No ‘Health for All’ by the 21st century

‘Modern high-tech warfare is designed to remove physical contact: dropping bombs from 50,000 ft ensures that one does not “feel” what one does. Modern economic management is similar: from one’s luxury hotel, one can callously impose policies about which one would think twice if one knew the people whose lives one was destroying.’

Joseph Stiglitz, former World Bank Chief Economist and Nobel Laureate in Economics, 2001.¹

Spectacular gains in life expectancy have taken place but the benefits have been unevenly distributed. Today’s world is beset with inequities exacting an enormous toll on health. The causes go way back but they have been deepened by macroeconomic policies imposed over the last few decades on the South. Serving the interests of the North they are in large part why WHO’s clarion call of ‘Health For All by the Year 2000’ remains a lofty dream.

If an alien were to land on earth today it would have a hard time explaining things to the mothership. It would flash back photographs of Citizen X, sipping mineral water in his luxury penthouse, followed by Citizen Y’s mother collecting water from a stagnant stream.¹

Today, 1.1 billion people do not have access to adequate amounts of safe water and 2.6 billion lack basic sanitation,² making hygiene impossible. Together they make Citizen Y vulnerable to a host of infections. She could be one of the 1.5 million children who die each year from diarrhea because of this.³ Because no

¹ In UNICEF-supported research in 23 countries more than a fifth of households surveyed spend more than an hour per trip to collect water and in areas with taps, irregular or interrupted supplies cause delays of hours.
health education ever reached her village, her mother does not know about lifesaving oral rehydration therapy. The clinic is too far to walk to and there is no money to pay for transport or the clinic visit.

If Citizen Y recovers, her chances of making it beyond her fifth birthday are slim. If infections don’t kill her, they could leave her blind or undernourished in her critical developmental years, with compromised physical and cognitive functioning. Disadvantaged at school, if she gets to go, what chance does she stand to perform well, graduate, get a job and escape the poverty she was born into? Poverty begets ill-health which begets poverty.

The alien would report that there is some trouble in paradise – living high on the hog makes Citizen X vulnerable to chronic diseases. But when he has his heart attack at 70 he will be rushed to a state-of-the-art hospital where the best medical team will work wonders.

We live in an era where spectacular things are possible. We’ve mapped the Human Genome, grown organ tissue from embryonic stem cells and may be close to cloning a human being. We can replace the human heart with an artificial one and do intricate surgery via computer. These are the days of ‘miracles and wonder’. But this offers little relief from the grinding poverty and ill-health experienced by almost half the world. They are the 2.8 billion people who live on less than $2 per day. In Ethiopia they are called *wuha anfari* – ‘those who cook water’.

**Spectacular gains, spectacular inequity**

Our hunter-gathering ancestors roamed the earth for 25 years on average. Major gains were only made in the mid-19th century and by the 1950s we were

---

ii Ironically chronic diseases are also on the rise amongst the poor (see Chapter 6).
roaming on average for about 20 to 30 years more. Improvements in socio-economic conditions with better living standards (including water and sanitation provision) and nutrition were largely responsible for the dramatic gains in life expectancy in the mid-19th century. While these gains pre-dated larger public health interventions including oral rehydration therapy and immunization, some argue that the role of these technological interventions is understated.

Life expectancy shot up in the last half of the 20th century, spiking today at 80 years in some parts of the world. Continuing improvements in socio-economic conditions and better medical interventions, notably treatment of infections and prevention and control of non-communicable diseases such as diabetes and cardiovascular disease, have been largely responsible for gains post-1950.

While the majority of the world is better off today than a century ago, these gains have been unequally distributed both between and within countries. In some parts of the world you would be lucky to make it to 40. Life expectancies have decreased in sub-Saharan Africa (largely because of HIV) and in the former Soviet Union (largely because of social disruption, increased poverty and the collapse of social services). In industrialized countries only 1 in 28,000 women will die from causes related to childbearing, while in sub-Saharan Africa the risk is 1 in 16. In wealthy Australia there is a 20-year gap in life expectancy.

