EDITORIAL

INVESTMENT, HEALTH AND DEVELOPMENT

Health is frequently an outsider beyond the fringe of the inner sanctums of economic planning of nations. This is particularly true in the plans imposed from outside by the agencies which have such a heavy hand in the loan-based planning process. It is thus a rare moment when the World Bank or the International Monetary Fund gives even transient precedence to health. For this reason it behoves us to examine carefully the World Development Report 1993, which is devoted to consideration of global health issues.

This Report, the latest of the annual World Development Reports issued by the World Bank, represents a departure from the Bank's past lip service to health components of economic development. As such it deserves to be taken very seriously, not least by the poorer, tropical regions of the world, since the Bank's views are influential on governments which seek loans to fulfill their dreams of increased prosperity. It comes at a time when the cold war-driven aid flows have ceased to be relevant. However, the richest 40% of the developing world's population still gets more than twice as much aid per head as the poorest 40%. Countries that spend most on armaments rather than health and education get most aid per capita. Approximately half of all aid is still tied to the purchase of goods and services from the donor country (Anonymous, 1993a).

This Report comes at a time when health systems in some rich countries are failing; thus the USA is in the throes of major revision in an attempt to limit runaway costs of a freewheeling non-system; Sweden, long an object of jealous admiration for its universal health care coverage, cannot afford to sustain its enviable structure with an aging population; Japan's proclaimed previously low-cost health care system is unprofitable with exploding bills (Anonymous, 1993b). The Report makes a strong case for putting the money where the greatest cost-effectiveness lies : in clinics, district hospitals and schools; it lambasts big teaching hospitals as inefficient and offten cost-absurd, the generators of budgetary wastage on expensive gadgets for treating diseases of lesser importance and inculcators of bad economic habits among trainee health care personnel.

Against the frequent subserviance of the Bank to vested rich country interests, this is a good start. Some key data are revealing. The USA, which spends more than 12% of GDP on health care is contrasted with countries such as China, which spends less than 4% of a very much lower GDP per capita on its health system; China's system is ajudged one of the most effective, USA's one of the least (World Development Report, 1993), a comparison inversely related to expenditure. This is heartening in the sense that it underscores the evidence that money alone does not buy good health and often buys profligate waste; more importantly, perhaps, relatively poor societies can deliver acceptable health care if the organizational management is appropriate. How China's health structure will fare under increasingly free market economic pressures is a critical question : the welfare of nearly a quarter of mankind depends on the outcome, as does its value as a model of cost effectiveness.

At present health care expenditure amounts to about 8% of total world GNP. Of this 87% is spent in rich countries, 42% in the USA alone, for which Americans receive inferior servies. Developing countries spend an average of $41 per capita per annum (although some spend a great deal less than this), while rich country populations consume an average of $1,900 per capita per annum. For some individual countries the extremes are much wider apart, as they can be within a given nation. But clearly inequity is the rule rather than the exception, within and between countries.

Lumping developing countries together makes the picture seem optimistic : in the 40 years from 1950 to 1990 life expectancy increased from 40 to 63 years on average. However, in this time Indonesia's child mortality dropped from 20% in the first 5 years of life to less than half that, while in Ghana the figure remained more or less the same. Some poorer countries have done remarkably well, others are struggling to deliver rudimentary health care. It is thus hazardous to generalize, just as it is to prescribe a single solution for widely differing situations.

Expenditure within each country, poor or rich, is frequently grossly asymmetric. Hospitals consume up to 80% of country health budgets. Overall figures of the number of doctors or nurses in each country's health system do not reflect distribution patterns, which is critical in assessing the accessibility of quality care for each individual or family. There is a tendency for doctors and nurses to be located in hospitals, particularly large urban or regional hospitals: there is also a tendency for many to start their careers in public hospitals, then to transit over time to the private sector, denuding the poor of their services.

