DOES WEALTH EQUAL HEALTH?

INTERNATIONAL INSTITUTIONS AND HEALTHCARE IN LATIN AMERICA.

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Good health is of paramount importance to individual well-being and thus societal well-being. However, just how good health within a population is achieved has long been the subject of debate between competing actors in the world of global health governance. Central to the debate is the contested assumption that wealth creation leads to better health (a view favoured by the World Bank). Arguably, this is not the case. As research by has repeatedly shown, positive health outcomes within a country are reliant on a much greater range of factors than just wealth. This essay will argue that: (1) the link between wealth and health has been widely disregarded; (2) that the pursuit of holistic health — led by the WHO (traditionally the leading international organisation on health matters) — has been undermined by the World Bank's continuation of policies focused on wealth creation. Though the Bank has had moderate success as a financier of health programmes, the lack of coordination within the organisation has led to a disconnect between rhetoric and policy. I will use Latin America — the world's most unequal region — as an illustrator of this point.

WORD COUNT: 8,868

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LIST OF ABBREVIATIONS

DALY	DISABILITY ADJUSTED LIFE YEAR
IADB	INTER-AMERICAN DEVELOPMENT BANK
IFI	INTERNATIONAL FINANCIAL INSTITUTION
IMF	INTERNATIONAL MONETARY FUND
GDP	GROSS DOMESTIC PRODUCT
GHG	GLOBAL HEALTH GOVERNANCE
GNI	GROSS NATIONAL INCOME
GNP	GROSS NATIONAL PRODUCT
HNP	HEALTH, NUTRITION AND POPULATION DEPARTMENT
LA	LATIN AMERICA
NCD	NON COMMUNICABLE DISEASES
PAHO	PAN-AMERICAN HEALTH ORGANISATION
PHC	PRIMARY HEALTH CARE
PRSP	POVERTY REDUCTION STRATEGY PAPER
SAP	STRUCTURAL ADJUSTMENT PROGRAM
SDH	SOCIAL DETERMINANTS OF HEALTH
TRIPS	TRADE RELATED INTELLECTUAL PROPERTY RIGHTS
WHA	WORLD HEALTH ASSEMBLY
WHO	WORLD HEALTH ORGANIZATION
WB	WORLD BANK

1. INTRODUCTION

Over the past three decades, the theory and practice of Global Health Governance (GHG) has changed significantly. Since the World Health Assembly (WHA) produced the 1978 Alma-Alta 'health for all' declaration, the view that international action on health was confined to a disease-orientated approach was dismissed and a more holistic strategy advocated.[1] Concurrently, the role that international institutions play in the macroeconomic development of countries has also been radically revised to accommodate more interventionist policy widely committed to 'economic stability' through the policies of neoliberalism.[2] These policies have been broadly focused on wealth creation at the expense of strong public health systems and this paper will question how wealth and health interact in the abstract and policy realm. To do so, it will first consider the theoretical framework of wealth and health in global perspective, before considering how the World Health Organization (WHO) — the international institution charged with health provision — and World Bank (WB) — the leading international institution concerned with wealth creation — operate within this framework in Latin America (LA): the world's most inequitable region in terms of wealth distribution and healthcare provision.[3]

To begin, an understanding of the interplay between the concepts of 'wealth' and 'health' is important, and definitions required for each. I will argue that 'health' is more than an absence of disease and should encompass a complete approach to an individual's well-being. Practically, this will mean that the Social Determinants of Health (SDH), Primary Health Care (PHC) and Non Communicable Diseases (NCDs) should be considered of paramount importance when formulating policy. Next, the implications of our understanding of 'wealth' on these findings will be considered and I will argue that the predominant conception of wealth is largely incompatible with positive health outcomes. Further, it will be seen that the 'wealth creation' approach to development often changes

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[1] Koivusalo, M. and Ollila, E., *Making a Healthy World*, (London: Zed Books, 1997), p. 11.

[2] *Ibid*, p. 28

[3] Belizán, J.M., Cafferata, M.L. and Belizán, M., 'Health Inequality in Latin America', *The Lancet*, Vol. 370, (10 November 2007), p. 1599.

health outcomes for the worse as free markets conflict directly with the health systems that will most effectively increase health and well-being within a population. Good health is an essential component of an efficient economy, yet this has been a large extent overlooked in economic policy.[4] By inverting the original statement, the much more accurate assertion that 'health equals wealth' is found.

How theory relates to policy will then be considered in the context of international institutions. I will argue that, though the WHO has both the expertise and legitimacy to be the leader in the international health arena, it has been usurped by the financial means of the WB: now the largest donor to development projects.[5] In part, this is due to its methods conflicting with the unilateral interests of the United States (the WHO's biggest donor). As a result, the US pushed the WB into the realm of health policy.[6] Whilst the Bank's intervention may be largely well intentioned, it can be contended that there is a basic conflict between the macroeconomic policies it advocates and its new-found commitment to health. The friction is particularly evident in LA where some countries have closely followed the WB's model, while others have eschewed it in favour of a more social approach.[7] This has resulted in great inequality and a diversity of health systems and outcomes: the Pan American Health Organisation (PAHO) has estimated that *"...47% of Latin America's population is excluded from needed services*" and the ratios of maternal mortality are 10–44 times higher in the poorest provinces of several countries in Latin America when compared to the richest.[8] [9]

Essential to any debate concerning health policy — and particularly one as broad as this — is a coherent definition of what 'health' is. Unsurprisingly however, this is far from straightforward as policy formulation and implementation will vary drastically depending

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[4] Sachs, J., *Macroeconomics and Health: Investing in Health for Economic Development*, (Geneva: WHO, 2001), p. 1.

[5] Sridhar, D. and Batniji, R., 'Misfinancing global health: a case for transparency and disbursements and decision making', *The Lancet*, Vol. 372, (27 September 2008), p. 1187.

[6] Ingram, A., 'Global Leadership and Global Health: Contending Meta-narratives, Divergent Responses, Fatal Consequences', *International Relations*, Vol. 19, No. 4, (2005), p. 385.

[7] De Vos, P., De Ceukelaire, W. and Van der Stuyft, V., 'Columbia and Cuba, contrasting models in Latin America's health sector reform', *Tropical Medicine and International Health*, Vol. 11, No. 10, (October 2006), p. 1604.

[8] WHO, *The World Health Report 2008: Primary Health Care: Now More Than Ever*, (Geneva: WHO, 2008), p. 32.

[9] Belizán, J.M., Cafferata, M.L. and Belizán, M., 'Health Inequality in Latin America', p. 1599.

on which definition is followed. I will now explore the different definitions of 'health' and their potential consequences.

2. INTERPRETING 'HEALTH'

2.1 DEFINITIONS

How health is defined in the realm of GHG is of the utmost importance as differing definitions will lead to contrasting conclusions in policy. At the most basic level, the dictionary definition of health is merely "*the state of being free from illness or injury*" yet it such a simplistic interpretation is problematic for a number of reasons.[10] Firstly, it is not clear whether less physical facets of health such as mental illness could be encompassed in such a definition. Second, the subjective nature of 'illness or injury' makes it difficult to describe one person as unhealthy while they themselves might consider themselves in a good state of health. In the policy realm also, such a definition fails to account for the context of patients and illness. As Gigase puts it: "*Sick peoples' perception of their disease is shaped by the disturbances that it causes in their everyday well-being*" so, while a foot injury might have minor implications for a person in Western Europe, the same injury could be devastating for an agricultural worker in Africa who could not work as a result.[11] Thus, in many respects, the social and personal context of 'health' is the most important factor.