What’s in a name?
Terminology describing countries’ varying degrees of ‘development’ is highly contested. This book tends to use ‘North’ and ‘South’, ‘Western’ and ‘Majority World’, ‘rich’ and ‘poor’, although they are all imperfect. For example, in 1990, the Fortune 500 included 19 transnational companies from the South. This rose to 57 in 2006. Journalist Thebe Mabanga quips: ‘World domination is now as likely to be plotted from an air-conditioned office in Mumbai as it is from New York’.
between Aboriginals and the Australian average. Premature death in African-American men is 90 per cent higher than in whites.\(^5\)

According to UNICEF global access to water increased from 78 to 83 per cent between 1990 and 2004. But this masks wide inter- and intra-country disparities particularly between urban and rural communities. In West/Central Africa for example, about 49 million people living in urban areas gained access to improved drinking-water sources during this period, but only 26 million people living in rural areas did so. In some countries the discrepancies are very high. For example, in Mongolia, 87 per cent of urban dwellers have access to safe water supplies while only 30 per cent of rural dwellers do.

Today’s global averages look less rosy when
disaggregated by gender, race, geographical location or bank balance. These factors, plus others, are referred to as ‘the socio-economic determinants’ of health. Reflecting differing levels of social privilege, they determine your exposure to risk, your access to life opportunities and resources (including safe water and sanitation, education, and health services). They determine how long and how healthily you live.

It is no surprise that absolute deprivation has negative health outcomes. This is why more than 10 million children die of hunger and preventable diseases every year—astoundingly, one every three seconds. They die largely from a few poverty-related conditions: pneumonia, diarrhea-related diseases, malaria, measles, HIV/AIDS, under-nutrition and neonatal conditions. Most of these deaths happen in the South.

But inequality per se within societies is also thought to result in negative outcomes through perceptions of social deprivation, even when relatively small. Lack of social cohesion and inadequate political support for redistributive policies in such societies are also thought to be responsible.

In fact poorer countries with less inequity often have equal or better health measures than wealthy countries with large disparities. For example, Sri Lanka and India’s Kerala state are both poor, but have limited income variation and invested heavily in redistributive, pro-equity policies. Basic curative and preventive health services were combined with strategies to ensure land reform, universal access to housing, education (emphasizing gender equity), subsidized school transport and nutrition, water, sanitation and extensive social safety nets.

Kerala’s per capita income is about a hundredth that of wealthier countries. It spends $28 per capita on health compared to the US which spends $3,925. But life expectancies of 76 for women and 74 for men
Economic growth and good health are not automatically synonymous

Once a minimum per capita income is achieved, education and other socio-political investments have greater health impacts than economic growth.* This is why poorer countries with less inequality often score better on health measures than wealthy counterparts with greater inequality. Sri Lanka for example scores higher on the Human Development Index* than South Africa which has a 4-fold higher per capita GDP but is one of the world’s most unequal countries.


<table>
<thead>
<tr>
<th>GDP (US$ per capita)</th>
<th>HDI coefficient*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.55</td>
</tr>
<tr>
<td>1,000</td>
<td>0.60</td>
</tr>
<tr>
<td>2,000</td>
<td>0.65</td>
</tr>
<tr>
<td>3,000</td>
<td>0.70</td>
</tr>
<tr>
<td>4,000</td>
<td>0.75</td>
</tr>
<tr>
<td>5,000</td>
<td>0.80</td>
</tr>
<tr>
<td>0.55</td>
<td>Sri Lanka</td>
</tr>
<tr>
<td>0.80</td>
<td>South Africa</td>
</tr>
</tbody>
</table>

*The Human Development Index (HDI) is a measure of wellbeing. The higher, the better. It combines life expectancy, literacy, education and standard of living.

Infant Mortality Rates (IMR) in Kerala at 14 per 1,000 live births are close to the US average rates (7 per 1,000). But citizens of Kerala fare better than African-Americans whose IMRs are well below the US average. They also fare better than those in equally poor parts of India where average IMRs are 68 per 1,000.

