

# **International Perspectives on Equity and Health: As seen from the UK**

**Proceedings from a Meeting of the  
Health Equity Network**

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Foreword by  
John Wyn Owen

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# Foreword

This publication is the second in a series based on seminar workshops organised by the Health Equity Network. These papers take an international perspective which is shown as essential partly because, as Ilona Kickbusch claims,

'Governments fought to preserve their rights and sovereignty over health care policy but have lost sovereignty over the determinants of health to multinational enterprises, global finance and marketing of lifestyle goods - food, tobacco, information - which determine health outcomes more than health care.'

The British Prime Minister has said that globalisation creates unprecedented new opportunities and risks. The White Paper on International Development set out the UK government's policies and a commitment to work across all parts of government in order to help eliminate world poverty and to co-operate with other governments and international institutions as part of a broader international effort. It is seen as consistent with domestic policies to tackle poverty and social exclusion in the United Kingdom. Mr Blair claims that 'the new millennium offers a real opportunity to eliminate world poverty. This is the greatest modern challenge facing our generation. Globalisation and making it work for the poor as a way of eliminating world poverty is a first order priority for the British Government.'<sup>1</sup>

Further, there are foreign policy implications, as Peter Hain states in his pamphlet,<sup>2</sup> which highlights a new diplomatic agenda and launches what is a crucial debate about the sort of world ahead of us. He says that the world faces new international challenges driven by growing connections between economies, governments and increasingly active citizens which define globalisation coupled with rising environmental pressures on the foundations of society. This is a world in which many of the most significant threats to stability, such as global warming or illegal drug use, do not stem from the ambition of some hostile power but from the individual consumption decisions of everybody. It is a world in which threats arise from failures of whole systems needing systemic solutions. Peter Hain argues that these challenges will require 'the evolution of a radical new approach based on global linkages recognising natural limits and embracing global responsibility. In the process we will see an end to traditional foreign policy and the evolution of a new foreign policy for a world in

<sup>1</sup> *Making Globalisation Work for Poor People*. DfID. December 2000. [www.dfid.gov.uk](http://www.dfid.gov.uk)

<sup>2</sup> Peter Hain. *The End of Foreign Policy*. Fabian. RIIA.

which there is no longer any such place as abroad, recognising natural limits and embracing global responsibility.'

**John Wyn Owen CB**  
**London: November 2001**

# Introduction

## Background

At the meeting of the Issues Panel for Equity in Health held at the King's Fund in London on 29 January 2001, John Wyn Owen, amongst others, highlighted that it would be useful if the Health Equity Network (HEN: [www.ukhen.org.uk](http://www.ukhen.org.uk)) organised a seminar on the UK's role in international health inequalities.

I and my fellow HEN organisers (Richard Cookson and David McDaid) took this request seriously, and in February 2001 we invited Roger Drew and Anthony Zwi to help us to organise a seminar along these lines.

Roger and Anthony enthusiastically accepted this invitation, and on 25 June 2001 a HEN seminar on international issues in the health inequalities debate was again hosted by the King's Fund. That we were able to convene this seminar so soon after John Wyn Owen's request was entirely due to the efforts of Roger and, in particular, Anthony. The list of attendees at the seminar is included in Appendix A.

## The seminar

The seminar had two fundamental objectives:

1. To increase understanding of the issues which link concerns with equity and health in the UK and globally, with an emphasis on low and middle income countries.
2. To increase linkages between groups and individuals working in the field of equity and health both in the UK and internationally.

The day was organised into four consecutive sessions, the programme for which is given in Appendix B.

