THE LIFE AND DEATH OF PRIMARY HEALTH CARE

or

THE McDONALDIZATION OF ALMA ATA

A talk by David Werner

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"And if I laugh at any mortal thing
'tis that I may not weep."

-- William Shakespeare

To those of us committed to the dream of *Health for All*, in today's troubled world one thing becomes increasingly clear: The health of people -- as individuals, as communities, and as an endangered species on this fragile planet -- is determined less by health services than by the relative fairness of social structures. In last analysis, the overall health of the world's people depends on the epic struggle between love and greed. To gain a clearer understanding of the fate of Primary Health Care over the last 15 years, we therefore need to place it in that context.

The Alma Ata Declaration of 1978 was seen by many as a breakthrough, for it officially declared that *the pursuit of health is inseparable from the struggle for a fairer, more caring society.* The Declaration -- drafted at a global conference in Alma ATA, Russia, and endorsed by the world's nations -- was a response to the failure of Western Medicine to meet the health needs of a large sector of the world's people, especially those in the South. Based on costly doctors and urban "disease palaces," the Western medical model catered to a small, privileged minority. Its high cost and limited outreach in some ways did more to intensify than cure the diseases of poverty.

The Alma Ata Declaration declared health as a basic human right. To advance toward the ambitious goal of *Health for All by the Year 2000*, it proposed a radical and potentially revolutionary approach to meeting all people's basic needs. This was called Primary Health Care.

Primary Health Care was conceived as a comprehensive strategy that would not only include a people-centered approach to health services, but would address the social and political factors that influence health. In recognition that change comes from organized demand, it calls for strong community participation, accountability of health workers and health ministries to the people, and social guarantees to make sure that the basic needs--including food needs--of all people are met.

Although primary health care was a radical new concept for most ministries of health, for years many of its practices had been implemented by non-government community-based groups and by a few, exceptional governments that gave high priority to people's basic needs. China's approach to community health care, featuring 'barefoot doctors', had provided much of the basis for the design of Primary Health Care.

However, for most governments and health professionals, comprehensive primary health care as conceived at Alma Ata was too revolutionary. To those in positions of power, the idea of *giving ordinary people more control over their health and lives* sounded dangerously leftist and subversive.

So very soon after the Alma Ata Declaration, high-level health 'experts' began to systematically extract the teeth of Primary Health Care and to convert it, at best, into a means for extending conventional, top-down health services into underserved areas.

Strategically, there have been *three major watersheds* that have undermined and dissipated the radical essence of Primary Health Care. The first was the introduction of *Selective Primary Health Care* in the early 1980s. The second has been the push for *Cost Recovery* or *User-financed Health Services*, introduced in the late 1980s. And the third is the *take over of Third World health care policy by the World Bank* in the 1990s.

All three of these monumental assaults on Primary Health Care -- Selective PHC, user-financing, and the Bank's take-over -- are a reflection of dominant socio-political and economic trends. So to put these interventions into context, let us first take a brief look at the underlying macro-trends.

The development of under-development:

As we know, the decade of the 1980s was a period of global recession and retrenchment of conservative powers. By the beginning of the 80s, high level "development" strategies had begun to backfire. The Big is Beautiful model of development, pushed in the 60s and 70s by huge loans from the North, had made poor countries more dependent on the global market, with its ruthless ups and downs. The rise of large-scale industry, by replacing labor-intensive production with energy-intensive industry, had intensified pre-existing inequities. In rural areas, big agribusiness concentrated farmland into large holdings, causing a massive exodus of landless peasants into mushrooming city slums. But in the cities, big factories had replaced millions of workers with machines. Unemployment, poverty, homelessness, hunger, and crime increased. And the growing unrest brought more repressive measures of social control. Even in countries that experienced so-called "economic miracles," like Brazil, real earnings of workers drastically declined. While the rich got richer, the poor got poorer. 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, as result of the giant development loans from Northern banks, poor countries were faced with a staggering foreign debt. Huge interest payments offset any benefits from economic growth, and Third World economies began to falter. Anticipating disaster, the banks got scared and withheld new loans. As a result, scores of countries went into a fiscal tailspin. Some announced that they simply could not pay. The Northern banks, with billions of dollars in loans to poor countries, were worried sick.

