

FINANCING HEALTH SERVICES IN THE THIRD WORLD NATIONS—CRISIS OF STRUCTURAL ADJUSTMENT

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ABSTRACT

Western nations and international financiers are usually the donors for most of the Third World countries. International funds allocated for development projects in these nations are under control of such groups, in which global corporate policy, bureaucracy, and neo-liberalization play a major role. International financiers also bias the socio-political, environmental, local administration, and even public health policy of the poor nations. Financial packages are usually sanctioned, distributed, and reimbursed under strict terms and conditions that Third World nations must heed and agree to with the fundamental commitment to change accordingly. Obviously, these terms and conditions are complicated for the local governmental authorities. In most of the implementation phase of a project supported by foreign loan/aid, the efficient features of their own of the donors may be reflected, while the proposal and prospects for the actual benefits are left to the local populace. Cutting government spending and neglecting the benefits to the poor people, global capitalism maintains corporate policy that may also focus on the goals of profit making instead of public benefit. As such, enhancing privatization, structural adjustments have been devised by the international financiers in many sectors. The reason is that private sectors must necessarily comply with the market dynamics of free choice and with the belief that it could be more efficient and equitable than the local government's action. It is thus important that healthcare professionals, government officials, and others solicit their opinions about international policy on privatization programs through a range of cost-benefit analyses. In order to identify and evaluate the negative effects of structural adjustment, this article aims to comment on international policy for financing health services in the Third World.

INTRODUCTION

During recent years, public health services have been negatively affected by the crises of structural adjustment (SA). This means the displacement of the public health services to the private sector (World Bank, 1993). Accordingly, health as a basic human right has been subordinated to economic interests, which has raised serious objections worldwide. On promoting the diversity of public health services, a certain formula has been imposed on some specific reforms that local government authorities may not be able to cope with, for instance, distribution of selective primary health care instead of public facility (Berman, 1982; Gish, 1982). Overshadowing government's actions and limiting public spending on healthcare, SA policy has brought multiple negative effects that have undermined basic rights of poor people living in many Third World nations (TWNs). As such, cuts in budget spending mandated by SA forces local governments to provide informal social supports for healthcare services. The International Monetary Fund (IMF) and the World Bank (WB) have been suggesting that local government authorities accept selective primary healthcare (Loewenson, 1993; Walsh & Warren, 1979) to cut government spending on public health. Health, nutrition, hygiene, sanitation, and/or occupational safety are usually treated as items of national importance, and are recognized as the people's basic rights. Therefore those items draw our attention that is surely a matter of social concern (Roberts, Smith, & Lloyd, 1992; Sekimpi, 1993; Williams, Popay, & Bissell, 1995). Slashing government spending, and emphasizing the priorities of private service, SA encourages commercialization of public services (Gee, 1994). Even individualization of health matters certainly reduces social and employers' responsibility in the case of sick and disabled people, and even industrial workers (Whitehead, 1992). Hence, restructuring social budget or public spending for "healthcare," the IMF/WB's policy is punitive for the poor people (see <http://www.al6.org>). The IMF/WB's policy also demands an increase in profit earnings through market competition (Gee, 1994), and thus it would not be right to equate people's need for basic health, nutrition, family planning, and sanitary facilities with any other commodity. The other reason is that all of these basic needs are of public concern. In this context, Unger and Killingworth (1988) noted negative consequences of health reforms by SA, which facilitates some actions in the selective programs. However, such form of adjustment is devised to soften the administrative power, bureaucracy, and state burden in many instances. According to SA, the government intervention is advised for certain reform on the privatization. The SA is also based on the transfer of potentially lucrative health service provisions and financing to the private sector. Laurell and Arellano (1996) explained how the IMF/WB proposal is related to the diversification of public health and conversion of "health" into market commodities. In practice, this proposal is a high cost intervention (Castleman, 1999; Laurell, 1991; Laurell & Arellano, 1996) that provides insufficient measures for the poor people. However,

the IMF/WB exercises global corporate policy and neo-liberalization to finance Third World governments. In the establishment and enforcement of privatization, such policy have also played the “sovereign” key role in the profit-making business (Gee, 1994). Linking development perspectives, global capitalism recognizes the dual nature of health matters as an end in itself, and as a means to foster some development. International financiers also play neoliberal policy by the name of such “development” for health reform to sustained crisis (Kanji, Kanji, & Manj, 1991; Laurell, 1991), and thus, Bodenheimer (1990) opined that if we should abolish the private health industry. To bring equality and equity for health matters, Whitehead (1992), Kanji et al. (1991), and Price (1988) revealed the consequences of privatization through the influence of SA. It showed crisis and chaos not only in South Africa (Price, 1988), but also in other nations (Ahasan, 2000; Kalumba, 1991; Laurell, 1991, 1993). However, this sort of development has been starving for many other reasons (Akin, 1987; World Bank, 1993). Since there is a growing recognition of the importance of placing greater priority on the provision of primary health care, and thus as a way of minimizing the cost of direct medical care, we should abolish the private health insurance industry for an agenda.