Very briefly, in the first session, Mehtab Currey compared health inequalities research and policy in the UK with that in developing countries, and Simon Maxwell discussed the problem of food deprivation in the developing world. In the second session, Mike Rowson argued against economic adjustment mechanisms set by the World Bank and the IMF in the developing world, Thelma Narayan described the process and activities of the People's Health Assembly, and Ben Jackson outlined the recent legal challenge raised by the Pharmaceutical Association of South Africa against the South African government concerning the government's intention to promote generic substitution and more widespread access to pharmaceuticals. In the third session, Gerald Bloom detailed the development of China, a country that faces no major constraints from the World Bank, and

Richard Garfield then went on to analyse the effects of sanctions on the health of the populations of Cuba, Haiti, Iraq and Yugoslavia. Finally, in the fourth session, Anthony Zwi outlined how globalisation has contributed in some settings to widening inequality and he linked this with conditions that have contributed to conflict. Dermot O'Reilly followed Anthony by offering a presentation on health inequalities in Northern Ireland, regarded by some as a post-conflict society.

This publication contains the full proceedings of the seminar. Though the reader may occasionally (or even frequently) disagree with what is written in the individual contributions, it cannot be disputed that these proceedings offer a fascinating insight into the views of experts from a broad array of perspectives and institutions.

## **Acknowledgements**

The meeting was financially supported by the Economic and Social Research Council (ESRC award number R451265135), and the Nuffield Trust. Logistical support was provided by the King's Fund. We are also grateful to all speakers and chairpersons, and, of course, to Roger Drew and, first and foremost, Anthony Zwi, who kindly gave their time to organise and contribute to the seminar. The seminar could not have taken place without them.

**Adam Oliver**  
**LSE Health and Social Care**  
**London School of Economics and Political Science**  
**October 2001**

## Appendix A

The meeting was attended by Mrigesh Bhatia, Gerald Bloom, Angela Brown, Christine Callum, Roy Carr-Hill, Emanuela Castelnovo, Frances Chinemana, Richard Cookson, Joan Costa, Mehtab Currey, Diane DeBell, Roger Drew, Richard Garfield, Asha George, Susanna Gilmour-White, Deirdre Grant, Andy Haines, Helen Hawkings, Elizabeth Hughes, Ben Jackson, Karen Jochelson, Derek King, Tor Lezmore, Graham Lister, Mary Lyons, Simon Maxwell, David McDaid, Monique Mrazek, Thelma Narayan, Monica Oliveira, Adam Oliver, Dermot O'Reilly, Sarah Ramsay, Geof Rayner, Nicolas Rea, Mike Rowson, Trudy Turner, Rob Vincent, John Ward, Caroline Woodroffe, John Wyn Owen, Pam Zinkin and Anthony Zwi.



## Appendix B

- 10am - 10.05am: *Anthony Zwi, London School of Hygiene and Tropical Medicine: Brief background to meeting and its objectives.*
- 10.05am - 11.15am: Session 1: Role of the UK government  
Chair: Andy Haines, London School of Hygiene and Tropical Medicine
- 10.05am - 10.25am: Mehtab Currey, Department for International Development (DfID).*
- 10.25am - 10.45am: Simon Maxwell, Overseas Development Institute (ODI).*
- 11.45am- 1pm: Session 2: Global issues/global responsibility  
Chair: John Wyn Owen, The Nuffield Trust
- 11.45am - 12pm: Mike Rowson, Medact.*
- 12pm - 12.20pm: Thelma Narayan, Community Health Cell, Bangalore.*
- 12.20pm - 12.35pm: Ben Jackson, Action on Southern Africa (ACTSA).*
- 2pm - 3pm: Session 3: Learning from local responses  
Chair: Roger Drew, HealthLink
- 2.00pm - 2.20pm: Gerald Bloom, Institute of Development Studies.*
- 2.20pm - 2.40pm: Richard Garfield, Columbia University and London School of Hygiene.*
- 3.30pm - 4.30pm: Session 4: Inequities in post-conflict situations  
Chair: Mehtab Currey, DfID
- 3.30pm - 3.50pm: Anthony Zwi, London School of Hygiene.*
- 3.50pm - 4.10pm: Dermot O'Reilly, Queens University, Belfast.*
- 4.30pm - 4.40pm: *John Wyn Owen, The Nuffield Trust: Concluding remarks.*

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# ARE POLICIES ADDRESSING HEALTH INEQUALITIES?

