prices they pay will work out to several times the market prices. This is the fallacy in World Bank's calculation of consumption-based poverty line. This faulty poverty line is used for international comparisons. Head counts are carried out; all those surviving on less than one dollar a day are classified as poor. When their income rises to over a dollar they become non-poor.

Poverty eradication strategies based on WB's measurements may appear good on paper but are detrimental to the poor. The World Bank planners seem to have the mindset that all what the poor need is a little extra income. But more income is only one of the several things poor people want.

The poor are not a different species. Their perceptions of life are the same as ours. They want better choices and opportunities to achieve physical, mental and social well being in addition to absence of disease.

Adequate nutrition, safe water at hand, better medical services, more and better schooling for their children, adequate shelter, cheap transport, continuing employment, secure livelihoods and productive remunerative and satisfying jobs are what they want.

Poverty and economic growth

Human Development Reports of 1990 and 1999 bring into focus the contradictions between the enormous economic growth and increasing poverty in the world.

1990 Report: "During the last three decades the developing world has made enormous progress. Against this background of achievement, it is all the more shameful that more than one billion people are living in poverty. These people are struggling to survive on less than one dollar a day. Life expectancy in Sub-Saharan Africa is just 50 years".

1999 Report: "There has been enormous economic growth. The world is more prosperous; average per capita incomes have more than tripled as global GDP increased from US\$ 3 billion to US\$ 30 billion in the last 50 years. Despite the tremendous progress, poverty is everywhere. An estimated 1.3 billion people, more than a quarter of the 4.5 billion living in the developing world, survive on less than one dollar a day. These people do not have access to basic needs; as a result they do not survive beyond the age of 40".

Within a period of 10 years, the life expectancy at birth of over a billion people has gone down by 10 years from 50 to 40. This is the greatest indictment against the existing world economic order – globalization, liberalization and multilateral trade agreements.

Intergovernmental policy making in today's globalized economy is in the hands of G7 – the seven richest industrial powers and the international institutions they control – WB, IMF and WTO. Their rules and regulations create a very secure environment for open markets but an adverse environment for social development as shown in the Human Development Reports, 1990 and 1999.

The finance ministers of these industrial countries are in daily telephone contact – and their staff in e-mail contact – shaping the annual G7 meetings to discuss global economic and political issues. The central bankers in these countries still guide the supervision of the global banking system.

And these rich industrial countries have taken upon themselves the task of eradicating poverty. At one of their summits, the G8 governments committed themselves to halving world poverty and reducing child mortality by two thirds by 2015. But the reality seems to be quite different.¹⁰

The Human Development Report 2001 has warned that the goal of reducing infant and maternal mortality is nowhere in sight. Ninety-three countries with almost two-thirds of the population will miss the target to reduce the under 5 mortality by two thirds. Table 2 confirms this.

Year by year the under – 5 mortality rates in these 15 countries are rising. The doubling of the mortality rate in Iraq can be explained by the inhuman sanctions imposed by the UN, which adopted the United Nations Convention on the Rights of the Child in November 1989 which was signed by all UN Member States except the US and Somalia. The increasing mortality rates in other countries are due to increasing poverty and neglect of PHC.

Another failed promise by the richest countries relate to the HIV/AIDS crisis. In April 2001, the UN Secretary General Kofi Annan called for a multibillion dollar global fund to control AIDS saying \$7 to \$10 billion is needed to halt the spread of AIDS. In May 2001 he addressed the WHA on the need for a Global Fund. He asked the rich nations to contribute and they all agreed. The President of US pledged \$200 million in May 2001.

There was general euphoria that a solution to the AIDS crises was in sight. The Fund became operational in January 2002. Up to 7 February 2002, only 1,960 million dollars were pledged. This will allow only \$700 million to be disbursed in 2002.

A fund that was to attract \$7 - 10 billion will disburse only \$700 million in its first year of operation because the rich countries promised but did not give. In fact, the poor developing and least developed countries in Africa have put to shame the rich industrial countries by pledging much more money expressed as a percentage of the GDP as shown in Table 3.

Table 2: Under 5 mortality rates in 15 developing countries – 1996, 1997 and 1998.