Then the World Bank and International Monetary Fund came to the rescue. They gave 'bail out' loans to allow poor countries to keep servicing their debts, and to promote economic recovery.
But there were strings attached, namely "Structural Adjustment" policies. Adjustment measures were designed to "stream-line" poor country economies, and to bind them into international trade accords that favor big business and "free market" interests in the North.

Structural adjustment has usually included the following measures:

- cutbacks in public spending;
- privatizatation of government enterprises;
- freezing of wages and freeing of prices;
- increased taxation, especially sales taxes
- increase of production -- including food -- for export rather than local consumption.

As so often happens, these heavy-handed "austerity" strategies hit the poor hardest. Budgets for health, education, and food assistance were ruthlessly slashed, while bloated military expenditures were left untouched. Likewise, public hospitals and health centers were turned over to the private sector, putting their costs out of reach of the poor. Falling wages, higher prices, food scarcity, and increased unemployment due to government layoffs, all joined to push low income families into worsening poverty.

The overall results of adjustment have been hotly debated. In some middle-income countries it appears to have helped stabilize the economies, although the human and environmental costs remain in question. But in many of the poorest countries, adjustment appears to have caused even greater economic stagnation.

In spite of overwhelming evidence to the contrary, at first the World Bank flatly denied that structural adjustment has hurt the poor. More recently, the Bank has conceded that adjustment may have caused "temporary hardships" for low income families, but that such "austerity" 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 strong that structural adjustment, linked to the other conservative, neo-liberal trends in recent years, has caused far-reaching setbacks in the state of world health.

The World Bank in its public statements consistently points out that over the past 30 years Third World health has steadily improved. However, these reports shrewdly omit or downplay the fact that *in many countries improvements in health have slowed down or stopped since the beginning of the 80s.* Indeed, in some countries rates of under-nutrition, tuberculosis, cholera, and other indicators of deteriorating conditions, have been increasing. And in a few countries, mortality rates appear to be rising.

In spite of all the talk of development aid and poverty relief, in the 1990s more than $50 billion net flows each year from the poor countries to the rich. Today, the income of the richest 20% of the world's inhabitants is 140 times as great as that of the poorest 20%. And the gap between rich and poor has grown 30% wider in the last 10 years. According to the UNDP, one quarter of the world's people do not get enough to eat.

It is in this context of unfair global economic policies and structures that we must look at the three major strategies that have contributed to the disempowerment of Primary Health Care.

1. Selective Primary Health Care

No sooner had the dust settled from the Alma Ata Conference in 1978, than top-ranking international health experts in the North began to trim the wings of Primary Health Care. They asserted that, in view of the economic recession and shrinking health budgets of poor countries, a comprehensive or holistic approach was unrealistic. If any health statistics were to improve, they argued, high risk groups must be "targeted" with a few carefully selected, cost effective interventions. To implement this new strategy, called Selective Primary Health Care, children under age 5 were "targeted" in what became known as the Child Survival Revolution. (Some critics call it a counter-revolution.) Two "low-cost, low-resistance" health technologies -- Immunization and Oral Rehydration Therapy -- became the "twin engines" of Child Survival.

Child Survival quickly won enthusiastic high-level support. For those in positions of privilege and power, it was politically safe. It prudently avoided confronting the economic and political causes of poor health, and left the *status quo* comfortably in place. No wonder so many health professionals, governments, USAID, and UNICEF, all jumped on the Child Survival bandwagon. Even the World Bank -- which had previously put little investment in health -- began to lend its support.

But technological solutions -- while sometimes helpful -- can only go so far in combatinh health problems whose roots are social and political. Not surprisingly, therefore, the Child Survival initiative has had far less of an impact than predicted. Between 12 and 14 million children still die each year, and most of their deaths are related to under-nutrition and poverty.