HEALTH-CARE SITUATION IN THE THIRD WORLD NATIONS

For many reasons (Ahasan & Partanen, 2001), the agenda for health reform remains neglected in TWNs. Special problems were identified by El-Batawi (1981) and Ahasan, Lee, and Partanen (2000). Due to many obstacles (Mwaniki, 1992; Wright, 1998), poor people’s health still suffers a lot. According to a report (World Health Organization, 1995), more than 52 million deaths occurred in 1996 worldwide. Of these, 40 million deaths occurred in the TWNs—that is, four times more deaths than in industrially developed countries. In most of the TWNs, infants are not vaccinated, clean water and sanitation are not commonly available, not even curative drugs and other treatments are within the reach of many rural people. Poverty is the main reason why these people suffer in all walks of life. Illiteracy, poor social status, and a poor economy erode their life style into a pitiful situation. The mounting health crisis also relates in part to the lack of adequate data and information (<http://www.who.int/aboutwho/>) in many developing nations.

The number of such people living in extreme poverty increased during the second half of the 1980s. The number of such people in 1990 living in poverty was estimated at a little more than 1.1 billion (WHO, 1995) worldwide. A person in the TWNs has an average life expectancy of 43 years, compared to 78-80 in some Western nations. Some poor countries have less than US\$4 per annum to spend on healthcare (Wright, 1998). There are widening disparities between rich and poor, and between one population group and another. Millions of people suffer daily from a basic healthcare crisis in TWNs while in other parts of the world, millions

of people spend money on habit/substance which are not healthful such as abusing drugs, smoking cigarette, or consuming excess alcohol. If not most, however many Western people believe a moderate amount of alcohol is good for health. In TWNs, a billion dollars could go far to help immunize people against deadly diseases. Such an amount is spent every 12 days in America on beer and every 5 days in the European Union on cigarettes (Stevens, 1989), for instance. It is believed that timely prevention of diseases would be beneficial through the integrated primary control programs. Most of the TWNs face various problems in the provision of healthcare services, including enough budget, emergency allocation of funds, expertise, and resources. The systems required to deliver them to the target populations do not exist, and are inadequate in quantity and quality since these nations always lack health-care and medical services.

The people living in TWNs are also suffering from deficient nutrition and concomitant infection. Due to unhygienic conditions and many other reasons, occupational health problems are acute in developing countries (Kromhout, 1999; O'Neill, 1998; Phoon, 1983). Hundreds of tropical diseases such as leprosy, malaria, or cholera are cursory to clinicians in TWNs. Due to many of the above reasons, over 17 million people have suffered from infectious and tropical or parasitic disease (WHO, 1996). A shortage of medical staff also compounds problems of these diseases. There is one doctor per 9,000 to 12,000 people in Bangladesh (Ahasan, 2000), for instance, one to 7000 in Zimbabwe (Kalumba, 1991), and one to 40,000 in Mozambique (Loewenson, 1993). Whereas some Western countries have one doctor for every 200-500 persons (Esping-Andersen, 1990). People in TWNs do not have access to the same quality of healthcare as enjoyed by people in the Western nations. Due to deficiencies in the proper implementation of health services, more than 15 million people suffer from circulatory diseases; over six million to cancers; and about three million to non-specific respiratory diseases (WHO, 1995; Wright, 1998). Many of those diseases are preventable at a cost of just a few pennies each. About one billion people worldwide do not have regular access to local health services while cheap, effective, and life-saving treatments sit unused on shelves. For these reasons, SA has no potential benefit to improve healthcare systems in either the quality or easier access to the poor people living in TWNs. The existing hospitals and health centers are limited at the district or sub-district level. Where clinics and hospitals exist, mostly in the cities and towns, they are often ill-equipped and are also beyond the reach of rural people. Referral hospitals with competent medical specialists and state-of-the-art medical equipment or diagnostic or pathological centers and laboratories are also non-existent. Thus, health care expertise may not be accessed from under-served locations. In remote and rural areas, it is also difficult to transport patients properly. Some 23 percent of deaths among children under the age of five occur in the first week of life and 33 percent within the first month in TWNs (WHO, 1995). Most of these deaths are associated with the delivery itself or immediate complications and infections. More than 12 million

