Commentary

The World Development Report 1993 and Human Rights

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This series of reports from the World Bank started 17 years ago in 1976, so its birth coincided with the developments that led up to the 1978 Alma-Ata Declaration on Primary Health Care. Much of the 1993 report (which concentrates on health) could be seen as an appendage to that declaration in that it states yet again that health infrastructures fail to meet the health needs of people (most particularly the poorest) partly because the health systems are inefficient, badly managed, poorly targeted, and inadequately financed; and partly because there is still a large number of people who are very poor and poorly educated (especially women). The pity is that the opportunity has not been seized to move the debate beyond that of Alma-Ata—yet much has happened in health since that time. In particular, a great deal of clarity has been achieved in separating the relative values of health systems, and of social and economic environments, in their differing impacts on people's health. The report seems very muddled about this distinction. It is this distinction that would allow us to develop the potential for the linking of improvements in health with those in human rights, since lack of these rights reflect the inequalities in power and the distribution of resources that lead to poor health. If we could achieve such honesty, we would be able to move away from the terribly simplistic social and economic indicators for health that are used by bodies such as the World Bank.

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Overview

The report is an honest attempt at providing state-of-the-art analyses for planners and managers in poor as well as rich settings. The consultation in the preparation of the report was quite extraordinary. The crucial difficulties with the document are that:

- it fails to provide adequate analysis for planners of the relative importances of the various social, political, cultural, economic, structural and personal factors that influence health;
- its analysis of poverty does not take into account reasons for poverty or inequitable access to resources at international, national and local levels;
- it shows no understanding of the "political" way in which we all understand health—how we decide to cope with some things and not with others, why some situations are regarded as more important than others.
- the suggestions it makes for approaches to be used by managers and decision-makers do not really help them, as the more fundamental issues are not addressed;
- it ignores the basic approaches for decision-making based on field-level participatory communication that have evolved over the last few decades;

In short, it has a narrow (and medicalised) view of the word "health". This narrowness is shown in the opening pages by the three-pronged approach it advocates to government policies:

> "*First*, governments need to foster an economic environment that enables households to improve their own health (which includes emphasizing the general education of women). *Second*, government spending on health should be redirected to more cost-effective programs that do more to help the poor . *Third*, governments need to promote greater diversity and competition in the financing and delivery of health services."

That's it!

What the report does

Instead of exploring the political and analytical issues which have received so much attention in development circles in the last decade (most particularly the challenges to development theory and the Health Transition analysis), the report settles for being a compendium of health service-based activities.

There is an attempt to help health planners assess which

areas to prioritize by providing a measure of the burden of ill-health in terms of Disability-Adjusted Life Years (DALYs). If this could be done, it would also provide an answer to the problem of defining a common output measure against which interventions could be measured. The DALYs combine mortality and morbidity statistics in a subjectively weighted pattern by disease type. It is clear that the DALYs provided can not yet be used as a true management tool since the weightings and country specificities would have to undergo much more rigid analysis, and because any such measurement is bound in the end to be subjective. Furthermore, as acknowledged in the report, such a system of measurement fails to take into account the interactions between specific aspects of ill health and their interactions with other social conditions.

The most interesting thing about such an analysis is that it *is* subjective—and it is this subjectivity that hides so many value-laden judgments about health. These are judgments that reflect attitudes to inequality in so many ways. It is quite astonishing that the World Bank Report did not understand this fundamental weakness of the DALY idea.

The lack of understanding of the ramifications of inequality is matched by a lack of the necessary analysis of the social and other factors that go to determine either our acceptance of situations, or the lack of possibility of control of the situations that influence health.

In addition to the emptiness, there is considerable hypocrisy in the analysis of the World Development Report. For example, the Report's section on reducing abuse of alcohol, tobacco and drugs mentions the few instances of advertising bans, and the World Bank's own policy on tobacco (which is hedged with caveats). Yet it cannot deal with the underlying problem. There is enormous reluctance by governments to tamper with the real main underlying factors leading to death because of the huge financial investments made in selling tobacco, food, alcohol, the toxic waste resulting from production of consumer products, firearms, motor vehicles and drugs. For example, the United Kingdom government steadfastly refuses to place a ban on tobacco advertising because of the enormous revenues involved ($30.8 million per day).

So, while the discussion of DALYs is a reflection of the wish to introduce rationality into decision-making about health,

the discussion is concerned only with some of the factors influencing health in a highly selective way. For the intellectually curious, it might be interesting to ponder how many DALYs would be allocated to a person who is stigmatised because they have the wrong political views, or because they have AIDS.