The WHO's definition tries to account for these difficulties, by defining health in a broad sense to explicitly encompass the social and mental aspects of health as well. Health, it says "*...is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.*"[12] Politically, such widely focused goal has had implications as

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[10] The Oxford Dictionaries definition of 'health' accessed on 3 May 2011 at: http://oxforddictionaries.com/view/entry/m_en_gb0369410#m_en_gb0369410.

[11] Gigase, P., 'The Notion of Health', *The UNESCO Courier*, (1987), p. 4.

[12] WHO, *Constitution of the World Health Organization*, (1946), p. 1.

"*Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures*."[13] Additionally, this definition allows the WHO to cherry-pick its areas of intervention. For many WHO member states, such an assertion may be uncontroversial, but for others, it skews with the dominant ideologies of power. One need look no further than the resistance to recent attempts to provide a basic level of universal healthcare in the United States to see that the acceptance of such proposals is far from decided.[14]

As the United Nations agency charged with the "*the attainment by all peoples of the highest possible level of health*", the WHO is the most obvious leader in GHG and, though its role has changed over the decades, it has remained central to any health debate.[15] The WB meanwhile, has come to regard itself, since the 1980s, as "*...the major funding agency for population and health issues*"[16] and is also essential to any global health discourse. As the two leading actors in GHG how each organisation defines health, will have a profound effect on the health of millions and it is these differing interpretations that I will now consider.

2.2 Primary health care and the social determinants of health

In the past, the international focus on health tended to manifest itself as policy concerned with individual diseases and 'technical matters' such as the eradication of smallpox with mixed success.[17] This is known as a 'vertical approach' to health as it tends to not account for factors indirectly connected to a disease (e.g. diet or unemployment) that might lead to poor health (whereas the 'horizontal approach' does).[18] The failure to wipe out malaria led to a a reevaluation of the technical approach, prompting the World Health Assembly's

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[13] WHO, *Constitution of the World Health Organization*, p. 1.

[14] Spillius, A., 'US Congress passes Barak Obama's historic health care reform bill', *The Telegraph*, (22 March 2010), accessed on 19 April 2011 at: http://www.telegraph.co.uk/news/worldnews/barackobama/7495770/US-Congress-passes-Barack-Obamas-historic-health-care-reform-bill.html.

[15] WHO, Constitution of the World Health Organization, p. 2.

[16] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 25.

[17] Davis, S.E., *Global Politics of Health*, (Cambridge: Polity Press, 2009), p. 35.

[18] *Ibid*, p. 35.

(WHA) 1978 Alma-Ata 'Health For All' Declaration which greatly widened the scope of international health policy and took the WHO's definition of 'health' in a much more complete sense.[19]

Significantly, it heralded a new approach to health that took into account the links between health, development and the community, known as Primary Health Care (PHC).[20] Among other points, PHC includes: taking health as context specific; providing preventative measures to disease; and a coordinated approach from *all* social sectors to ensure good health.[21] PHC goes well beyond the remit of what many might see as the field of healthcare. Indeed, the first point highlights that economic and sociocultural factors are among the most important to health, while the subsequent ones outline a very interventionist approach to governance. In particular, point three of the declaration can be seen as important:

> "[PHC] *includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs."*[22]

This statement has quite clear political implications if taken as a basis for policy by member states and also conflicts with ideology of neoliberalism: synonymous with the US and at the WB.[23]

2.3 An ideological gap

More recently, this ideological gap between complete health and neoliberalism has continued to widen. Notably, two reports released in 2008 by the WHO have been

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[19] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 11.

[20] WHO, 'Declaration of Alma-Ata', International Conference on Primary Health Care, Alma-Ata, USSR, (6 September 1978), accessed on 3 May 2011: http://www.paho.org/English/DD/PIN/alma-ata_declaration.htm.

[21] *Ibid*.

[22] *Ibid*.

[23] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 28.

remarkably explicit in advocating an interventionist approach to health: *Closing the gap in a generation: Health equity through action on the social determinants of health* and *Primary Healthcare: Now more than ever*.[24] [25] The former cites the goal of 'full and fair employment' as a central pillar of health — highlighting the direct correlation between less permanent employment contracts and an increase in mental illness: a connection that can be remedied with legislation guaranteeing workers' rights.[26] In contrast, a paper focusing on reforms implemented in LA by the WB and the Inter-American Development Bank (IADB), calls a move to a less permanent workforce 'progress' and aims for less legal/social support for workers.[27]

The second WHO report makes it clear that PHC remains relevant and is tied very closely to extensive social welfare moves such as employment protections, safety regulation and the provision of safe water and sanitation.[28] It also cited Cuba as an example of successful implementation of PHC and the SDH in spite of a per capita GDP of just $4500.[29] In health indicators, Cuba is consistently highly successful: life expectancy is the second highest in the Americas and infant mortality is only 6 per 1000 children, compared with 54 in Bolivia which has a comparable per capita income.[30] [31]

> "*Cuba's success in ensuring child welfare reflects its commitment to national public-health action and inter-sectoral action. The development of human resources for health has been a national priority. Cuba has a higher proportion of doctors in the population than any other country. Training for primary care gives specific attention to the social determinants of health. They work in multidisciplinary teams in comprehensive primary-care facilities, where they are accountable for the health of a geographically defined population providing both curative and preventive services.*

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[24] WHO, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health*, (Geneva: WHO, 2008), p. 32.

[25] WHO, *The World Health Report 2008: Primary Health Care: Now More Than Ever*, (Geneva: WHO, 2008), p. 32.

[26] Artazcoz, L., Benach, J., Borrell, C. and Cortés, I., 'Social inequalities in the impact of flexible employment on different domains of psychosocial health', *Journal of Epidemiology and Community Health*, Vol. 59, (2005), p. 761.

[27] Lora, E., *Structural Reforms in Latin America: What Has Been Reformed and How to Measure It*, (New York: Banco Interamericano de Desarrollo, 2001), p. 16.

[28] WHO, *The World Health Report 2008. Primary Health Care: Now More Than Ever*, p. 25.

[29] *Ibid*, p. 65.

[30] *Ibid*, p. 65.

[31] UNDP, 'International Human Development Indicators', accessed on 3 May 2011 at: http://hdr.undp.org/en/data/map/.

> *They work in close contact with their communities, social services and schools, reviewing the health of all children twice a year with the teachers. They also work with organisations such as the Federation of Cuban Women (FMC) and political structures. These contacts provide them with the means to act on the social determinants of health within their communities... National policy in Cuba has not succumbed to a false choice between investing in the medical workforce and acting on the social determinants of health. Instead, it has promoted inter-sectoral cooperation to improve health through a strong preventive approach. In support of this policy, a large workforce has been trained to be competent in clinical care, working as an active part of the community it serves.*"[32]

This illustration of how PHC can be applied is important, but also often dismissed by leading actors (in particular, the US) because of political circumstances which such success could undermine.[33] Though a holistic approach has proven to be successful on numerous occasions, many organisations still rely on a vertical approach to health: that is, following low expenditure interventions that take a linear view to single diseases.[34] While such an approach does have a clear logic, the conclusions are entirely dependent on what indicators are used to determine health.