children under the age of five die from the preventable causes every year. Seven out of ten babies are born without the help of a trained attendant (WHO, 1995). Hence, mothers dying in maternal death in childbirth is due to reduced life expectancy, disability, and starvation. Family disintegration and substance abuse are common in TWNs. Public health services face the world's most serious problems in this part of the world. In this regard, Kemper and Novak's (1993) speculation was published in the *International Journal of Health Services*. Population growth, global change, rapid industrialization, and the emergence of new diseases are increasing the demand for health and safety services (Graham & Wiener, 1997; Rayner, 1993). Development of health services is still neglected in many African nations (Kalumba, 1991; Loewenson, 1993; Mwaniki, 1992; Packard, 1989). With a few exceptions, most of the Asian nations are suffering from insufficient health services. The same picture could be found in the Latin America and other parts of the Third World.

The number of hospitals and clinics along with the doctors and nurses is simply inadequate for TWNs overwhelming health needs. There is an increasing recognition that health services must be provided close to the people who need them, and thus an integrated and cost-effective approach is necessary. However, integration of health, hygiene, and sanitation program has a long way to go before it is recognized in most of the developing nations. The inevitability of privatization of such programs is to provide health services on a selective basis (Berman, 1982; Gish, 1982; Walsh & Warren, 1979) that should be discussed more as global agenda.

WHAT IS STRUCTURAL ADJUSTMENT?

SA is treated as the "standard" or of cutting government's action on basic services and enhancing privatization. While the directives [<http://www.eu.directives.com>] of the European Union are used to maintain other forms of "standards," such as legislation and regulations for an improved standard of living, or for an improved quality of life and safe manipulation of machines, equipment or environment-friendly production. This type of measure sought to be superior to the IMF/WB's policy on commercialization of health services because it affects negatively on the general welfare of the Third World populace. Comia, Jolly, and Stewart (1987) opined this adjustment as the adjustment with a human face. The SA perhaps limit possible state intervention because the IMF/WB encourages some measures by cutting government subsidies to the provision of public health services. They encourage the promotion of market competition or privatization of health service. According to SA, health matters are usually considered as private matters, and are to be solved through the competitive market, non-governmental organizations (NGO), or individual families. Exacerbating the exploitation of the vast majority of the poor people in TWNs and overlooking essential parameters of the local benefits, SA therefore brings idiosyncratic policy

to the development of privatization. A negative and extensive concept such as privatization of health services does not pay attention to the well being of local people. SA is devised to achieve fiscal balance, which provides a pragmatic formula. SA also limits possible measures to those involving pollution controls, for instance. Warford (1995) noted the role of economic instruments and policies on environment, health, and sustainable development that the United States and its allies should take care of their policy for global interest. Accompanied by SA programs, global corporate policy (Comia et al., 1987; Himmelstein & Woolhandler, 1990) also influence social, economical, and political matters that have received serious objections worldwide [http://www.oneworld.org/ips2/mar00/03_01_001.html]. However, SA has been depleted throughout the TWNs of its poor policy for evaluative and ethical significance.

SA is the interventions of public expenditure and reduction of state subsidies (Laurell, 1991). According to its narrow definition, it builds consensus on such determinations that healthcare is to be considered as a matter of people's personal necessity, rather than a social right. With the aim of diversified health services, basic components such as health and hygiene are recommended to be individual responsibility. Similarly, by adopting such measures and taking the risks of unhealthy situations, the populace should resolve these issues as individual problems. Other critical views of SA policy were noted by Laurell (1991, 1993) and Laurell and Arellano (1996). In an evaluation of cost and satisfaction for health services among the OECD countries (OECD, 1994), the United States was found to have the poorest showing because of its high costs and low satisfaction (Navarro, 1982). The well-known and extensively documented chronic crisis of health services was afflicting the United States populace (Navarro, 1986). It recounts the inefficiency and inequity of health benefits in the United States (Navarro, 1990). However, the United States is the largest and most influential shareholder of IMF/WB and corporate consultants of TWNs (www.corporatepredators.org).