Health equity means ‘any group of individuals defined by age, gender, race-ethnicity, class or residence is able to achieve its full health potential.’ Addressing
poverty and inequity is unequivocally the greatest challenge facing public health in the 21st century.

So how did it get to be this way?

Simply put, the haves have, because everyone else has not. Since the days when sea-faring adventurers set forth to pillage and plunder, the world has been a bargain bin for wealthy nations. For the vanquished, life was cheap and full of hardship. Entire civilizations were wiped out. Later forms of colonialism were equally cruel. In the 1890s, Cecil John Rhodes, mining magnate and politician in South Africa, said
shamelessly: ‘We must find new lands from which we can easily obtain raw materials and at the same time exploit the cheap slave labor that is available from the natives in the colonies. The colonies [will] also provide a dumping ground for the surplus goods produced in our factories’. By the mid-20th century, colonial powers were still sucking countries dry of resources, expropriating land from peasants for large-scale cultivation to feed the empires and lowering local food production. People were worked to death or spat out when they were sick and dying. Over a century later, modern forms of colonialism, dressed in the rhetoric of ‘the free market’ are doing the same. But more on that later.

While the health of the colonized deteriorated, two tiers of health services prevailed – quality services for the élites and third-rate care for the rest. Services were based in urban areas, and largely curative in nature.

In 1948, in the idealistic aftermath of the Second World War, the United Nations (UN) was born, and with it came global acknowledgements of health as a human right linked inextricably to social and economic justice. The Universal Declaration of Human Rights held that ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.’ The 1966 International Covenant on Economic, Social and

The right to health

‘General Comment 14’, added to the UN’s International Covenant on Social, Economic and Cultural Rights in 2000, states that the right to health is ‘an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information, including on sexual and reproductive health’.
No ‘Health for All’ by the 21st century

If there was no poverty...
During the 1980s, the richest 1 per cent in the US increased their share of the country’s wealth from 31 to 37 per cent. Yet in 1991 almost one-fifth of mortality in people between ages 25 to 74 was due to poverty.

Poverty’s impact on health
The Harvard Public Health Disparities Geocoding Project team calculated what would happen to the number of cases in their study if everyone faced the same risk as people who were living in areas where fewer than five per cent of residents were impoverished.

<table>
<thead>
<tr>
<th>% of cases that would not have occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicides and legal interventions</td>
</tr>
<tr>
<td>Syphilis</td>
</tr>
<tr>
<td>Gonorrhea</td>
</tr>
<tr>
<td>Weapons injuries</td>
</tr>
<tr>
<td>Childhood lead poisoning</td>
</tr>
<tr>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Chlamydia</td>
</tr>
<tr>
<td>HIV/AIDS deaths</td>
</tr>
<tr>
<td>Low birth weight (&lt;2,500g)</td>
</tr>
<tr>
<td>Premature mortality (death before age 65)</td>
</tr>
</tbody>
</table>

Cultural Rights (and more recent additions) elaborated on this even further (see box: The right to health p17). The World Health Organization (WHO) was established as the UN’s specialized health agency to serve as the world’s ‘health conscience’ and safeguard this inalienable right to health. It defined health as a state of wellbeing, not simply the absence of disease.

The rise of Primary Health Care (PHC)
Postcolonial concerns for health and social justice varied. In some countries the oppressor simply became ‘home-grown’. Inequities continued and even intensified. Many countries continued to follow the colonizers’ medical model of health care with costly urban hospitals and ‘doctors as God’. For others, radical change was in the air. With oppression came a
strong consciousness of the link between poor health and social injustice. Countries such as Mozambique and Tanzania trail-blazed a people-centered model of development. Bringing health to the people was seen as an act of liberation. In 1977 the Frelimo Government in Mozambique stated its objective to make ‘each citizen a sanitary agent and to arm and organize the people to defend themselves and their health’. China’s famous ‘barefoot doctors’ were villagers trained to provide basic health care in their own communities.