Country	Under 5 mortality per 1000 live births		
	1996	1997	1998
Angola	179	191	204
Botswana	57	94	105
Burundi	96	116	106
Guyana	60	71	n.a
Haiti	104	109	116
IRAQ	59	113	n.a
Lesotho	81	94	144

Liberia	151	200	n.a
Malawi	212	221	229
Namibia	91	98	112
Rwanda	161	197	205
Sierra Leone	242	251	283
Togo	118	130	144
Zambia	140	149	192
Zimbabwe	103	108	125

Source: *World Health Reports 1997, 1998*
World Development Report 2001

Table 3: *Money pledged to the Global Health Fund expressed as a percentage of the country's + GDP by the seven richest countries, two LDCs and two developing countries with a per capita income of \$520 and \$310 respectively .*

Pledges to the Global Fund as a percentage of GDP			
Developed Countries		Developing Countries	
G7	Pledge%	Developing Country	Pledge %
Japan	0.005	Zimbabwe	0.016
Germany	0.006	Nigeria	0.03
US	0.006	Uganda	0.03
France	0.009	Rwanda	0.50
Canada	0.017		
Italy	0.018		

Source:(1) *Office of the spokesman for the Secretary General*
<http://www.un.org/News/ossg/aids.htm>
(2) *World Development Report 2001*

Two LDCs and two poor developing countries' pledges as percentages of their GDP are several times higher than some of the richest of rich countries.

Poverty and health

Poverty, in addition to being the deadliest disease, is also the commonest cause of ill-health. The consequences are very low standards of health characterized by unacceptably high infant, maternal and under 5 mortality rates and low life expectancy at birth.¹¹

Infant mortality rates (IMRs) (number of deaths of children under one year for every 1000 live births) in the developed industrial countries vary between 3 and 7.

The IMR is over 50 in 79 developing countries, over 100 in 23, over 150 in four and over 175 in one.

Maternal Mortality rates (MMR) the number of deaths of mothers for every 100,000 live births in developed industrial countries is under 10. The MMR is over 100 in 96 countries developing countries, over 500 in 26 and over 1000 in three.

Under 5 mortality rate the number of deaths of children under 5 years for every 1000 live births in developed industrial countries is under 7. The under 5 mortality is over 100 in 46 developing countries over 200 in 10, and over 250 in two.

The life expectancy at birth is over 75 years in the developed industrial countries. The life expectancy at birth is under 60 years in 118 developing countries, under 55 in 68, under 50 years in 27 and under 40 in two.

The chilling data published in UN Reports clearly demonstrate the extremely low health standards in developing countries. And worse, the indications are that the standards are continuing to fall.

One of the best strategies, perhaps the only option available, is to re-invent PHC as the key to HFA.

Poverty and debt

Several developing countries are heavily indebted. Table 4 gives external debt as a percentage of the GDP in 32 developing and least developed countries.

Table 4: External debt as a percentage of GDP in 82 developing and least developed countries.

External debt as a percentage of GDP	Number of Countries
>200	3
>100	12
>50	82

Source: World Development Report 2001

Table 5: Debt servicing as percentage of revenue from exports of goods and services in 42 developing and least developed countries.

Debt servicing as a percentage of revenue from exports of goods and services	Number of Countries
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>100	1
>50	2
>40	5
>20	42

Source: World Development Report 2001

Tables 4 and 5 clearly indicate that these countries can never repay their debts in full. On the other hand many of them will get into more debt.

To be entitled to receive aid, these countries get into further new debt to service outstanding debts. The debt relief promised at the Cologne G8 summit to end the debt crisis is another broken promise. Two thirds of countries which are now receiving debt relief are spending more on debt servicing than on health. A half spend more on debt servicing than on primary education and health care. The Heavily Indebted Poor Country (HIPC) initiative is failing to achieve what it was created for, as Mr Wolfensohn, the World Bank President declared, "... To eliminate debt as an obstacle to poverty reduction".¹²

Who cares for health when debt servicing is the priority?

The escalation of poverty

The paradox of enormous economic growth and simultaneous poverty growth was best explained in the Human Development Report 1997 which stated, "A rising tide of wealth is supposed to lift all boats. But some are more seaworthy than others. The yachts and ocean liners are indeed rising; but the rafts and row – boats are taking on water – and some are sinking fast".

The raft and row-boats are the very poorest and structurally weakest countries, which the United Nations classified as "Least Developed Countries" (LDCs). The first list in 1971 had 21 LDCs.¹³ A special committee of the UN periodically reviews the list every three years and updates the list.

The last revision was done in April 2000. The number of LDCs has now risen to 49 countries with a total population of 620 million. Two more countries, the Republic of Congo and Ghana were also identified as meeting the criteria for LDC status. But since both these African nations have, for now, refused to have their economic status downgraded, they were not added to the list of LDCs.