The practical outcome of SA, however, implies public withdrawal from financing healthcare and other sources to poor people. The technical basis of SA is the evaluation of health reform in terms of global burden of illness and diseases (WHO, 1996), which has left the TWNs poorer in the process of injustice adjustment. It leaves poor people to pick up the pieces of privatization by eliminating government services. It has contributed to rising income and inequality of wealth distribution in TWNs (Stevens, 1989). It has forced the poor to be dropped from public benefits and suggested some formula that the poor generally suffer. Of particular importance are Latin American health reforms launched a few years ago (Laurell, 1991; Laurell & Arellano, 1996) and which contributed to shifting government subsidies to large-scale privatization. And therefore the per capita income of the general populace was stagnated by the influence of equity and

health provisions (Castleman, 1999; Kanji et al., 1991; Laurell, 1991; Laurell & Arellano, 1996).

Providing a pragmatic formula, SA has been introduced in some other countries for health reform for their ability to channel resources to the poor people. Costa Rican health reforms (World Bank, 1993) and the Korean example (Walsh & Warren, 1979) have been, however, recognized as chaos for other nations. Inversely, the Chilean health measures (World Bank, 1993) have been proposed as a model for others. It is because of its radical privatization and budget cuts on public expenditures. Irrespective of geographical location, SA in part may link to the health service's option, where one group who has money will be served and other group without money will suffer. If privatization of health services is introduced in TWNs, then poor people will not be able to bear the cost of expensive treatment from the private clinics. Health services must be integrated regardless of cost-benefit analysis. Its effective and available options are to be prioritized for the people who need them first. For selective healthcare, however, a common understanding of how an efficient form of health measures could be appropriate for specific groups of people, yet in certain situations be lacking. In addition, the local government authorities are being deprived of accepting their responsibility to offer or distribute adequate services, according to the SA (World Bank, 1993), and according to the "selective primary health care policy" (Berman, 1982; Gish, 1982; Walsh & Warren, 1979).

GLOBAL CORPORATE POLICY FOR FINANCING THIRD WORLD NATIONS

Given the increasing power of the supranational institutions (e.g., IMF/WB) for financing TWNs, it has given loans as a "selective relief" and according to the income levels of the people. Global corporate policy does not distribute the basic facility to developing nations. It can play as "international double standards" (Castleman, 1999) and block internal policy from a centralized form of unseen reform through the corporate venturing (Block & MacMillan, 1995). In many instances it does not conform to local needs because global venturing implies an idiosyncratic policy (Warford, 1995) in sanctioning money for health related projects. Kähkönen (1996) noted the European funding situation for health and safety related research and development projects in East African nations, where most of the projects end up with no solution. International funding for financing health services takes a trade-off for some nations between competing claims to arrive at a desired level of project funding, while in some other countries attempts to assess the funding requirements are non-existent. It is of vital importance to know that the existing government faces problems while foreign aided projects or financial allocations that were made to the previous government for the dictators need to be repaid, even though these were used for wasteful military spending or boondoggle projects. According to global corporate policy, is

there any scarcity of cases of politically motivated lending? Why was President Marcos of the Philippines, for instance, a grateful recipient of loans from the West? Why was similar philosophy applied to ex-Presidents Suharto of Indonesia and Mobutu of the former Zaire? The former Soviet Union equally and well-supported Nicaragua, Mozambique, and Cuba. Very little attention was paid to how the money was used or abused in such nations. One-fifth of all TWNs' debt consists of loans given to prop up compliant dictators. But when the dictators fall, it is expected that their democratically elected successors should repay those debts. Lenders must take a much greater share of the responsibility and absorb the losses that makes poor countries to be more poor.

Should Nicaragua and Honduras, both heavily indebted countries and badly hit by Hurricane Mitch in 1999, continue to pay a total of \$2 million a day in debt repayments? Whereas, this money could provide healthcare and temporary housing for thousands of people in these regions. In the name of development, global corporate policy implicates neo-liberal policy for which African nations, for instance, are in heavy debt to the IMF/WB (Onimode, 1989). Mozambique's debt service will only fall from \$112 million a year to \$100 million, a savings equivalent of about 80 cents per capita per annum. While reducing total debt is important for each of the TWNs, no one can invest more in health services. The key to finding new resources lies in cutting those debts that countries actually service and not those considered unrecoverable. To keep a country's books looking healthy, Tanzania and Ethiopia, for example, have suffered from delays in relief because they did not make the adjustments deemed necessary. However it does contradict such types of macro-economic adjustments to ensure that the poor will benefit from the IMF/WB. Gondwe, the IMF's African Department Deputy Director, argued to the familiar argument of moral hazard, such as writing off debts and service payments will reduce the incentive to better manage finances in the future that may worsen already poor credit ratings. This argument is valid when loans have been made for sound economic investments. But what about money loaned not primarily for investment reasons rather for political reasons to win allies or to increase foreign exports (LaDou & Jeyaratnam, 1994; O'Neill, 1999)? In this regard Shiva (1992) expressed concerns about the environmental degradation and subversion of human health. The need for effective investment of foreign aid is, however, vital, but local economists have brought charges of misappropriation of the donors' funds (Weisbrot, 2000). In this regard, TWNs must create their own resource base to finance development projects against the backdrop of steady decline in official development assistance.