These efforts influenced global trends and in 1978, at WHO’s International Conference on Primary Health Care (PHC) in Alma Ata (now Almaty), Kazakhstan, member countries committed to this approach. PHC was more than just providing basic services. It was a revolutionary concept with social justice at its core. Eradicating inequity was to be a global priority. Services would provide integrated basic preventive, curative and rehabilitative care close to where people lived. More complex problems would be referred to the next level of health service. PHC services would work closely with health-related sectors responsible for education, safe water and sanitation and food security. In this way, addressing the socio-economic determinants of health would be part of the PHC equation. Communities would be active participants in the entire process.

At Alma Ata, governments committed to achieving ‘Health For All by the Year 2000’ with PHC as a central strategy. It was a time of great optimism and ‘another world’ seemed possible.

**The fall of Primary Health Care**

But the heady idealism soon faded in the 1980s as the right to health was systematically eroded. While some countries like Sri Lanka remained steadfast, in most PHC was reduced to rhetoric and lip-service.

One reason for this was that influential donors
viewed it as too costly. They advocated a whittled down package of interventions and ‘selective primary health care’ became the new buzzword. It was derided almost immediately by critics as ‘Health for Some by the Year 2000’.

Many packages were also vertically applied, a trend which continues to dominate the health landscape today. Unlike comprehensive, integrated PHC which ensures a one-stop shop for a wide spectrum of essential health care services, selective, vertical programs are run as separate silos. Many vertical programs are single-disease focused, to the exclusion, and at the cost of, other equally important health needs. Mass immunization drives are one such example. They have made significant inroads in child health. But because of their narrow focus, broader strategies to improve

**Funny money – growing debt**

Under structural adjustment programs (SAPs), debt repayment got completely out of hand. Nigeria for example borrowed $5 billion in 1986, paid back $16 billion but absurdly now owes $32 billion. By the late 1990s, debt in the South amounted to $3,000 billion.

**Total Latin American and Caribbean external debt**
health get neglected, including the strengthening of the health system as a whole.

Some believe governments and international donors found the concept of community control over health care delivery too revolutionary. It certainly held little appeal for the medical establishment. Sadly too, some communities associated quality care with big hospitals and bypassed the PHC service. Because PHC was often under-funded, it reinforced the view of a second-rate service.¹⁰

Many post-independence governments were committed to development and experienced impressive average annual growth. But others were corrupt and repressive, lining the pockets of their élites instead of investing in the health of their citizenry. This hardly helped generate funds or political will for PHC.

Critically, the Alma Ata strategy was predicated on a New International Economic Order that never materialized. It was presumed money would be diverted from militarization but in many areas wars escalated. Simultaneously macro-economic forces that led to spiraling debt, fiscal austerity measures and market-driven health sector reforms deepened inequities and devastated the public sector. This was perhaps the greatest reason for the failure of PHC.

**Macro-economic mayhem**

Things started to go awry across Africa, Latin America and Asia, when the Organization of Petroleum Exporting Countries (OPEC) massively increased the price of petroleum. A surplus of ‘petrodollars’ ended up in commercial banks in the West. These banks looked to increase lending to the South which now desperately needed money to pay its fuel bills and fund development. The oil crisis plunged the North into recession. Interest rate hikes and later the devaluation of the dollar shot Southern debt into the stratosphere.
Some of this debt was also owed to the World Bank.iii While the Bank’s original job was to assist countries to rebuild themselves post-World War Two, its mandate soon shifted as the West recovered. It began to loan money to newly independent countries, largely to build infrastructure capacity.