Difficulties with what is promoted

The promotion of DALYs actually reveals a much deeper problem with development thinking. It is probably correct that most donors have an interest in cost-effectiveness/efficiency at a time when they are decreasing the amounts of money available to poorer countries—mainly because they would like to prove that the small amount of money they provide can be effectively used. However, if you really look at the idea of cost-effectiveness/efficiency, it is just about planners and policy-makers being able to manage their systems effectively and efficiently. But the constraints in doing this (ranging from the political to the financial) often seem insurmountable to local managers.

How would DALYs and cost-effectiveness discussions help? If, for example, the donors funded each decision-maker to make estimates of DALYs for each of the situations faced in their localities, and to make accurate assessments of the effects of the interventions being made, would the lives of the managers be any the better? The answer to this is probably "no," for the unfortunate reason that the managers would probably not be allowed independence in their judgments. We can see the paradox immediately in the Report. Although the whole concept of DALYs must rest on detailed *local* analysis, priorities for action are already set up by that Report on the basis of the flimsy analysis done remote from the countries concerned. In fact the Report proposes a package of health services (p.66) against which it compares current performance. In its attack on tertiary care systems, it does not set out in practical steps how to deal with them. Should they be blown up, for example?

It will be very interesting to see how donors would react to the presentation of planning based on DALYs that are arrived at using criteria for disability that are very different from their own, and set in a cultural perspective that sets priorities differently. The lesson from past funding is that the criteria we end up with are the criteria of the donors. The truth is that the need for foreign exchange in poor countries is far greater than the particu-

lar priorities managers might like to set in the majority of cases, so mostly the priorities of the donors are ostensibly accepted in the hope that somehow they can balance these with local priorities later.[1] There are huge earnings to be made in foreign exchange from donors as well as from the accompanying use of expatriate workers who come to work and live in the countries.

Why it reads like *Newsweek*

The Report also deals with a number of priorities that seem to have been set more out of political correctness than the pure objective use of DALYs. In this there are further difficulties. For example, the discussion of the need for education (especially for girls) contains nothing new. The report skims over the surface of the needs and realities, and the understanding of why education has an impact rests heavily on the "because it helps people use technology for health" axis. It fails to link the debate to costs of schooling, opportunities after school, or why people choose (or have) to keep their children out of school.

There is also almost no discussion of community involvement in health, and this reflects a general lack of human perspective. Although there are statements scattered throughout the text that highlight issues such as "violence against women," these read more like articles out of *Newsweek* than articles that seriously challenge decision makers and indicate lines of political action for them. This reflects a general trend towards empty rhetoric in the reports put out by major international agencies.

Thus, in the section on violence against women, after defining the problem, there is a statement that:

> This is an issue with complex economic, cultural and legal roots, and is therefore not easily dealt with by public policies. Prevention will require a co-ordinated response on many fronts. In the short to medium term, the right measures include training health workers to recognise abuse, expanding treatment and counselling services, and enacting and enforcing laws against battering and rape. In the long term, much depends on changing cultural beliefs and attitudes towards violence against women.

After a few examples of what some women's groups in Africa have done (groups that were not and could not be financed through World Bank loans), and what the American Medical Association did to educate physicians about family violence, it dis-

cusses what can be done. The answer (astonishingly) is this:

> The achievements of the past point to the requirements of the future—above all, to economic growth and the expansion of schooling and health services.

It need hardly be said that the real requirements relate to the fostering of debate and criticism in all countries concerning rights and the enforcement of the legislation to back those rights, of women who suffer violence, and of people who are oppressed or marginalised in general. Of course it is true that the increase in education will allow more to take up the challenge, but most governments are already clever enough to realise that—and that is why education for women remains low on the agenda.

The Report then makes the statement that health service infrastructures are enormously important, and that the World Bank will put much effort into supporting the development of that infrastructure—particularly at regional and district levels—whilst encouraging governments to place less emphasis on their tertiary health care institutions.

Let's step back a little

This takes us right back to 1974. At that time the health planning world was keenly aware of the results of building costly tertiary care systems; they crippled countries financially, and had no impact on overall health or disease patterns. As a result, the NGO community prepared a series of reports on the feasibility of various primary care options that depended on devolution, close co-operation with other social and development services, and the full involvement of people in determining and working on the priorities for action. These movements culminated in the recognition by WHO of the potential of such thinking, the conference with UNICEF at Alma-Ata in 1978, and the development of the "Health for All by the Year 2000" strategy in 1980.

What happened? Why does the World Bank not analyse the failure of the very policies it is now espousing?

The fact is that the unequal distribution of most health problems is a reflection of inequalities in opportunity, in wealth, in power and in rights—at international, national, local and individual levels. While the report clearly says that there is a strong link between poverty and ill-health, the programs suggested for the alleviation of the poverty naturally lie along the lines adopted

by most UN agencies—who are, after all, essentially governmental agencies.