DISCUSSION

There are many reasons, however, why SA policy is a priority option for many countries. The local governments in TWNs is in such a situation that it

seems economically weak by the way that the public sector is inefficient, corrupt, and frequently inequitable. It is true that there are many local problems (e.g., natural disasters, geographical problems, and socio-political instability), budget shortages, inefficiencies, and flexible attitudes on the part of the local administrations. The local government is often kept under pressure due to varying degrees of power wielded by the opposition political party through public strikes, from time to time various demands from the labor unions, and so forth. On the contrary, the private sector has no such pressure. It is recognized as efficient and more equitable since it must necessarily comply with the market dynamics of free choice and competition. The suffering caused by SA and the financial tempests rattling the global corporate policy bring new reasons to tighten the debt of many TWNs. Owing to the potential problems of SA for health services in TWNs, preventive healthcare and control programs would be more important than blaming each other. The concept of SA may be unjustified because global capitalism in general usually overlooks multiple situations of TWNs. It is necessary to grasp the real idea and meaning of SA and its relationship with such a privatization or market dynamics. Since more than 50 percent of the people are illiterate in many of the TWNs, they have yet to understand the concept of SA. Implementation of appropriate measures therefore should be versatile, and applied in such a way that it synchronizes with the existing situation and local tradition. TWNs will not be able to afford such measures, i.e., neither privatized care nor the cost of individual care. Increasing demand and rising healthcare costs have to be matched by the funding of the health sector in most of the TWNs. Another reason is an efficient service due to unstructured and dispensable nature of primary health care. It is quite natural that the SA can be treated as an undue shift of primary care to private health care from secondary care. Increasing demands on health are being placed on primary health care services as structural changes begin to have an impact. As a major consequence, public services have potential benefit for the subsidized, available and low-cost access to health care for countries with limited medical expertise and resources. External support and funding can be contemplated but the sustainability of the delivery system should be scrutinized carefully before committing significant progress of global capitalism. To meet this challenge, government and private health-care providers must make use of existing resources for the benefits of local people. It is generally believed that the service delivery system for public spending on health, nutrition, sanitation, and other components are not distributed properly in TWNs. It is perhaps due to the fact that government officials do not work efficiently. There is misuse of national resources, corruption, money laundering, and other problems. Privatization can also raise concerns about liability, confidentiality, competition, and other policy and regulatory issues. Therefore, SA processes need to be carefully implemented, considering all the intervening and local factors.

CONCLUSION

As far as health service in TWNs is concerned, the SA process needs to be revised or halted. The author speculates on this adjustment effect because there is a growing pressure from the international financiers and donor agencies to implement privatization. Despite some false starts in the process of SA, we shall need to find solutions that are appropriate to the needs of local people and availability of resources at its present standards. Instead of SA, NGO-based pilot programs can be used, and non-conventional links between the various levels of the health services can feed them through to district-level hospitals as appropriate, which in turn can transfer patients to more specialized centers if necessary. The reasons health care will be privatized and appropriate measure yet to be successful, a series of questions however arise regarding how health services could be developed in spite of its diversification and privatization. Other questions are how to increase people's awareness globally through easier access to health care services. As such, how do we measure and assess an individual's responsibility so that healthcare services will be effective for the poor? And, by what means should efficient measures be implemented so that health services would cause benefit for the poor? Which tool can influence the improvement of health services? Who is to be assigned to supervise and inspect private health care, if SA is to be implemented? How to enhance this responsibility irrespective of varying cultures and with varying social, economic, and political situations? Who will follow up the parameters necessary to reduce diseases and illness? How will essential parameters of "human health" and SA of healthcare services be synchronized? Will it truly reduce public spending or only increase poverty and problems? How do we improve the management of morale of the concerned department? How will health-related acts, regulations, and legislation be enacted if SA is to be imposed?

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