Much debt owed is considered ‘odious’, that is, lent knowingly by Western bankers to repressive, corrupt dictators. The astronomical accumulation of wealth by these leaders at the expense of their citizens is legendary. Former Philippines’ president Ferdinand Marcos stole around $10 billion. Some ended up on his well-heeled wife Imelda, who insisted she had ‘1,060 pairs of shoes, not 3,000’. Loans also propped up dictators to serve the goals of the Cold War. Millions went to ‘development’ projects, which were often outright scams. Past rulers of Nigeria stole or misused some £220 billion/$400 billion. Two thirds of its 130 million citizens now live in abject poverty. Citizens who suffered under these regimes are again victimized through payment of debt not of their making. Nicaragua’s odious debt is over five times the country’s total GDP.

Capital flight from private investors into Western bank accounts, often a mechanism for tax evasion, also lost huge amounts available to governments for development. Between 1976 and 1984, for example, Argentina, Brazil, Mexico, the Philippines and Venezuela lost between $55 billion and $132 billion because of this. During this period, debt in those countries increased by a total of $243 billion.11

As economies were collapsing under the debt burden they were forced to enter into loan agreements with the IMF. Loans from the IMF and World Bank were

---

iii The World Bank is one of three international bodies referred to as the Bretton Woods Institutions. The others are the International Monetary Fund (IMF) and the General Agreement on Tariffs and Trade (GATT). They were established at a post-war conference in Bretton Woods in 1944 to set out the rules for a stable post-war global economy. GATT subsequently became the World Trade Organization (WTO).
contingent upon the adoption of fiscal austerity measures which later became known as ‘structural adjustment programs’ (SAPs). Measures included the rapid privatization of state enterprises and liberalization of trade and investment through the deregulation of financial markets. This included reduced corporate tax and labor controls and the removal of tariffs and quotas (as barriers to trade). Subsidies for basic foodstuffs were removed and social spending cut in essential services such as education, health, housing, water and sanitation. In the health sector, cost-recovery strategies such as user-fees were instituted.

While the North continued to subsidize its producers, the South was expected to open markets to international investors and cut their own subsidies. This made it impossible to compete and these unfair terms of trade persist up to today. Primary exports dwindled. Investors ousted local production to make way for export crops. People lost jobs and literally starved. According to the Food and Agriculture Organization (FAO) between 1992 and 2000, at the height of SAPs, the number of hungry people increased by almost 60 million.

The rationale behind SAPs, with its downsizing of the state and its market liberalization, was to free up public funds and to attract foreign currency to repay debt and grow the economy. The assumption was that, as the economic metaphor goes, ‘the rising tide will lift all boats’. Trade would drive growth and growth would drive development. Wealth would trickle down to uplift the poor. Government ‘interference’ in the markets would discourage foreign investment. But in most instances, only the bigger boats floated and without state regulation, it became apparent that wealth does not trickle.

Jobs were lost and wages plummeted. In countries like Tanzania, real wages have fallen by 70 per cent since 1986.¹² Co-payments for health care and other public services meant the poor had to pay for essential care. Hard choices had to be made between food,
No ‘Health for All’ by the 21st century

Out of pocket
The trends in India mirror the global picture. With increasing privatization into the 21st century, the cost of health care falls on those least able to afford it. In many countries it consumes most of the household budget. Serious illness can bankrupt households worldwide and according to WHO pushes about 100 million people into poverty each year. Oxfam maintains that in Zambia, where almost 60 per cent of the population lives on a monthly income of less than $18, it costs $8-10 to treat one episode of pneumonia.

Share of entities in total health spending in India during 2001-2002

Only about one-fourth of India’s health dollars came from the government in 2001-02, while more than 70 per cent came from private sources, mainly citizens’ pockets. Because those who use the national health system suffer long waits and substandard care, even the very poor turn instead to the large private sector of clinics and hospitals. Lacking health insurance, many families are overburdened – even bankrupted – by medical expenses.

school or health. Under SAPs, desperate families sold off livestock and other valuable assets to pay for healthcare. Children left school. Inequity increased on all fronts. Women were disproportionately affected
(see Chapter 4). Usage of health services dropped with catastrophic results. When President Museveni of Uganda ended user-fees in 2001, attendance at clinics soared by 50 to 100 per cent.