2.4 NON-COMMUNICABLE DISEASES

In keeping with the wider debate, the indicators that are used to deduce the health of a population are determined by what definition of health is used. Factors such as child mortality can be useful indicators of the development rate of a country, but are limited when considering health as a wider concept. If one is to take into account the SDH, then factors such as Non-Communicable Diseases (NCDs) become much more important. Outside of Africa, NCDs are now the most common cause of death worldwide, but have been largely overlooked in development policy.[35] [36] Unlike communicable disease, NCDs are not just reliant on chance, but more widely linked to lifestyle and social health in

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[32] WHO, *The World Health Report 2008: Primary Health Care: Now More Than Ever*, p. 65.

[33] Spiegle, J.M. And Yassi, A., 'Lessons from the Margins of Globalization: Appreciating the Cuban Health Paradox', *Journal of Public Health Policy*, Vol. 25, No. 1, (2004), p. 85.

[34] Davis, S.E., *Global Politics of Health*, p. 46.

[35] WHO, *The Global Burden of Disease: 2004* Update, (Geneva: WHO, 2008), p.18.

[36] WHO, *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases*, (Geneva: WHO, 2008), p. 5.

general. For example, research has shown that as a country develops beyond the initial 'poverty barrier' the immediate risk of death at an early age diminishes and other factors that will affect NCDs, such as employment and education, begin to gain salience.[37] Education on the dangers of tobacco and convenience food in relation to cancer and obesity respectively are important and, as suggested earlier, sufficient employment protections are essential to preventing mental illness.[38] [39] Due to their nature, NCDs tend to affect the working age population — so can be particularly damaging to a country's economy and thus have knock-on effects for other sectors of society.[40] The impact of NCDs is clear, but they have tended to avoid the focus of development programs, potentially due to their usually chronic nature and the coordination required in their treatment.[41] On top of this, Strong et al. point out that a large majority of deaths from chronic disease will occur within middle- and low-income countries and that, in many ways, chronic disease can be more damaging because of the financial burden of long term health care.[42]

NCDs are also however, easy to prevent, as their incidence rests largely on three factors: diet, physical exercise and tobacco use.[43] [44] Simple measures — such as the regulation the fast food and tobacco health industry — can have monumental effects on the rates of NCD: "*An estimated 80% of premature heart disease, stroke, and type 2 diabetes, and 40% of cancer, could be avoided through healthy diet, regular physical activity, and avoidance of tobacco use*."[45] Particularly in the developing world, globalisation, fast-food chains and the

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[37] WHO, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health*, p. 32.

[38] WHO, *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases*, p. 19.

[39] WHO, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health*, p. 76.

[40] Anderson, G.F., Waters, H., Pittman, P., Herbert, R., Chu, E. and Das, K., *Non-Communicable Chronic Diseases In Latin America and the Caribbean*, (19 February 2009), p. 12.

[41] Samb, B. et al., 'Prevention and management of chronic disease: a litmus test for health-systems strengthening in low-income and middle-income countries', *The Lancet*, Vol. 376, (20 November 2010), p. 1785.

[42] Strong, K., Mathers, C., Epping-Jordan, J. and Beaglehole, R., 'Preventing chronic disease: a priority for global health', *International Journal of Epidemiology*, Vol. 35, Issue 2, (April 2006), p. 493.

[43] *Ibid*, p. 493.

[44] Sachs, J., *Macroeconomics and Health: Investing in Health for Economic Development*, p. 3.

[45] Strong, K., Mathers, C., Epping-Jordan, J. and Beaglehole, R., 'Preventing chronic disease: a priority for global health', p. 493.

advertising might of the tobacco industry are having a negative effect on public health: an area that again expands the remit of health into the business realm. Education and quality primary care are particularly important influences on creating a healthy environment from an early age. To confront the considerable power of the tobacco and fast food industries requires significant strength from a government; particularly as such regulation runs contrary to the dominance of neoliberalism in global governance.[46] [47]

When formulating policy, NCDs are largely overlooked — possibly because NCDs require a wider approach to treatment/prevention addressing SDH factors. To address this, it seems advisable to consider rates of cardiovascular disease and cancers as essential indicators in the formulation of health policy. As NCDs would clearly fall under even the most narrow definition of health, it is important to incorporate indicators that account for them in all health policy: including those in lower-income nations. To effectively address NCD, a PHC approach to health is by far the most effective. As mentioned earlier, there might be ideological issues with using PHC and SDH within policy, but it is clear that that such an approach is required in order to effectively improve health.

2.5 Health indicators

Key to successful formulation and implementation of policy addressing disease (including NCDs) appropriate measures of health must be applied. In 1993, the Disability Adjusted Life Year (DALY) was introduced in an attempt measure the impact of a particular disease on a population.[48]

> *"The disability-adjusted life year (DALY) extends the concept of potential years of life lost due to premature death to include equivalent years of "healthy" life lost by virtue of being in states of poor health or disability (3). One DALY can be thought of as one lost year of "healthy" life, and the burden of disease can be thought of as a*

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[46] Nestle, M., *Food Politics: How the Food Industry Influences Nutrition and Health*, (London: University of California Press, 2007), p. xiv.

[47] Yach, D. and Bettcher, D., 'Globalisation of Tobacco Industry Influence and New Global Responses', Tobacco Control, Vol. 9, No. 2, (June 2000), p. 206.

[48] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 35.

> *measurement of the gap between current health status and an ideal situation where everyone lives into old age, free of disease and disability.*"[49]

This analysis allows for a 'burden of disease' framework to be set up and calculate the total damage of an individual disease. DALYs do account for NCDs and have been used as a tool to highlight the underfunding of NCD prevention:

> "*In terms of the burden of disease, donors provided about $0.78/DALY attributable to NCDs in developing countries in 2007, compared to $23.9/DALY attributable to all HIV, TB, and Malaria. If donors provided just half the support to avoid NCD DALYs that they provide to the three infectious diseases, it would amount to almost $4 billion in DAH for NCDs.*"[50]

Though useful for assessing the cost-effectiveness of initiatives, the DALY has a number of flaws. The problem with the DALY, Davis says, is that it completely fails to take into account the previously highlighted importance of the social context of disease, instead treating it is a comparable and linear factor.[51] Further, DALYs fail to account for the inter-related nature of diseases (particularly chronic NCDs) and tend to lead to singular interventions, where complete health system strengthening would tackle many targets at once. As Samb et al. articulate:

> "*Efforts to scale up interventions for management of common chronic diseases in these countries tend to focus on one disease and its causes, and are often fragmented and vertical. Evidence is emerging that chronic disease interventions could contribute to strengthening the capacity of health systems to deliver a comprehensive range of services—provided that such investments are planned to include these broad objectives.*"[52]

Health system strengthening can be considered closely linked to PHC as the extension of health provision can help provide for conditions beyond basic care. It is important therefore that policy makers supplement DALYs with a range of other health indicators. Alongside more traditional indicators such as infant mortality and life expectancy, rates of

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[49] WHO, *The Global Burden of Disease: 2004 Update, 2008, p. 3.*

[50] Nugent, R., 'New Study Reveals NCDs Remain Severely Underfunded - The NCD Alliance interviews author Rachel Nugent', *The NCD Alliance*, (3 November 2010), accessed on 1 May 2011 at: 'http://www.ncdalliance.org/node/3206.