It is also obvious that the World Bank was not going to criticize the Structural Adjustment policies or the current climate of world economics that have caused a disproportionate share of the suffering in poor countries. There is no recognition, for example, that the short-term effects of these policies probably contributed significantly to the spread of HIV in several of the poorer countries in Africa and led to the need for short-term emergency measures which are, of course, now too late to be effective against HIV.

At heart, the report represents the simplistic view of interventions for development without taking into account the dimensions of the problems in countries, nor the international forces that contribute to those problems. The analysis goes along these lines: surveys show that women's education is linked to their health and that of their children, so the policy is to increase the availability of education for women. Poor people have a lack of access to health care, so increase the availability of health care to them.

Yet the mere provision of services without corresponding changes both in attitudes to the people being served and in the social and economic environments that determine so much of their health, will also result in little improvement.

This lack of understanding is reflected in the simplistic analysis of how to tackle HIV. In essence it reflects the astonishing belief that the implementation of a few key targeted programs on a large enough scale will bring the epidemics of HIV infection to a halt. Unfortunately, the social and economic environments that would enable such interventions to work are not there either for the poorer countries seeking loans from the World Bank, or for the poorer communities in the countries that have ostensible access to so many resources.

What can be done?

It has been often argued that prevention, though perhaps more desirable, is far more costly than cure. For countries to have, for example, the same low level of maternal and infant mortality and morbidity as is found in Scandinavia, requires the same level and distribution of general wealth for the infrastructure (social services, roads, industry), legislation and social and economic sup-

port for housing, employment, women's rights, education, public health measures that is found in such countries. A myth has grown in the donor community that this or that particular intervention will make all the difference to a poor community. This of course is nonsense, although it should be recognised that particular interventions can be very useful for particular communities for a certain amount of time. It is also nonsense that simplistic interventions targeted at the poor of the type advocated in the Report will make any difference at all.

Donors and loaners are unlikely to change the World Economic Order, nor are many countries really going to make any attempts to reduce inequalities or reduce poverty. The World Bank is forced to invest money by giving loans, mainly for infrastructure. That is no bad thing. Infrastructure is vital. Without services, no amount of banging on drums about rights would achieve anything.

However, it is the general developmental approaches that will do the most to prevent ill health. That work is more important and requires new thought and action.

We already have very good experience in assessing health, development, and human rights status in this way. In 1978, in the UK, the Black Report showed very clearly how health status was related to social inequality in the UK, and provided a number of structural and societal markers for health status.[2] It also suggested practical ways of improving the situation. The only problem was that the report was never accepted by the UK government—not because it was not correct, but because it was not acceptable politically. It is only now, in 1994, that the UK government is beginning to allow figures to be presented officially that link inequality with health.

If this framework for analysis is accepted, it includes the important questions of human rights. However, since this question of health in relation to rights is so closely determined by cultural values for health, then the parameters for the priorities have to be set locally by local people. It is this aspect that may prove to be the most difficult to swallow for those who like imposing their support from outside.

If we restrict the analysis to the health service approach, the Report does spend time on how to set priorities, but the approach suggested is cumbersome, costly, bureaucratic, paternalist and top-down. There are many ways in which priority-setting

within health services could be improved with an approach that is flexible, and takes into account local perceptions of health, illness and suffering.

Such a management approach was very simply and clearly outlined in the publication put out by WHO in 1980 called "On Being In Charge" (a guide for field managers—especially at district and regional levels). The problem was that there was no large-scale follow-up or training around this approach, and little is heard of it nowadays. Yet such an approach is possibly the single most fundamental aspect of putting into place systems that will be responsive to local needs.

The World Bank could afford to be hard-headed about the emptiness of the rhetoric used by many when advocating "community participation," and point to the reasons why governments don't want to adopt or support such approaches.

Unfortunately, the Report fails on this and several other counts. It not only fails to analyse the political context of health and decision-making, it also fails to provide an adequate analysis of the relative importance (and the balance) between the various factors that influence health: for example, the extent to which ill-health is dependent on poverty, marginalization, powerlessness, opportunity and vulnerability, and the extent to which it is dependent on technological and information inputs.

It is therefore pointless to criticise this report on the basis of its lack of a "people's" perspective. It is hardly surprising that the report does not really raise the question of human rights—it cannot even begin to relate to the question.

The title reveals much. "Investing in Health," for the World Bank, means just that. Put a few million dollars into infrastructure, which the governments have to pay back. In the meantime, let's all just have a jolly good read about poverty from the comfort of our rather well-padded offices. It takes only a little longer than *Newsweek*.

Notes

1. This acceptance does have limits. In general these are to ensure fundamental societal structures are not tampered with (and this is why few donors or lenders are in any way involved in human rights).
2. The word "inequality" here is all-important. It is not only that there is, in fact, an inequality in the availability of resources, but this inequality is the result of deliberate political decision about who has what, who is favored, and how society is supported.