The disappointing impact of Oral Rehydration Therapy (ORT) can be traced, in part, to structural adjustment. The damage might have been avoided if ORT had been promoted by teaching families to mix home-made drinks, which would help foster self-reliance. But unfortunately, WHO and UNICEF have strongly promoted factory-made "ORS packets," creating dependency on a manufactured product outside the control of families and communities. At first ORS packets were distributed at health posts free. But when health budgets were slashed through structural adjustment, health ministries were pressured to privatize the production and distribution of ORS packets. This meant, in some countries, that poor families with earnings of less than half a dollar a day, were expected to spend up to a third of their daily earnings on a single packet of ORS.

When we consider that *under-nutrition is the main predisposing condition leading to death from diarrhea,* it is easy to see how the social marketing campaigns that induce poor families to spend their limited food money on commercial ORS packets can actually be counterproductive in terms of lowering child mortality.

And if the commercialization of ORS is not enough, the hatchet job that structural adjustment has done on wages, health services, and food subsidies provides the final *coup de grace* for millions of hungry children. And so, in poor countries today, one of every 4 child deaths is still caused by the vicious cycle of under-nutrition and diarrhea.

Of course, in addition to the continuing debt crisis and adjustment policies, other unbridled market forces also contribute to the high incidence of death from diarrhea. Bottle feeding, for example, is still unscrupulously promoted by multinational producers of infant formula, despite the International Code and IBFAM boycott. Studies in several countries show that *the death rate from diarrhea can be over 20 times as great in bottle-fed as in breast-fed babies.* UNICEF estimates that the unethical

promotion of bottle feeding contributes to more than 1.5 million infant deaths a year -- up 50% from the estimate 5 years ago.

2. User financing and cost-recovery schemes

The next big set-back to Primary Health Care has been growing pressure to make disadvantaged people in poor countries pay for the cost of health services.

To make the conversion to user-financing or cost recovery schemes more palatable, often they are promoted as a way of fostering *self-reliance* and *community participation.*

One of the biggest promoters of these user-financed community health services has been UNICEF. Its so-called Bamako Initiative now functions in many African countries. While UNICEF has some reservations about the Initiative, it argues that in today's hard times it sees no better alternative. In the 1980s, cutbacks in health budgets resulted in the closure of many rural health posts, largely for lack of medicines. UNICEF recognized that people want medicines and are willing to pay for them. So, through Bamako, consumers are charged enough for medicines to keep the health post functioning. A positive feature of the Bamako Initiative is that only essential drugs are used. Also, in some of the community-run health posts, participation is active and enthusiastic.

But many such user financing schemes have some serious -- and perhaps life-threatening -- drawbacks. Just because poor families are *willing* to pay for medicines does not mean they are *able* to pay for them. As with ORS packets (which are included as essential medicine) poor families will often spend for medicine the money they need to feed their sick children. . . And they may even pay for more medicines than are needed. When health posts are largely financed through sale of medicines, the temptation for health workers to over-prescribe is considerable.

Because the poorest families get sick most often and tend to require more medicines, they may carry more than their share of cost for the health post. While Bamako has provisions to charge less to families who are very poor, such "safety nets" work better on paper than in practice.

Reportedly, in some areas the Bamako Initiative has given good results. But studies in some countries have shown that *when cost recovery has been introduced, utilization of health centers by high risk groups has dropped.* In some cases the incidence of illness -- including sexually transmitted diseases -- has increased.

Whatever their immediate impact, the introduction of these cost recovery schemes has disturbing implications. Placed in historical perspective, *when a health system begins to saddle the poor with the burden of its costs, this is a great step backwards.* It means that health care is no longer a basic right. During most of this century society has made gradual if halting progress toward "human rights for all." With a push from the Left, people gradually accepted the concept of proportionate taxation: those who have more pay more, so that the community as a whole can guarantee that the basic needs of all people are fairly and adequately met. In short, there has been a gradual trend toward a spirit of collective responsibility, toward recognition that the well-being of each is linked to the well-being of all, and that sharing is more fulfilling than greed.