**Mehtab Currey**  
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## Introduction

Policies to reduce health inequalities, in both developing and developed countries, continue to ignore specific action required to reach the disadvantaged. Both the International Development Targets (recently replaced by the Millennium Development Goals) and the UK Department of Health targets for reducing health inequalities among their respective international and UK populations, apply to total populations and are not specific to the disadvantaged. The problem with setting such general targets is that they can be achieved among the total population without making much difference to the health of the disadvantaged sub-populations (Gwatkin 2000), and may even exacerbate existing health inequalities.

## Health Inequalities

Inequalities in health exist both within and between developed and developing countries and are related to income, gender, geographic distribution, social groupings, etc. Examples of inequalities within countries are:

*England (1998):* The district with the worst infant mortality rate was reported to have a rate three times higher than the district with the best infant mortality rate (Department of Health, 1998a).

*India (1992-93):* The infant mortality rate was 44 per thousand population for the richest population sub-group and 109 per thousand for the poorest population sub-group (Gwatkin, 2000).

Table 1: Examples of inequalities between the UK and India

	UK	India
Population (1998)	58 million	982 million
Annual growth rate (1978-98)	0.2%	2.0%
Infant mortality rate (1998)	7 per 1,000	72 per 1,000
Maternal mortality rate (1998)	9 per 100,000	407 per 100,000
Total health expenditure (1995)	6.9% of GDP	5.6% of GDP
Public sector health expenditure (1995)	5.8% of GDP	1.2% of GDP

## **Health policies to address inequalities in the UK**

In 1997 the government recognised that the health divide had widened in England over the previous two decades. Basically, the poorer and more socially deprived were likely to suffer relatively more ill health and die younger than those higher up the social ladder.

As a response, policies were set across government departments in order to address the root causes of health inequality. For example, policies were introduced to provide: opportunities for people to re-enter employment; minimum wage rates to tackle low pay; decent homes for people to live in; and an education system to serve as a springboard to opportunity. Moreover, a Social Exclusion Unit was established at the heart of government to look at ways in which to bring those living at the margins back into mainstream society.

## **Recommendations of the Acheson Report**

The groundbreaking Acheson report (Department of Health, 1998b) confirmed the large health inequalities in England and set a number of directions for addressing them. These included the need to:

- emphasise the importance of social inclusion and increase opportunities for all members of society;
- tackle the fundamental causes of poverty and social exclusion, and not just alleviate the symptoms;
- introduce new deals for employment;
- increase access to high quality public services, with particular emphasis on improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children;
- set challenging but achievable targets for closing the health gap at local levels and monitor performance through the NHS performance assessment framework;
- work with the Health Development Agency to promote campaigns to reduce health inequalities;
- introduce policies to promote the material well being of older people;
- evaluate the health impact of all policies in terms of their ability to reduce health inequalities;
- specifically consider the needs of minority ethnic populations in developing and implementing policies to reduce health inequalities; and
- further develop services that are sensitive to the needs of minority ethnic populations and that promote greater awareness of their health risks.

## **Government health inequalities targets in the UK**

In response to the Acheson Report, a Department of Health policy document published in 1998 noted that 'Health inequalities are widening. The poorest in our society are hit harder than the well off by most of the major causes of death. In improving the health of the whole nation, a key priority will be better health for those who are worst off (Department of

Health, 1998c). The document ignored the recommendations of the Acheson Report that upstream action was needed outside the health sector (Macintyre, 2000), and went on to note two key aims of government with respect to the health sector:

1. To improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness.
2. To improve the health of the worst off in society and to narrow the health gap.

The specific targets set by the Department of Health in 1999 for achievement by 2010 were:

- To reduce the death rate from cancer in people under 75 by at least one-fifth;
- To reduce the death rate from coronary heart disease and stroke and related diseases in people under 75 by at least two-fifths;
- To reduce the death rate from suicide and undetermined injury by at least one-fifth;
- To reduce the death rate from accidents by at least one-fifth and to reduce the rate of serious injury from accidents by at least one-tenth.