[51] Davies, S.E., *Global Politics of Health*, p. 46.

[52] Samb, B. et al., 'Prevention and management of chronic disease: a litmus test for health-systems strengthening in low-income and middle-income countries', p. 1785.

particular NDCs should be included as concentrating on them can be seen as a 'litmus test' for the wider health system as a whole.[53]

3. Interpreting 'wealth'

While the need to define 'health' seems clear, what 'wealth' is and how it is measured also requires clarification as it is an essential aspect of a majority of development policy and will inevitably have a knock-on effect for healthcare. As with 'health', there are significant implications for how 'wealth' is interpreted. The World Bank is the primary international institution concerning itself with wealth creation.[54] Under its own mandate, one of the Bank's key aims is to "*...promote economic development, increase productivity and thus raise standards of living in less-developed areas of the world...*"[55] What this 'economic development' — or wealth — is and how it is measured is of great importance. Though wealth is often over simplified to national income, the ownership and distribution of resources is essential to understanding the effect that policies aimed at wealth creation will have on health.[56]

3. 1 Beyond GDP/GNP

Since the inception of international institutions concerned with macroeconomic 'development', Gross Domestic Product (GDP) has been emphasised as an indicator of a country's status in the world economy.[57] Though this has since been superseded by the use

[53] Samb, B. et al., 'Prevention and management of chronic disease: a litmus test for health-systems strengthening in low-income and middle-income countries', p. 1785.

[54] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 25.

[55] *Ibid*, p. 25.

[56] Biggs, B., King, L., Basu, S. and Stuckler, D., 'Is wealthier always healthier? The impact of national income level, inequality, and poverty on public health in Latin America', *Social Science & Medicine*, Vol. 71, (2010), p. 266.

[57] Meier, G.M, 'The Old Generation and the New', in (eds.) Meier, G.M. and Stiglitz, J., *Frontiers of Development Economics: The Future in Perspective*, (New York: Oxford University Press, 2001), p. 24.

of Gross National Income (GNI) — itself interchangeable with Gross National Product (GNP) — both measures provide an overly basic and unreliable measure of a country's internal development: particularly in health and social issues.[58] Broadly speaking, the argument that an increase in GDP will lead to better living conditions is based on the theory that as national income increases, individuals will be better resourced to finance their own well-being.[59] However, this view is far from conclusive: numerous studies have highlighted that inequality is the most accurate predictor of poor health.[60] Biggs et al. concluded a study into the connection between health and GDP by pointing to only a marginal connection between them while the links with poverty and inequality were strong.[61]

> "*In Mexico, for instance, the incomes of the poorest 30 per cent of the population have actually declined over the past 16 years. All of the income gains (reflected in increases in average GDP per capita) have occurred among the richest 30 per cent, and especially among the richest 10 per cent. According to the Inter-American Development Bank, no country in Latin America for which data on income distribution are available can boast a decline in income inequality during the 1990s (IDB, 2000).*"[62]

As the poor of a country are disproportionately affected by poor health, it is easy to see why GDP can be seen as a poor indicator for health.

Former Chief Economist of the World Bank, Joseph Stiglitz has been vocal critic of using GDP as a measurement of 'progress' and also highlights the absurdity of how it is calculated. During the formulation of GDP, ownership of a country's capital is not considered: thus, the holdings of foreign owned companies are considered a part of GDP despite providing no direct asset to the host country.[63] GNI has rectified this by only

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[58] The World Bank, 'How we Classify Countries', accessed on 3 May 2011 at: http://data.worldbank.org/about/country-classifications.

[59] Abbasi, K.,'The World Bank and world health under fire', *British Medical Journal*, Vol. 318, (10 April 1999), p. 1003.

[60] Biggs, B., King, L., Basu, S. and Stuckler, D., 'Is wealthier always healthier? The impact of national income level, inequality, and poverty on public health in Latin America', p. 267.

[61] *Ibid*, 270.

[62] Stiglitz, J., 'Employment, social justice and societal well-being', *International Labour Review*, Vol. 141, No. 1, (2002), p. 25.

[63] Stiglitz, J., 'Joseph Stiglitz: The Economics of Information', speech given to the *Asia Society*, (2 May 2008), viewed on 21 April 2011 at: fora.tv2008/02/05Joseph_Stiglitz_Economics_of_Information#fullprogram.

counting all domestically-owned capital, but is still largely subject to the same problems as GDP.[64] The use of GNI/GDP can also lead to perverse outcomes when considering the wellbeing of a population: Stiglitz points to the example of the health spending in the United States, which, while being the most expensive in world, has much less effective outcomes than cheaper systems elsewhere.[65] This inefficiency is not considered when calculating the percentage of GDP spent on health and can lead to false conclusions being drawn about the quality of healthcare in a country. Unfortunately, the emphasis on GDP growth as a political tool is large and, as Stiglitz has argued, politicians will not promote policy that lowers GDP; the 'holy grail' of economic growth.[66]

Taking these flaws into account, indicators that focus on inequality and poverty — perhaps the greatest correlating indicators to health — seem more apt and, in more recent studies, the Gini coefficient has entered use for this reason.[67] This move is a result of the acceptance that growth in GDP and GNP are not sufficient; as Basu suggests, while general measures can be useful, measures such as focusing on the per capita income of the poorest 20% in a nation are much more effective at assessing the quality of life.[68] In many international organisations (the World Bank and IMF in particular), there is an over-reliance on macroeconomic indicators that take no account of distribution: despite their commitment to raising living conditions within under-developed countries.[69] The direct implications for using traditional financial indicators as a basis for policy are a rising inequality and little improvement — if not deterioration — in the health of the lower portion of the population.[70] Yet, a 'trickle-down' view of health is often advocated: *"On the one side of the debate are those optimists who believe that the health goals will take care of*

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[64] *Ibid*.

[65] *Ibid*.

[66] Meier, G.M., 'The Old Generation and the New', p. 24.

[67] The World Bank, 'GINI index', accessed on 3 May 2011 at: http://data.worldbank.org/indicator/SI.POV.GINI.

[68] Basu, K., 'On the Goals of Development', in (eds.) Meier, G.M. And Stiglitz, J.E., *Frontiers of Economic Development: The Future in Perspective*, (New York: Oxford University Press, 2001), p. 24.

[69] Abbasi, K.,'The World Bank and world health under fire', p. 1003.

[70] Biggs, B., King, L., Basu, S. and Stuckler, D., 'Is wealthier always healthier? The impact of national income level, inequality, and poverty on public health in Latin America', p. 272.

themselves, as a fairly automatic byproduct of economic growth."[71] During Sachs' 2001 report *Macroeconomics in Health: Investing in Health for Economic Development*, he highlights such a view and emphasis as damaging and counterproductive to world health. The key message of the influential report is to reverse the hypothesis: focusing on improving health will lead to economic development.