In the epic struggle between equity and greed, since the early 1980s, humanity has in some ways regressed. The conspiracy between big government and big business has undermined democratic process, and given almost free reign to powerful market forces. Main stream economists promote a

so called free-market system -- that is, a market system free of democratic controls -- that seeks unbridled economic growth, regardless of the human and environmental costs. The United States seeks to impose its *Greed Centered Development* model on the entire world. Yet poor people in USA have been trampled by the same powerful market forces and adjustment policies that have widened the gap between rich and poor in the Third World. Progressive taxation is being systematically undermined as the government gives bigger tax breaks to the rich and raises taxes for the rest. Ten years ago, 1 in 7 children in the USA lived in poverty; today it is 1 in 5. And since the early 80s, public services and welfare assistance have been brutally cut. In response to the growing rates of homelessness, desperation, street children, and crime, the government does not provide more public services or a higher minimum wage, but rather more policemen and jails. In the great American spirit of "self reliance," the disadvantaged must care for themselves.

And so we see that the Bamako initiative and other cost-recovery schemes in poor communities -- while perhaps the only alternative in face of an unjust social order -- are consistent with the neo-liberal "free market" forces that are trying to free the owners of the markets from their social and ethical responsibility.

3. The World Bank take-over of health policy planning

The World Bank tells us that it has turned over a new leaf and has come to recognize that real development must take direct measures to eliminate poverty. But the way it is going about it, one wonders if the Bank would not prefer simply to eliminate the poor. . . or at least the children of the poor. Certainly population control -- or rather, "family planning" -- is high on its agenda.

The World Bank has so consistently financed policies that worsen the situation of disadvantaged people that we must question its ability to change its course. *Perhaps the most effective step the World Bank could take to eliminate poverty would be to eliminate itself.*

In recent years the World Bank has become increasingly involved in Third World health care and health policies. The Bank's 1993 World Development Report is titled *Investing in Health.* A better title might be *Turning Health into Investment,* for the Bank takes a dehumanizingly market-oriented view of both health and health care. Its chilling thesis is that *the purpose of keeping people healthy is to promote economic development.* . . But I can't help feeling that the Bank has it backwards. Wouldn't it make more sense to say that *the purpose of economic development is to promote health?*. . . What are we, *ants?*
The Bank has worked out an elaborate scheme whereby it tries to measure the value of each person (that is to say, the *dollar* value) by what it calls "Disability Adjusted Life Years" or "DALYs." But I can't discuss all that because it is so foreign to my way of thinking.

In its Report, the Bank stresses the urgent need to *overcome poverty* and to guarantee that the *health needs of all people are met.* It quite rightly criticizes the persistent inequity and inefficiency of current Third World health systems. And it echoes much of the Alma Ata call for community participation, self-reliance, and health in the people's hands. . . So far so good.

But on reading further, we discover that under the guise of promoting an equitable, cost-effective, and country-appropriate health system, the World Bank's key recommendations spring from the same sort of market-friendly, structural adjustment paradigm that has exacerbated poverty and been so devastating to the health of the world's neediest people.

According to the World 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 'fine print' from the text of the Report, we can restate the policy's three prongs more clearly:

1. Put the responsibility of covering health costs back on the shoulders of the poor . . . in other words, *fee for service* and *cost recovery through user financing.*

2. Reduce government spending on health by drastically reducing services from a comprehensive to a very narrow, selective approach . . . in other words, a new brand of *Selective Primary Health Care.*

3. Turn over to private, profit-making doctors and businesses all those government services that used to provide free or subsidized care . . . in other words, *privatization of most medical and health services.*

Thus we find the new health policy is little more than old wine in new bottles: a rehash of the conservative strategies that have systematically derailed Comprehensive Primary Health Care, with elements of structural adjustment to boot. It is a market-friendly version of Selective Primary Health Care combined with privatization of medical services and user-financed cost recovery. Through elaborate statistical studies, the Bank has selected those interventions calculated to be most cost-effective in increasing "Disability Adjusted Life Years" of productive work to advance the national economy. How the community -- or even host country -- is supposed to participate in (or even understand) this extreme form of globally computerized planning remains vague.