These targets applied to the whole population and did not specify how they would be applied to the 'worst off in society', nor how achieving these targets would reduce health inequality and thus 'narrow the health gap'. There is reference in the document to Local Authorities having responsibility to address local health inequalities.<sup>2</sup> It is possible, as noted by Whitehead (1998), that the health gap can be reduced by just reducing the health status of those in the healthier group, unless it is specified that it is to be achieved by improving or 'levelling up' the health status of those in the less healthy group.

## **Health inequalities in developing countries**

Health inequalities in many developing countries are not as readily identified as in the UK, mainly because there is little hard data, whether by economic and social class, gender, geographic location, or other classification. Studies of health inequalities are not uncommon; however, they are time, location or population specific and so difficult to use for national or international comparisons to track either temporal or spatial changes in inequalities. Where longitudinal health data is available, as in the Demographic and Health Survey, it is not possible as yet to get a breakdown by different socio-economic groups. The World Bank has produced a series on Socio-economic Differences in Health, Nutrition and Population (Gwatkin *et al.*, 2000) for different countries, which specifically highlight health inequalities.

<sup>2</sup> At the time of writing, a Department of Health consultation on 'Tackling Health Inequalities: Consultation on a Plan of Delivery' is underway, and may well develop targets that specifically relate to disadvantaged groups.

Table 2: Differences in health and health service use indicators among the rich and the poor in India (Gwatkin *et al*, 2000)

<b>Indicator</b>	<b>Population average</b>	<b>Poorest population</b>	<b>Richest population</b>
Infant mortality rate	<b>86.3</b>	109.2	44.0
Under 5 mortality rate	<b>118.8</b>	154.7	54.3
Immunisation coverage:			
All	35.4	17.1	65.0
None	30.0	48.4	7.9
Delivery attendance by a medically trained person	34.3	11.9	78.7

## **Policies to address health inequalities in developing countries**

Developing countries do have policies and strategies to address health inequalities, mainly in national development plans and in health sector strategies. The initiative of developed countries to provide debt relief to Highly Indebted Poor Countries (HIPC) has been taken forward by the IMF and the World Bank, through requiring these countries to prepare poverty reduction strategy papers (PRSPs). These enable developing countries to access debt relief as well as Poverty Reduction Growth Funds (PRGFs) and Poverty Reduction Support Credit (PRSC). The poverty reduction strategies are expected to include strategies to address inequalities, including health inequalities.

A World Bank desk analysis (informal document June 2001) of 36 interim PRSPs showed that all refer to or have a section on health, and many explicitly link health to poverty reduction. Moreover, the majority of the health plans in PRSPs combine disease specific objectives with objectives to strengthen health care systems, but these objectives are worded only in very general terms. For example, 'reduce morbidity and mortality rates associated with principal diseases' and 'enhance equity, quality, efficiency and sustainable access to essential health care' (Mauritania).

Forty percent of PRSPs stated more than 6 health objectives; 43% more than 3-5 health objectives; and 17% contained 2 or fewer health objectives. Reference to monitoring and evaluation is generally very weak in all PRSPs, including in the sections that refer to health. Moreover, an analysis by the WHO (2001, unpublished) of the pro-poor content of health policies and of their implementation by countries shows that, even where there is specific pro-poor content, implementation is weak. However, pro-poor policy is hindered by the fact that most developing countries do not have health specific data disaggregated by socio-economic groups and so are unable to substantiate differences in health status and health outcomes between the poor and the non-poor.

## **Health targets of developing countries**

The International Development Targets (IDTs) - now the Millennium Development Goals (DfID, 2001) - derived largely from agreements at international summits and to be achieved by 2015, are:

- To reduce the under 5 mortality rate by two-thirds;
- To reduce the maternal mortality rate by three-quarters;
- To halt and begin to reverse the spread of HIV/AIDS;
- To halt and begin to reverse the incidence of malaria, TB and other major diseases.

As with the UK Department of Health targets noted above, these targets apply to the general population in developing countries and are not specific to the economically poor or those who are worst off with respect to these health indicators. The targets can be achieved by improving the health of the better off population, without affecting the current health status of the poor. To ensure that inequalities are removed through improving the health of the poor, targets specific to the poor would need to be set.