Slashing health budgets resulted in poorly maintained and equipped health services with weak procurement and distribution of medicines and supplies. As a result, those who made it to the health services were met with supply shortages from drugs and bandages to health workers. Shrinking salaries forced skilled personnel out of the public sector or encouraged corruption, poor morale and patient abuse.

Debt continued to spiral with interest piling up on interest. By the late 1980s poverty was getting worse. Health systems had collapsed and reforms had all but destroyed social services and safety nets.

All this came with a heavy price on health. With soaring IMRs UNICEF, supported by WHO, devised a package of ‘selective PHC’ dubbed ‘GOBI-FFF’ to maximize health benefits for children. It fed into acrimonious debate within the international health arena on the value of selective and vertical programs. Their proponents were accused of ‘selling out’ PHC.

Increasingly beholden to donors and the IMF/World Bank, countries’ ability to shape their own destinies was shrinking rapidly. GOBI-FFF resonated with these influential agenda setters and often money would be withheld if a country did not ‘come to the table’.

Later UNICEF proposed more humane macro-economic measures calling for ‘Adjustment with a Human Face’. It recommended, inter alia, debt rescheduling and guaranteed social safety nets as part of the ‘adjustment package’. Child survival programs were to be prioritized.

In 1987 UNICEF launched the Bamako Initiative, a selective PHC package promoting community-financing

iv Growth monitoring, Oral rehydration therapy for diarrhea, Breastfeeding, Immunization, Food supplements, Female education and Family planning.
mechanisms as a middle ground. It was adopted in many parts of Africa and hailed by UNICEF as a success. But contested by many, it was largely abandoned because of its inability to make a significant impact on child survival.

The health market place
In the late 1990s under the Washington Consensus (World Bank, IMF and the US) structural adjustment policies and the drive for greater market-driven health sector reforms intensified. Donor countries were also in support of increasing liberalization trends. The rationale was that government-run services were bloated and inefficient, and the private sector could do better.

Privatization took different forms, from ownership of health facilities to outsourced service delivery (everything from management, clinical care to catering). Health insurance schemes also flourished. Transnational corporations from the North were the main beneficiaries. These trends would move $38 billion to the private markets in South America alone.\(^{13}\)

But studies show repeatedly that left to their own devices, privatization efforts are not necessarily efficient or equitable and evidence associates better health outcomes with a larger role of the public health sector.\(^{14}\) Cherry-picking the wealthier markets and skewing services to better-off urban areas, privatized health leaves the poor in the cold. Supposedly allowing for greater consumer choice, an increasingly fragmented health sector with a chaotic mix of private and public options, assumes a greater degree of health literacy than even educated consumers have. The cost of private care also makes a mockery of ‘consumer choice’ (although where public services collapse, private service use increases). Far from supporting the public sector, an unregulated private sector erodes it. It dumps poorer, sicker patients and the chronically
ill on public services, undermining cross-subsidization and risk-pooling. It siphons off skilled personnel and large sums of money flow away from service provision towards administration and investor return. In most cases, a downsized state is in no position to provide the necessary stewardship to regulate the private sector in the interests of public health.

The Bank devised a package of ‘best buy’ health interventions for low- and middle-income countries based on a ‘cost-effectiveness analysis’. This has been widely criticized as priority-setting based on price rather than on ‘need’ or ‘rights’. Two-tiered health systems evolved – one for the rich who could buy choice, and a Cinderella version for the poor, who would be forced to accept the Bank’s package. Co-payments under ‘best buy’ plans meant patients also had to pay for vaccines and other preventive measures. Many just could not – with disastrous consequences including the re-emergence of epidemics such as dengue fever and typhus in Latin America. User-fees, instituted ostensibly to contribute resources so government could expand coverage, improve the quality of the health services and thereby improve equity, had the reverse effect.