What can I say, except that all this is very scary. And it is dangerous because the World Bank, with its enormous money-lending capacity, has almost god-like clout. It can force poor countries to accept its health care blueprint by tying it to loan programs, as it has done with adjustment.

The commercial medical establishment has celebrated the Bank's new World Development Report as a 'major breakthrough' toward a more *cost efficient* health care strategy. But many health activists see the Report as a disturbing document with dangerous implications. They are especially worried that the Bank will impose its recommendations on poor countries that can least afford to implement them.

It is an ominous sign when a giant financial institution with such strong ties to big government and big business bullies its way into 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.

It is urgent that all of us concerned with the health and rights of disadvantaged people become familiar with this World Bank Report, with the harm its unrealistic policies are likely to do, and whose interests they are really designed to serve.

Some concerned groups are already taking action. 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. To become better informed about the full range of objections to the Report and the World Bank's blueprint for health, you can write to:

Health Action International -- Europe
Jacob van Lennepkade 334 T
1053 NJ Amsterdam
The Netherlands

Another important development is that the Save the Children's Fund in the UK, and other concerned non-government organizations are forming a Bank-Watch group to monitor the activities and policies of the World Bank, and try to make it more accountable.

Successful approaches to Primary Health Care

As we have seen, Primary Health Care as conceived at Alma Ata has run into serious problems. This is no surprise. A revolutionary approach to health care requires a revolutionary process in society as a whole. In that context, a few countries have been relatively successful in introducing Primary Health Care. Nicaragua under the Sandinistas introduced a very comprehensive, strongly participatory approach to Primary Health Care, with remarkable improvements in health. Cuba, since the Revolution, has taken a very comprehensive approach which guarantees to meet the basic needs of all people for housing, education, health care, and food. As a result, Cuba has health statistics equal to that of the Northern, industrialized countries.
Unfortunately, however, many countries that have opted for people-centered development, in defiance of the development paradigm that favors big business, have been subject to relentless attacks and terrorism. For this reason their health care programs -- and improved health of their people -- have been hard to sustain.

Nevertheless, hundreds of grassroots groups and movements around the world have kept a liberating approach to Primary Health Care alive, often against great obstacles. Activists realize that, in the long run, the health of our planet and its people depends on far-reaching social change.

Conclusion:

I have given this talk as a protest -- or "URGENT ACTION ALERT" -- warning that the global power structure, spearheaded by the World Bank, is poised for the final death blow to Primary Health Care, so that the health systems of poor countries will fall in line with what we might call *the McDonaldization of Global Development.**

On one thing the World Bank is certainly right: *Achievement of a healthier society requires the reduction of poverty.* But the changes needed to overcome poverty will never come from the Bank nor the powers it represents. They can only come from the bottom up. In last analysis, the social

transformation needed to bring Health for All turns on the ability of a world-wide coalition of grassroots groups and concerned world citizens to bring the present global power structure under control.

I close with the conclusion of the International People's Health Council:

> *Health for All* can only be reached through a united grassroots struggle for *EQUITY, ACCOUNTABILITY,* and *PARTICIPATORY DEMOCRACY.* The struggle for health is a struggle for social justice.

* I first heard the term "the McDonaldization of Development" in a talk by Helena Norberg-Hodge, a linguist by training, who spent 17 years with the isolated Ladakh tribe on the border of India and Tibet. In documenting the modernization of this warm-hearted, ecologically integrated traditional society, she describes the people's strong spirit of sharing and caring. She quotes the Development Commissioner of Ladakh as saying:

> *"If Ladakh is ever going to be developed we have to figure out how to make these people more greedy. You just can't motivate them otherwise"*
>
> -- f`rom *Ancient Futures: Leaning from Ladakh,* by Helena Norberg-Hodge. 1991. Sierra Club, 730 Polk Street, San Francisco, CA, USA