4. BALANCING WEALTH AND HEALTH

Though it might seem an important consideration, the relationship between good health and economic development is often overlooked. As previously touched upon, an increase in GDP has little effect on health outcomes unless combined with a decrease in inequality or poverty.[72] Thus, the pursuit of wealth in policy may not have a positive effect on health outcomes, unless it is specifically geared towards making a society more equal. In practice however, this is rarely the case: a point shown to be particularly relevant when considering the conditionalities of World Bank loans aimed at macroeconomic stability which tend to dismantle the redistributive structures of the state in favour of opening markets to foreign investment.[73] As will be seen later, this has been particularly prevalent in LA which, as the world's most inequitable region, could benefit greatly from a change in focus.

Synonymous with the traditional neoliberal approach is a presumption in favour of unregulated markets.[74] This, as mentioned earlier, can have a severe knock-on effect on health services. While the dangers may be widely accepted, tobacco use, alcohol

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[71] Sachs, J., *Macroeconomics and Health: Investing in Health for Economic Development*, p. 3.

[72] Biggs, B., King, L., Basu, S. and Stuckler, D., 'Is wealthier always healthier? The impact of national income level, inequality, and poverty on public health in Latin America', p. 266.

[73] Poirier, S., 'How 'inclusive' are the World Bank poverty reduction strategies? An analysis of Tanzania and Uganda's health sectors', *Simon Fraser University*, (2006), p. 49.

[74] Homedes, N. and Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', *Health Policy*, Vol. 71, (2005), p. 84.

consumption and fast food remain wildly popular throughout the world and among the highest contributing factors linked to ill health — particularly NCDs.[75] Where multi-nationals have gained access to the market as a precondition of WB macroeconomic policy, the promotion of such products can be damaging for life-expectancy and increase NCD throughout a nation.[76]

4.1 HEALTH AS A WEALTH CREATOR

When the direction of the relationship between health and wealth is inverted, an interesting correlation between health and economic development is seen. In his influential report, Sachs draws the conclusion that health is a particularly strong determinant of wealth and not the other way round.[77] The difficulty that poor health in a population poses to economic growth is emphasised:

> *"The linkages of health to poverty reduction and to long-term economic growth are powerful, much stronger than is generally understood. The burden of disease in some low-income regions, especially sub-Saharan Africa, stands as a stark barrier to economic growth and therefore must be addressed frontally and centrally in any comprehensive development strategy."*[78]

Sub-Saharan Africa is the most effective example of how poor health can stifle any attempts at economic development due to the burden of disease in the area: in Malawi the AIDS epidemic is directly negatively impacting on the projected growth of the economy.[79] Beyond the national level, it has been estimated that on an international scale, HIV has cost Africa about 15% of its GDP.[80]

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[75] Strong, K., Mathers, C., Epping-Jordan, J. and Beaglehole, R., 'Preventing chronic disease: a priority for global health', p. 493.

[76] WHO, *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases*, p. 19.

[77] Sachs, J., *Macroeconomics and Health: Investing in Health for Economic Development*, p. 16.

[78] *Ibid*, p.25.

[79] Cuddington, J.T. and Hancock, J.D., 'Assessing the impact of AIDS on the growth path of the Malawian economy', *Journal of Development Economics*, Vol. 43, (1994), p. 366.

[80] Poku, N., 'AIDS and the Future of the African State', in (eds.) Foller, M., and Thorn, H. *Politics of AIDS*, (Basingstoke: Macmillan, 2008), p. 65.

Not only does the good health of a population prevent this from occurring, an increase in health directly leads to economic growth. This is quantified by Sachs who calculates that investment in health would lead to "*...hundreds of billions of dollars per year of increased income in the low-income countries. There are large social benefits to ensuring high levels of health coverage of the poor, including spillovers to wealthier members of the society*."[81] By attempting to quantify the potential effect that an increase in health spending could have, the way in which policy makers tend to view aid as more of a short term measure than providing real long term benefit will hopefully begin to change. A potential problem with convincing politicians to take such an approach is the long-term, and sometimes difficult to measure nature of such investment. Politicians will prefer to provide aid that will provide obvious effects in the short term so that they will benefit from looking effective within the political realm, but this will need to be set aside: "*Note that the donor assistance will be required for a sustained period of time, perhaps 20 years, but will eventually phase out as countries achieve higher per capita incomes and are thereby increasingly able to cover essential health services out of their own resources*."[82] It is important to note that here an investment in health is seen as a step towards achieving a higher national income, not the other way round.

The relationship between wealth and health is complex and inter-related. It might seem self-evident that increased economic growth (wealth) leads to better health outcomes in a country, but the relationship is not this linear in its nature. Measures to reduce inequality and poverty within a nation are much more important for a population's well-being and health and thus, it would seem that the rhetoric of 'development' through macroeconomic growth is usually misleading. Not only is health a goal in its own right, the links between a healthy population and economic growth are strong. In areas that carry the highest burden of disease, the importance of increasing funding of health to break the vicious circle of disease and poverty cannot be underestimated. It would seem therefore that the perceived trade-off between wealth and health is often misunderstood: it is true that an over-focusing on wealth can be harmful for health outcomes, but an emphasis on health in

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[81] Sachs, J., *Macroeconomics and Health: Investing in Health for Economic Development*, p. 16.

[82] *Ibid*, p. 12.

development policy will be beneficial to both. How this relationship plays itself out in the tangible realm of global governance will now be explored.

5. THE WHO

5.1 STRUCTURE

The WHO is open to all states and is governed by the World Health Assembly (WHA) which meets annually to review the organisation's work, and plan for future projects.[83] The WHA nominates the members of the Executive Board and appoints the Director General: a position that can have a profound effect on the direction of the organisation.[84] Members of the executive board do not operate as a national delegates, instead working in a personal capacity: a move that was aimed to focus the organisation beyond politicking and towards health goals.[85] The next tier of the organisation is the regional offices of the WHO: in LA, the regional office is the Pan American Health Organisation (PAHO). Regional offices, such as PAHO take the primary share of the WHO's budget and have relatively large autonomy over how to spend this.[86] The WHO is staffed by personnel from around the world: many of them health professionals. In keeping with its name, the WHO aspires to be the leading health organisation globally, but in reality, the limited resources of the organisation and reliance on donor countries has pushed it down the order in global health governance.

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[83] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 7.

[84] Davis, S.E., *Global Politics of Health*, p. 35.

[85] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 8.

[86] *Ibid*, p. 6.

5.2 CHANGING ROLES

Under its own constitution the WHO defines itself as: "*...the directing and co-ordinating authority on international health work.*"[87] The constitution of the WHO came into force on the 7 April 1948, and since then its role in world health has been a varied one. During the organisation's early years, it was focused more acutely on the treatment and eradication of particular diseases, but after the Alma-Alta conference 1978, a new commitment to PHC objectives was agreed upon.[88] This declaration represented a move towards the centre of global health governance. As a specialised agency, the WHO has a large base of expertise in all areas of health policy. However, it is also entirely reliant on funding from member states. The ability of member states to withhold funds from the WHO can make the implementation of policy advice difficult: particularly when that advice is seen to conflict with the interests of a member. This scenario was seen when the WHA passed the International Code on infant formula in 1981 to which only the US (the WHO's largest donor) objected.[89] The US increasingly claimed that the WHO was taking a politicised role and this continued to create a rift between the organisation and its biggest donor. The creation of an essential drugs list and the condemnation of free breast milk substitutes entrenched this divide further.[90]

The WHO's increasing commitment to social programmes — which the US saw as ideologically aggressive — was an increasing source of annoyance to the US and Ingram outlines the US view succinctly: "*...the World Health Organization has also been severely criticised by US libertarians as an ineffective, self-perpetuating bureaucracy that has replaced its original, noble mission of infectious disease control with an agenda of social control.*"[91] Around the same time that WHO policy began to conflict with the desires of its biggest donor, the WB entered the realm of health governance.[92] Considering the increased power that the US has

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[87] WHO, *Constitution of the World Health Organization*, p. 1.