Certainly, reforms to the health sector were necessary to achieve equity and many public health practitioners grappled with ways to achieve this. These attempts were very different from the market-driven efforts. The net effect of market-driven reforms was to reduce health from an inalienable human right to a commodity to be bought and sold on the open market. These were international trends in an increasingly privatizing world. Market-driven health sector reform has also eroded hard-won gains in the traditionally welfare states of Europe where solidarity values such as community risk-pooling and publicly accountable services are being dismantled.

Other essential services such as education and water provision were also opened up to investment from
transnational corporations and user-fees were also widely instituted. Here too there is no evidence that as a rule the private sector is better able to deliver. There are instances of public sector effectiveness and efficiency and there is evidence of failure and corruption on both sides.\textsuperscript{17} Senior executives of Suez and Vivendi (two of the largest private water transnationals) have been sentenced in France for paying bribes to obtain water contracts.\textsuperscript{18} Methods to ensure payments such as self-disconnecting prepaid water meters, banned as a health threat in Britain, are now on the rise across Latin America, Asia and the Philippines. They have been linked to recent cholera outbreaks in South Africa. Those who can’t pay must do without, with all the knock-on effects on health. Remember Citizen Y.

The World Bank invested heavily itself in market-style health reforms. Between 1983 and 1999, the share of total sales of the Top 200 companies made up by service sector corporations increased from 33.8 per cent to 46.7 per cent in large part due to this trend.\textsuperscript{19}

‘Esap’s’ tales
SAPs exacerbated the debt crisis which spiraled by 400 per cent, reaching a staggering $3,000 billion by the late 1990s. Nigeria for example borrowed $5 billion in 1986, paid back $16 billion but absurdly now owes $32 billion. Across Africa, where one in every two children of primary school age is not in school, governments transfer four times more to Northern creditors in debt repayments than they spend on the health and education of their citizens.\textsuperscript{20}

Even Argentina, which followed prescriptions to the T, and appeared to be doing well in the process, experienced a total meltdown in 2001 when ‘conditions sparked off massive social unrest and the country defaulted on $155 billion of its foreign debt’.\textsuperscript{21}

It is difficult to separate the effects of SAPs on health from the economic recessions that preceded their
imposition. But in the 1980s, during the period when SAPs intensified, there are clear relationships between slowing of gains in IMRs and increasing debt as well as other negative health impacts. In Zambia for example the proportion of hospital deaths related to malnutrition, from 1980 to 1984, increased two-fold in children under 5.

In the instances when SAPs led to growth, wealth accrued to an élite and in most instances did not lead to social development. Despite the fact that total world income increased by an average of 2.5 per cent annually, the number of people living in poverty increased by almost 100 million. Inequities in the 1990s reached unprecedented proportions. The rising dominance of neo-liberalism – the ideology behind SAPs – with its deregulated, free-market economy, is in large part responsible.

Laissez-faire economic liberalization creates unrestrained market forces with potentially devastating effects. When the IMF imposed rapid liberalization in the former Soviet Union, élites got lucky but 10 to 20 million people died and almost every country in the former bloc experienced significant drops in life expectancy.

Stiglitz maintains that ‘inside the IMF it was simply assumed that whatever suffering occurred was a necessary part of the pain countries had to experience on the way to becoming a successful market economy, and that their measures would in fact, reduce the pain the countries would have to face in the long run’. Yet after a plethora of UN treaties and commitments the dream of ‘Health for All by the Year 2000’ remains a dream and for multitudes the ‘pain’ continues.

The new targets on the block are the Millennium Development Goals (MDG) to be achieved by 2015 (see Chapter 7). While some progress has been made, it is clear that most of the goals will not be met on a global scale. So the goalposts will shift yet again.
No ‘Health for All’ by the 21st century

In the final analysis, SAPs, with their push to liberalize markets, formed part of an ongoing international drive on behalf of the North to facilitate transnational investment. Presided over today by the World Trade Organization (WTO) the last decades of the 20th century became the era of globalization where corporations run the global show and governments and international financial institutions often simply front on their behalf. The story of the effects of this on health unfolds in the next chapters.