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The free market vs. global health

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When the global economy settled into the Chicago School of Economics' visible hands in the early 1980s, the health sector was by no means exempted. The face of health services and health policy was deeply impacted, and over subsequent years would swap the comprehensive Alma Ata 'health for all' idealism of 1978 for a narrower focus on the health intervention for small number of diseases. The shift in health policy exemplified the era's general migration from Keynesian social democracy and corporatist development to the anti-development market hegemony of the Washington Consensus. The de-articulation of the State in the area of health care, replaced by the primacy of the market and privatization of the sector, would have profound impacts on those living in the most extreme conditions of poverty around the world.

The move from social democratic to neoliberal strategies for health governance represented not merely an unfortunate retreat by the global community in terms of its willingness to confront one of the world's most vital development concerns, but also a regression into the logic of self-interest rooted in a quasi-religious faith in Adam Smith's invisible hand. However, the reason that the free market's hand cannot be seen probably has less to do with invisibility, and more with its absence. That is to say market principles cannot be trusted to distribute health services, as they are rendered inaccessible to some of the people who most need them. It is only through deliberative action by social forces, employing a redistributionist agenda, that universal access to health care could conceivably be realized.

Global health governance in two acts

Two distinct periods mark the contemporary thinking and practice of global health governance. The first, stretching from the end of the second World War to 1980, is rooted in the Keynesian or social democratic idea that one of the essential roles of the state is to strive to meet the needs of society. In terms of health, this meant the expansion of government-funded programs with the ambitious but generally elusive goal of universal coverage. However, with the onset of the 1980s debt crises and debilitating inflation rates, 'developing' countries of the world warmed to the Washington Consensus doctrine of an austere State in which the priority of balancing financial accounts left little room for ambitious health programs. Following the advice of the international financial institutions and the U.S. Treasury Department, most of the world accepted the neoliberal framework, swallowing the bitter pill of shock treatment as a necessary evil on the road to stability. One of those shocks would turn out to be access to health care by those living in poverty.

With the adoption of the Declaration of Alma Ata in 1978, global health governance within the United Nations, and subsequently the World Health Organization (WHO), advanced toward a framework of universality, egalitarianism and multilateralism. The Declaration

ambitiously set a deadline (now long passed) to achieve a benchmark in global health: “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.” The Alma Ata agenda included the concept that health is a human right, and affirmed that States and the international community have a responsibility to provide comprehensive primary health care, complemented by health initiatives undertaken at the family and community level.

In the early 1980s, the World Bank and International Monetary Fund (IMF) oversaw the implementation of neoliberalism around the world. Public health joined other social services in being recast within a market framework. Across the Third World, frayed but tangible social safety nets were replaced by things somewhat less concrete than nets: ideas and promises, framed in a model presented as the only remaining option. The ‘end of history’ had arrived, and with it the foremost question of political economy had been settled: the State should adopt a subservient economic role to let the market do its job. One of the tenets of the new consensus was the efficient provision of social services, which included an opening for the private sector into what was previously, in many instances, principally or entirely a public domain; the incorporation of competition into the provision of social services; and the application of user fees. Under the new framework, the commitment to primary health care was stripped bare, replaced by a much more limited strategy that sought to address a narrow range of health interventions while ignoring the broader health context.

By the early 1990s, many began to question the uneven economic outcomes that accompanied the neoliberal framework. The World Bank initiated a series of programs to address issues of equity, such as the Heavily Indebted Poor Countries (HIPC) debt reduction initiative and micro-credit lending, which provided some relief to impoverished countries and people while maintaining its free market approach and continued conditionality. In its 1993 World Development Report, “Investing in Health”, the Bank advocating for open competition between public and private health care service providers, the elimination of protections for domestic suppliers, and reduced government spending on high-cost, tertiary medical facilities and training. The State’s focus should be on providing low-cost clinics for essential services and maintaining health policy frameworks in which both the public and private sector can operate side-by-side. Such an approach, they argued, represents a practical strategy for confronting the scarcity of health resources. Competition among suppliers of health services will reduce the cost of service, improving access and the ability to deliver health care to a broader segment of the population, the Bank reasoned.

By 2000, the global health agenda was centered on private-public partnerships and stakeholder participation, maintaining the limited role for the State. This theme of a circumscribed State was also the centerpiece in the ascendant power of the third pillar of neoliberalism, the World Trade Organization (WTO). To the present day, privatization and market principles continue to occupy the centre of the global health agenda, under the purview of the WTO, international financial institutions and aid agencies.

Challenging the neoliberal order

Critics of the neoliberal approach to health have leveled their guns at privatization, arguing that social services like health are a public good that must remain in public hands. The development of a separate, private health regime, explains the Canadian Centre for Policy Alternatives and the BC Health Coalition, leads to two-tiered provisioning and draws

financial resources away from the public system and into the private realm. With the development of a private system, profit-motivated providers begin to practice 'cream-skimming', the attendance to easy-to-treat patients, thereby minimizing risk while maximizing income, and for recruiting talented physicians away from public service into the private sector since they are typically able to offer them higher salaries. Such a dichotomy inevitably reinforces existing social inequalities and de-valorizes the public system, potentially rendering it unsustainable.

One of the principal loci for global health debates in recent years is the patent protections codified within the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement of the WTO. In the TRIPS Agreement, countries were restricted from providing patent-protected drugs, except through direct purchasing from the patent holder, including the development of generic alternatives. The impact of this language has been an incalculable number of deaths of people priced out of access to life saving medicines.

Various researchers have looked at the empirical effects of the expansion of global markets on health. In the southern India state of Kerala, Thankappan linked neoliberal reforms, including social sector expenditure reductions and the imposition of user fees, to a five-fold increase in health care costs, regressively affecting the poorest people of Kerala at a rate of 768% as compared to the richest, whose costs rose by only 254%. He also found a decrease in the quality of the public health system, as budgetary limitations affected the availability of supplies, including drugs. The Third World Network similarly documented the decreased usage of health facilities in four African countries after the introduction of health care user fees. Studies conducted by Janes in Mongolia found that the effect of privatization in the secondary and tertiary areas of the health system alongside a universal yet limited public system of primary care was that it created an uneven, fragmented system that denied access of care above the primary level to the vulnerable poor, and resulted in heightened maternal mortality among rural poor women. And in Latin America, Hershberg and Rosen argue that the reduction of state expenditures on public health and the shift of resources toward privatized health care shrank already inadequate and underfunded systems.A final area that has been impacted by neoliberal restructuring is that of government spending on social programs, including sanitation and health infrastructure. The reduction of public expenditures has for more than two decades been one of the conditions demanded of countries that sought loans from the IMF and World Bank. The result was described by Hong as a "drastic decline in [disease] control and prevention measures". Chossudovsky has documented the linkage of budget cuts and the resurgence of deadly diseases including cholera, yellow fever and malaria in Sub-Saharan Africa; malaria and dengue in South America; malaria, tuberculosis and diarrhea in Vietnam; and the bubonic and pneumonic plague in India.

Among the voices calling for a new approach to global health governance, some posit that health services in 'developing' countries can be improved through piecemeal modifications to the present order, such as the relaxation of patent protections and the allocation of more resources toward health. The Third World Network and other groups based in the Global South, as well as many northern non-governmental organizations, more accurately contend that much deeper action is necessary, and that only through a wholesale abandonment of the neoliberal model can the structural root causes of poor health be addressed. At the foundation of neoliberalism is the belief that the State must assume a minimalist role, which is both inherently contradictory to equitable access to health and the process of development, and contrary to the 1978 commitment made by the majority of the world in

Alma Ata.

Useful sources

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