[88] Davis, S.E., *Global Politics of Health*, p. 35.

[89] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 9.

[90] *Ibid*, p. 9.

[91] Ingram, A., 'Global Leadership and Global Health: Contending Meta-narratives, Divergent Responses, Fatal Consequences', p. 385.

[92] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 30.

within the WB structure, it could be argued that this is not coincidental. The WHO remains a source of contempt from neoliberals: in extreme cases, the WHO's attempt to address the prevalence of NCDs is seen as a political step beyond its licensed sector.[93]

Unlike the WB, the WHO operates on a one country, one vote system that can lead to results in which otherwise dominant states, are undermined by the majority.[94] On this basis, the World Bank was a much more hospitable option as the US possessed much greater comparative influence within the Bank.[95] It does not seem unreasonable to make a connection between a preference for increased power by the US and the increased concern of the WB in the healthcare sector. Considering the US preference for unilateral action in global issues, the increased forays of the WB — in which the United States holds the greatest influence — into a sector that, under WHO guidance, was confronting US interests could be seen as a political move.[96]

5.3 The WHO and Latin America

As the WHO has been instrumental in the development of GHG theory, the principles that it has taken to policy formulation have largely followed the same route. However, due to the limited funds of the organisation — when compared to the WB and International Monetary Fund (IMF) — the scope of projects have tended to be largely limited to technical interventions on particular diseases — this has also been followed by the PAHO in LA.[97] This is largely due to the funding structure of the WHO which is divided into 'core' and 'extra-budgetary' funding.[98] Many donors choose to direct their funds to these extra-budgetary programs as it allows more influence over where the funding goes.[99] In

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[93] Doherty, B., 'WHO Cares?', *reason.com*, (January 2002), accessed on 1 May 2011 at: http://reason.com/archives/2002/01/01/who-cares/2.

[94] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 8.

[95] *Ibid*, p. 26.

[96] Ingram, A., 'Global Leadership and Global Health: Contending Meta-narratives, Divergent Responses, Fatal Consequences', p. 385.

[97] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 16.

[98] Davis, S.E., *Global Politics of Health*, p.34.

[99] *Ibid*, p. 34.

many ways it also undermines the power of the WHO as a centralised agency: something that states worried by the WHO's politicisation could see as beneficial.

In LA, the WHO has had to contend with large scale interventions by the WB and IMF which have fundamentally altered the health structures of many countries.[100] While the WHO and PAHO have secured written commitments from members concerning an implementation of a PHC while taking into account the SDH, the lack of strong targets on the continent is telling.[101] It is clear that the WB is now the prime mover within the financing of health systems and how the WHO and WB cooperate is of paramount importance to the practical role that the WHO will play in policy formulation. At a vertical level, cooperation between the WHO and WB has been relatively successful — the WB serving as fiscal agent and the WHO as the executing agency. The programme to treat 'River Blindness' in Southern Africa is just one such example.[102] However, in a broader context, the WHO has jumped between criticism for toeing the WB line and, more recently, promoting policy that runs contrary to WB economic policy.[103]

The 1993 World Development Report, *Investing in Health*, represented a significant collaboration, but the WHO has also been widely criticised for endorsing a perspective conflicting with its core principles.[104] The influence of former WB staffers, that had recently joined the WHO, on the report was also brought into question.[105] Further reports (joint or otherwise) continued to legitimise the WB's prioritisation of privatising health services which signalled a period of neoliberal tendencies of the WHO — coinciding with the directorship of Dr H. Nakajima (1988 - 1998). Armada et al. argue that this was telling

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[100] De Vos, P., De Ceukelaire, W. And Van der Stuyft, V., 'Columbia and Cuba, contrasting models in Latin America's health sector reform', *Tropical Medicine and International Health*, p. 1604.

[101] The Ministers of Health of the Americas, *Health Agenda for the Americas 2008-2017*, (Panama City: PAHO, 2007), p. i.

[102] The World Bank, 'Global Partnership to Eliminate Riverblindness', accessed on 2 May 2011 at: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTREGINI/EXTRIVBLINEGTRODISE/0,,contentMDK:22694144~menuPK:7474463~pagePK:64168445~piPK:64168309~theSitePK:3933498,00.html.

[103] Armada, F., Muntaner, C. And Navarro, V., 'Health and social security reforms in Latin America: The convergence of the World Health Organization, the World Bank, and transnational corporations', *International Journal of Health Services*, Vol. 31, No. 4, p. 730.

[104] *Ibid*, p. 745.

[105] Homedes, N. and Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', *Health Policy*, p. 89.

of a wider convergence between International Financial Institutions (IFIs), multinational corporations and the WHO.[106] Further, they claim that the PAHO which, during this time echoed the Bank's message of 'increasing competition in the health sector', was fully complicit in neoliberal reform in LA — which has since been shown to be damaging to health outcomes.[107] [108] The election of Dr Margaret Chan to Director General reverted the WHO towards its 'health for all' objectives and recent reports have emphasised this. However, the influence of the WHO in the policy realm remains largely dependent on the position that the WB takes towards health in its consideration of development.

6. The World Bank

Since the system of Structural Adjustment Programs (SAPs), the WB has courted controversy and accusations of following a neoliberal agenda set out by the US.[109] In many ways, it is difficult to argue against these accusations as the structure of the Bank is explicitly geared towards a vote per dollar system of which the US is by far the biggest shareholder.[110] Since its inception in 1944, the WB has been a major actor in wealth creation on the stage of global governance, however, the 1980s saw the WB encroach into the health sector. The presidency of Robert MacNamara (1968 - 1981) can be credited with the Bank's first skirmish into health issues after he made a number of speeches focused on the projected effects of a rising world population.[111] Initially, the Bank focused on small scale projects that aimed to provide 'cost effective solutions' to health problems, but this expanded with the inevitable ramifications that the Bank's program of SAPs had on the

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[106] Armada, F., Muntaner, C. And Navarro, V., 'Health and social security reforms in Latin America: The convergence of the World Health Organization, the World Bank, and transnational corporations', p. 729.

[107] *Ibid*, p. 745.

[108] Homedes, N. and Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', p. 89.

[109] Davis, S.E., *Global Politics of Health*, p. 47.

[110] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 16.

[111] *Ibid*, p. 25.

health sectors of many developing countries.[112] In an eventual response to these criticisms, health started to become a considered factor in the planning of the SAPs replacement; Poverty Reduction Strategy Papers (PRSP). However, the differences between them have been questioned as the World Bank has continued to push ahead with neoliberal reform, except it is now focused on the health sector.[113]

The development of the post-Washington consensus was a pivotal to this change in rhetoric — and possibly approach. Led by Stiglitz, this was an acceptance that the over-simplicity of the Washington consensus — concerned primarily in the strong neoliberalism through reducing the state, privatisation and opening the market to foreign investment — was having a negative effect on the lower income countries that were accepting its terms and needed reform.[114] PRSPs were part of this change, but again, whether the WB can move beyond the potential conflicts of economic growth measures and the well being of citizens remains controversial.