The UN Committee for Policy Development which sits in judgment over which country should or should not be ranked as an LDC has identified another 16 countries which meet some, but not all, of the criteria for inclusion in the list of LDCs. These are Cameroon, China, Cote d' Ivoire, North Korea, Guyana, Honduras, India, Indonesia, Kenya, Mongolia, Nicaragua, Nigeria, Pakistan, Sri Lanka, Vietnam and Zimbabwe.

If the economies of some of these developing nations continue to deteriorate – promoted mostly by rising debt, falling commodity prices and sharp declines in development and foreign investments – the ranks of LDCs will keep swelling over the next decade.¹⁴

The growth in the number of LDCs reflects the worsening of economic conditions in the developing countries and consequent escalation of poverty.

If and when their level of development increases, the UN committee will “graduate” them from LDCs to developing countries. But in the 30 years since LDC ranking began, only one LDC had improved its economic status – Botswana.¹⁵

The People’s Health Movement and the People’s Charter for Health

Twenty-three years after Alma Ata, and after the enormous resources that have gone into interventions in the name of PHC, we find the health standards of billions of people are sliding down according to several UN Reports. Over 1.3 billion people live in absolute poverty, the deadliest disease according to WHO. Over half the population has no access to even a few basic essential drugs. Healthcare systems have either collapsed or not even built in many countries.

It is quite clear that current approaches have failed. People have lost faith in multilateral aid through international agencies or bilateral aid with strings attached; governments and intergovernmental agencies seem to have ignored the commitment made at Alma Ata, in 1978.

There is, therefore, an urgent need for a new approach to mobilize the interests, commitments and resources of a broader constituency for the poor.

Thousands of socially oriented indigenous groups exist in the South. All these groups provide some form of PHC to vast number of people who have no other sources of help. None of these group’s or people’s voices have been heard outside. These groups are waiting for additional ways and means to apply their experience, energies and leadership. Social and political activism is not new, but it can be put to new use at local, national, regional and international levels.

The People’s Health Movement has now provided the international forum for all these groups and individuals. They got together with academicians and health activists and began preparatory actions in 1998. There was unprecedented enthusiasm and participation of a broad cross sections of people around the world. Representatives of all these groups assembled in Dhaka, Bangladesh. From 4-8 December 2000, 1453 delegates from 92 countries participated in the People’s Health Assembly (PHA).

Through a participatory process over 18 months, the collective wisdom of all these people, was distilled into the People’s Charter for Health. The Charter is a political statement to the world that the agenda for better health lies in the hands of the people and people’s organizations. The People’s Health Movement will use the Charter as the main campaigning and lobbying tool to bring PHC back to national and international fora deciding on health policy issues.

The Charter underscores the fact that actions at all levels are needed to combat the health crisis. The Charter contains a long list of actions which provide very good entry points to break the vicious cycle of poverty and ill-health.

This call for action is directed to players at all levels - individuals, community, national, regional and global - and in all sectors. The call for actions is given under the following sections:

1. Health as a human right;
2. Tackling the broader determinations of health;
 - Economic challenges;
 - Social and political challenges;
 - Environmental challenges;
3. Wars, violence, conflict and national disasters;
4. A people centered health sector; and
5. People’s participation for a healthy world.

A very wide spectrum of calls for action is included under the different sections. These provide a wide choice of activities for individuals and organizations both big and small, to choose from depending on their own interests and resources available. There are, therefore opportunities for every individual and organization to take on a health related activity to make HFA a reality.

¹ Globalization and access to Drugs: Perspectives on the WTO/TRIPS Agreement. Health Economics and Drugs, DAP Series, No 7. Revised. World Health Organization, 2000

² The World Health Report, 1996

³ Michael Renner, Budgeting for Disarmament: The Cost of War and Peace, World Watch Paper, 122, Nov 1994, P5

⁴ Ibid, P10

⁵ UNICEF, State of the World's Children, 1987, P17

⁶ Ibid, P72

⁷ Ibid, UNICEF, STATE of the World's Children 1990, P1

⁸ Marek Thee, The Third Special Session of the UN Assembly Devoted to Disarmament: Between Disarmament and Development, Transnational Perspectives, Vol 14, Nb 3 (1998) pp 6-11

⁹ World Health Report 1998, p9

¹⁰ Oxfam Policy Papers– Oxfam International Briefing Paper – 07/01. "Where is the Money? G8 promises, G8 failures"

¹¹ World Development Report 2001

Human Development Report 2001

¹² Oxfam Policy Papers

¹³ <http://www.un.org/event/dc3/prepcom/history.htm>

¹⁴ Least developed countries grow– in numbers. Third World Network <http://www.Twnside.org.sg/title/grow.htm>

¹⁵ bid