The ratio of doctors to nurses varies over a wide range, best interpreted by examining the population per medical personel, *eg* Thailand has 5,000 people per physician but only per 550 nursing person, Nepal has 16,830 and 2,760, Malawi has 45,740 and 1,800, Tunisia has 1,870 and 300 respectively. Clearly these types of figures reflect differing economic situations; they also reflect differing approaches to human resource utilization in order to cope with health demands in the short versus the long term. No one formula for doctor/nurse ratio is universally appropriate; on the other hand we know that the very high doctor/patient ratios in many rich countries lead to overservicing in wasteful health systems and thus should not be used as models for less rich countries to follow. Unfortunately many are heading that way.

In many countries governments disproportionately support the wealthy per expensive hospitals and subsidised insurance systems, in others there has been a dogged determination to make good services available free or nearly so for the poor through district hospitals or clinics. In Indonesia, an example of the former, public subsidies for the richest one tenth of households were almost three times as great as subsidies to the poorest one tenth.

Drugs comprise up to 30% of many health expenditure patterns, with wastage rates often being very high, especially where the transition from proprietary to generic drugs has been slow to occur. WHO estimates that less than half the medical equipment in developing countries is actually usable. In both cases the pressure from the rich world to enforce patent protection restricts innovative opportunity in poorer countries to substitute cheaper compounds and machines. Thus some rich nations are not only losing their own battle to maintain adequate health care systems but are bent on trying to ensure that poor nations will lose any hope they may now have of containing costs sufficiently to provide viable options. The much heralded potential of genetic engineering, especially the promised gold that is predicted to emanate from the human genome project may well end up with the poor world providing even greater subsidies to the rich than they already do.

But the truly basic elements of health care are beyond the hospital, the doctor's office or even the village clinic. They lie partly with education, with cultural modes, with community leadership at the broad level. But they also lie with financial policy of governments, the investment policies of transnational corporations, the lending policies of international banks. While health is a major proclaimed target of economic development it rarely if ever features in the formulation of the principal elements of economic policy. Until this occurs it is unlikely that appropriate funding will be available for equitable, efficient and effective health care which favors the poor. As it stands, in most countries health in considered as a social service rather than as a contributor to sustainable development.

The Bank report proposes an approach to financing more equitable health care through a combination of public and private sector servicing, a solution which has a familiar ring to it, reflecting as it does the current confidence that free market economics will resolve most problems. This conventional wisdom carries with it a high degree of uncertainty. This simplistic resolution does not meet with universal acclaim. The report recognizes that private sector provision of health care services is likely to be beneficial only with effective regulation, a caviat that does not augur well where effective implementation of regulations is difficult, resulting in potentially high private sector costs. The idea of restricting publicly provided health care to a limited range of essential services, judged according to their cost-effectiveness, is questionable (Woodward, 1993).

The relative success in terms of equity of health care delivery in China has been related to community participation, local political leadership and health education as much as to the work of medical personnel. It has also been related to the extensive decentralization that marks the decision making process. The Report emphasizes the

desirability of decentralization in attaining more effective health care systems, yet the approach it recommends tends to be based on centralized concepts. It proposes that the World Bank should set the agenda and coordinate donor policies which should then be followed by developing country governments, with major emphasis on the user-pays principle.

Here comes the crunch, the familiar arrogance that the West knows best, the politices of patronage. This is a disappointing finale to a Report that has much to offer in a constructive framework. Western health care systems, with their hi-tech bias, are not showing themselves to be robust enough over the long haul and are useless models for poorer nations in which the majority dwell. Much better, surely, to take elements of the more successful developing country systems and begin to build new model, with careful attention to culture- and economy-specific idiosyncracies, rather than pushing us all into the one mold. The tragedy is that the Bank, with its considerable power vested in its lending functions coupled with the insistence on rather rigid economic policy directions to be applied by loan recipients, is in a position to push uniformity against diversity. The Report could be a good beginning for new dialog but it would make a very sad ending as its stands now.

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