6.1 A FUNDAMENTAL CONFLICT?

Much of the debate surrounding whether the WB can be an effective actor within the health policy realm is dependent on whether the Bank can reach a balance between economic policy and health that would benefit both. It is widely accepted that during the time of the Washington consensus, this balance was not achieved, however, Poirier argues that at least on the surface, the transition from SAPs to PRSPs represent a movement towards an 'embedded liberalism'.[115] 'Embedded liberalism', she claims sets health as a fundamental positive 'freedom': an enabler for individuals to achieve their potential.[116] In trying to reason why the Bank's rhetoric/action has changed, it has been proposed that the globalised nature disease treatment (i.e. the development of national welfare is dependent

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[112] Cheru, F. (2002). Debt, Adjustment and the Politics of Effective Response to HIV/AIDS in Africa. *Third World Quarterly* 23 (2), p. 302.

[113] Homedes, N. and Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', p. 89.

[114] Davis, S.E., *Global Politics of Health*, p. 44.

[115] Poirier, S., 'How 'inclusive' are the World Bank poverty reduction strategies? An analysis of Tanzania and Uganda's health sectors', p. 9.

[116] *Ibid*, p. 9.

on international interactions) has created the sense that health as a 'public good' is now a shared burden: "*...although responsibility for health remains primarily national, the determinants of health and means to fulfil that responsibility are increasingly global*"[117] The pressure that civil society, through NGOs, exerts on international institutions has also been cited as possible reason for the recent change in discourse by the World Bank.[118] These two factors, combined with an acknowledgement that health is an essential component of increased economic efficiency have been central to the Bank's perceived change in direction.

Just how effective the Bank's move to PRSPs has been is up for debate. Though the institution has gone out of its way to sound more concerned with social welfare, PRSPs still posses many of the facets of the neoliberal approach to development.[119] A failure to protect health and education from the inequities of the free market remains consistent with SAPs, while the introduction of Trade Related Intellectual Property Rights (TRIPS) by other IFIs also highlight an inconsistency with prioritising human welfare above economic development.[120] The limits placed on spending have also been problematic for health: while advocating increased interest in health, the PRSP for Tanzania limited health expenditure to 8.7% of GNP. This was well short of the *minimum* 12% recommended by the Sachs report.[121] Finally, PRSPs have been criticised for overlooking 'poverty' in their title. A WHO evaluation of PRSPs found that:

> "*In the main, PRSPs do not systematically identify those health issues which are the biggest contributors to poverty or the greatest brake on economic growth, and then set out to tackle them. Nor do they look systematically at the health situation of the poor – beyond noting that they tend to have the worst health outcomes and are unable to afford health care fees.*"[122]

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[117] Poirier, S., 'How 'inclusive' are the World Bank poverty reduction strategies? An analysis of Tanzania and Uganda's health sectors', p.11.

[118] Ruggie, J.G. 'Taking Embedded Liberalism Global: The Corporate Connection', in (eds.) Held, D. and Koenig-Archibugi, M., *Taming Globalization: Frontiers of Governance*, (Cambridge: Polity Press, 2002), p. 93.

[119] Davis, S.E., *Global Politics of Health*, p. 47.

[120] Poirier, S., 'How 'inclusive' are the World Bank poverty reduction strategies? An analysis of Tanzania and Uganda's health sectors', p. 51.

[121] Davis, S.E., *Global Politics of Health*, p. 47.

[122] WHO, *PRSPs: Their Significance for Health*, (Geneva: WHO, 2004), p. 18.

The introduction of user fees for health has been particularly detrimental to the situation of the global poor as it can mean that illness is either ignored or becomes a heavy burden on families: always affecting the poorest most obviously.[123]

To summarise, it would seem that the World Bank has undergone a change in approach since the introduction of PRSPs: a reaction to international pressure on the failure of SAPs. However, beyond the rhetoric, much of the neoliberal content of SAPs remains. Many critics have argued that this is an inevitable consequence of the fundamental conflict between the Bank's stated commitment to act only on economic grounds and the realities of health care.[124] [125] This paper will now consider the role that this has played in a LA context.

6.2 Wealth to health? World Bank reform in Latin America

6.2.1 Chile

A majority of national health systems in LA were overhauled in the 1990s in a response to the 1993 *Investing in Health* WB framework that advocated "*...cost recovery and user fees, separation of the purchaser and provider functions, and privatisation*."[126] Chile, Columbia and Bolivia are particularly good examples of this reform as the former two have been held up as an example of successful reform while the latter is still ongoing.[127]

The Chilean reform dismantled a previous universal health system that had been largely successful in its outcomes in favour of privatised health and user-fees.[128] This took place in stages. Firstly, decentralisation led to a prioritisation of urban dwellers over the rural — though it is rural workers who required healthcare the most. Secondly, the introduction of private insurance schemes led to a situation in which divided health services along wealth

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[123] Homedes, N. and Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', p. 88.

[124] Koivusalo, M. and Ollila, E., *Making a Healthy World*, p. 37.

[125] Abbasi, K.,'The World Bank and world health under fire', p. 1003.

[126] De Vos, P., De Ceukelaire, W. and Van der Stuyft, V., 'Columbia and Cuba, contrasting models in Latin America's health sector reform', p. 1604.

[127] Homedes, N. And Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', p. 89.

[128] *Ibid*, p. 89.

lines: "*the new model has fragmented health care among social classes, a small percentage of the population consumes a sizeable amount of the health resources, and co-payments represent a heavy economic burden for those with lower incomes may even post- pone needed care*."[129] Importantly for such reforms, the success of Chile's prior National Health Service should not be underestimated: under the old system, all Chileans has access to healthcare and the WB reforms failed to resolve the issues under the old system.[130] Homedes highlights the acceptance that in the sector of healthcare, neoliberal reforms did little to benefit Chile:

> "*Recently, the Ministry of Health acknowledged that the Chilean health system was "extremely inequitable". Citing the World Health Report of 2000, the Ministry reminded fellow Chileans that the country ranked 168 out of 191 nations regarding users' financial burden, and fared poorly regarding other variables such as timely access, access to social assistance during treatment, quality of the setting, relations with providers, and ability to select providers. In all of these indicators Chile was behind more than 100 nations. In a bold statement, the Ministry blamed the creation of the ISAPRES and the derogation of the employers' contribution to the health system for the inequities*."[131]

6.2.2 COLUMBIA

Since 1990, Columbia has followed a similar route to Chile (i.e. wholesale neoliberal reform), but is heralded as one of the success stories of WB intervention and used as a model for other Latin American nations.[132] The new system offers universal access to those that are affiliated with the system. To affiliate, workers are required to pay 12% of their salary for insurance premiums and a 1% 'solidarity fund' for the poor.[133] The private sector is instrumental in the delivery of the new system, though there are legal obligations to provide care for the poor as well as the option for relative autonomy. This autonomy has led to many hospitals in Bogotá closing down.[134] Despite praise, many critics have highlighted a number of issues with these reforms not least claiming that there was a bias

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[129] Homedes, N. And Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', p. 89.

[130] *Ibid*, p. 89.

[131] *Ibid*, p. 89.

[132] De Vos, P., De Ceukelaire, W. and Van der Stuyft, V., 'Columbia and Cuba, contrasting models in Latin America's health sector reform', p. 1604.

[133] Homedes, N. and Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', p. 90.

[134] *Ibid*, p. 90.

in the World Health Report from ex-Bank staffers who had previously played a role in formulating the Columbian model. This criticism was even echoed by one of the report's authors.[135]

It would seem that whether the reform itself has really provided the benefits claimed is also up for debate. It is estimated that between 1984 and 1997, total health expenditure in Columbia increased by 178%: clearly such an increase would have some effect on the provision of services irrespective of reform.[136] Some analysis also suggests that the coverage of healthcare is now less comprehensive than it was without reform: "*Hernández Álvarez, for example, claims that in 1999 only 61% was covered by the new social security system, while in the pre-reform days it was estimated that 75% of the population had access to some type of health care services.*"[137] It seems that in spite of very large increases in health expenditure and extensive reforms, the World Bank model at the least, has large coverage gaps. Considering the Bank's ongoing prioritisation of privatisation and decentralisation over health outcomes, this might not be surprising to some.

> "*The Colombian reform has not been able to materialize its promises of universality, improved equity, efficiency and better quality... we argue that the basic premises of the ongoing health sector reforms in Latin America are not based on the people's needs, but are strongly influenced by the needs of foreign – especially North American – corporations.*"[138]

In summarising the Columbian reform, it seems that reconciling market principles and health care has been problematic yet again for the WB. As De Vos points out:

> "*Colombia's new health system is clearly not able to solve the continuing problems of accessibility, equity and efficiency. Serious contradictions exist between the theoretical objectives of the reform law and its actual implementation. This is not surprising, as health care has been placed in a market context, where economic efficiency and profitability are the primary objectives.*"[139]

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[135] Homedes, N. and Ugalde, A., 'Why neoliberal health reforms have failed in Latin America', p. 90.

[136] *Ibid*, p. 90.

[137] *Ibid*, p. 90.

[138] De Vos, P., De Ceukelaire, W. and Van der Stuyft, V., 'Columbia and Cuba, contrasting models in Latin America's health sector reform', p. 1604.

[139] *Ibid*, p. 1608.

6.2.3 BOLIVIA

Finally, Bolivia has been one of the most recent targets of the WB PRSP program and perhaps is the best illustration of the conflict between neoliberal economic reform and health. In 2001 the Bolivian Poverty Reduction Strategy (BRSP) was launched articulating a need for extensive changes in order to address the wide ranging poverty in the country. Counter-productively, as the Bank facilitated the writing of a document with such high ideals, it was forcing the privatisation of the water companies in the country as a conditionality for loans.[140] A sudden increase in pricing by the new company directly led to rioting in Cochabamba — Bolivia's third largest city — and a number of deaths.[141] In many ways it is difficult to see how such opposing actions could be compatible in one organisation. One explanation is that the opening of LA health markets is down to an over-saturation of the US market which has led health corporations to lobby the WB into opening markets in the nearest unsaturated region.[142] [143]

6.3 THE FUTURE

It is not necessarily surprising that the WB has found it difficult to balance its new role of health with its traditional role concerned with wealth as the pursuit of the latter has been greatly oversimplified. The Bank has had varied success with individual vertical projects through its Health, Nutrition and Population (HNP) department — an internal investigation found a third of the HNP's programs resulted in unsatisfactory results.[144] This was due to: "*...inadequate risk analysis or technical design, inadequate supervision,*

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[140] Goldman, M., 'How "Water for All!" policy became hegemonic: The power of the World Bank and its transnational policy networks', *Geoforum*, Vol. 38, (2007), p. 794.

[141] The Democracy Centre, 'The Water Revolt', accessed on 30 April 2011 at: http://www.democracyctr.org/bolivia/investigations/water/.

[142] Jasso-Aguilar, R., Waitzkin, H. And Landwehr, A., 'Multinational Corporations and Health Care in the United States and Latin America', *Journal of Health and Social Behaviour*, Vol. 45, (2004), p. 149.

[143] De Vos, P., De Ceukelaire, W. and Van der Stuyft, V., 'Columbia and Cuba, contrasting models in Latin America's health sector reform', p. 1605.

[144] IEG, *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population: An Evaluation of World Bank Group Support Since 1997*, (Washington: The International Bank Reconstruction and Development/The World Bank, 2009), p. xiii.

insufficient political or institutional analysis, lack of baseline data on which to set realistic targets, overly complex designs in relation to local capacity, and negligible monitoring and evaluation."[145] It is therefore important that the WB consider this when setting out policy: it could benefit from taking a financing role to the WHO's formulation. The decision to collaborate on health system strengthening will be an interesting test of collaboration between the two organisations. It would be unfair to dismiss the WB's forays into the health realm as completely without merit: particularly in the realm of AIDS/HIV in which it has made significant progress through its 'MAP' programme.[146] Much of the contradictions seem to stem from the size of the organisation — over 10,000 people — and a lack of coordination between departments is clearly an issue for the WB that needs to be rectified.[147]

7. Conclusion

In conclusion, this paper has shown that the relationship between wealth and health has been largely misinterpreted in GHG. More than most debates, this one is shaped by the definitions given to the topics. The WHOs repeated broadening of its interpretation of health has, in many ways, shaped the entire sector of health governance and resulted in the increased focus on the PHC and SDH. In turn, this was responsible for a divide between state-central and market approaches to health. Wealth — or economic growth — has been taken as a linear increase of a country's wealth without considering distribution or poverty: an oversight considering their importance to a population's well-being. This false assumption has been greatly overemphasised by global actors — particularly the WB.

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[145] IEG, *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population: An Evaluation of World Bank Group Support Since 1997*, p. xvi.

[146] The World Bank, 'Multi-Country HIV/AIDS Program', accessed on 3 May 2011 at: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20415735~menuPK:1001234~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html.

[147] The World Bank, 'About Us', accessed on 2 May 2011 at: http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/0,,pagePK:50004410~piPK:36602~theSitePK:29708,00.html.

The nature of wealth distribution within a country is just as important as an overall increase. Further, health has been largely cast as a coincidental factor in the development debate instead of a standalone goal in itself: Sachs has shown that investing in health system strengthening will be beneficial for the productivity a nation as well citizen's self-fulfilment. My analysis of the theoretical framework surrounding the interrelationship between the two topics concludes that though, there are times when they could seen to be opposing aims, the two can be balanced effectively if health is valued as it should be.

By far the most important event in GHG of the past 30 years has been the introduction of the WB into health policy: something that has led to confusion between the internal departments of the Bank which find themselves often at odds with one another. Until the leadership of Dr Chan, the WHO had struggled to reevaluate its position in relation to the WB, but it seems it has now begun to reassert itself away from the Bank with the release of the 2008 reports. LA serves as a good illustrator of the different approaches and their varying effectiveness: Cuba being one of the best global examples of PHC being implemented, while Chile, Columbia and Bolivia have more capable services, but these have come at the expense of universal access: a key tenant of WB and WHO health proposals.

Finally, the answer to the question of whether 'wealth equals health' is too complex and dependent on interpretation to give a one word answer. However, a much simpler answer is found if one turns the statement on its head to 'does health equal wealth?', the answer to which is a clear, if under-appreciated, 'yes'.

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