## **Summary**

There are inequalities between developed countries (e.g. England) and developing countries (e.g. India). In both contexts, health targets to reduce health inequalities are set for the population in general rather than for specific disadvantaged groups or contexts. It is possible to achieve the targets without affecting the currently most disadvantaged.

## **Suggested future research and knowledge generation**

- We need to develop longitudinal information systems in developing countries, in order to identify and benchmark inequalities, as is currently done in the developed world.
- Analyses of how health impacts on poverty reduction, as being undertaken by the Commission on Macroeconomics and Health (under WHO), needs to be made widely available to policy makers as evidence for leveraging resources towards the health of the poor.
- There is a need to develop inter-sectoral approaches to health in developing countries, so as to realise the benefits of other sectors (e.g. employment) on the health of the poor.

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# **CAN DEBATES ABOUT POVERTY IN DEVELOPING COUNTRIES ENRICH DEBATES ABOUT HEALTH IN DEVELOPED COUNTRIES?**

**Simon Maxwell**

Overseas Development Institute

## **Introduction**

This paper is written primarily for people working on health and health inequalities in the UK. Its main purpose is to suggest that the current debate about poverty reduction in developing countries can, as the title suggests, enrich the debate about health in developed countries (see also Maxwell and de Haan, 1998; Maxwell, 2000; Maxwell and Kenway, 2000). Partly, this is a question of delving into what I call the 'Smartie box', looking for interesting comparisons between experiences in North and South. More ambitiously, it involves looking for explanations of poverty and inequality, including in the field of health, which cut across an increasingly artificial geographical divide. Here, globalisation provides a convenient and informative analytical frame.

My own interest is in food and nutrition, rather than health *per se*, but the connections are obvious. Under-nutrition has an adverse impact on the survival, growth and the health of children, as well as on the intelligence and productivity of both children and adults (Box 1).

Foetal under-nutrition also has a direct connection with ill-health in later life, particularly obesity, late onset diabetes and hypertension. Over-nutrition, of course, has similar outcomes. This twin onslaught helps to explain the explosion of chronic dietary disease (CDD) among adults in developing countries, presenting a new 'double-burden' for health services, which are required to take on the new burden of CDDs as well as the old burden of high mortality and morbidity among children. The numbers are improving, but not fast enough, especially in Africa (Box 2).

Reducing poverty has a big part to play in reducing under-nutrition, and this paper concentrates on poverty issues, but it is important to make the point that the correlation is not perfect. In particular, a comparison between poverty and child under-nutrition in South Asia and sub-Saharan Africa (Table 1) shows that under-nutrition is much higher relative to poverty in the former than in the latter. There is a separate stream of thinking and policy work concerned specifically with nutrition-specific interventions.

## **The new construction on poverty reduction**

Let us stick, however, to poverty reduction. Here, a new international construction has been formed, more ambitious and potentially more robust than its predecessors. It links together five key elements:

### Box 1

#### Survival:

- 54% of all deaths of children under five are associated with low weight for their age; low birthweight children are ten times more likely to die.

#### Growth:

- Low birthweight babies become small adults: on average, 5 cm shorter and 5 kg lighter.

#### Health:

- Malnutrition is the highest risk factor in the global burden of disease: 12% of all deaths, and 16% of total loss of DALYs are due to malnutrition.
- Foetal malnutrition causes health problems in later life (hypertension, diabetes).

#### Intelligence:

- Iron deficiency delays psychomotor development and impairs cognitive development, lowering IQ by 9 points.
- Non-stunted children score 25% higher than stunted children in non-verbal intelligence tests.

#### Productivity:

- A low body mass index (BMI) reduces work output and productivity.

Sources: UNICEF 1998, James *et al.*, 2000, ACC/SCN 2000.

### Box 2

#### In the world as a whole:

- 16% of babies are low weight.
- 32% of pre-school children are stunted, 27% are underweight.
- 243 million adults are severely malnourished (BMI<17) (but in many countries more than half are overweight).
- 2 billion children and adults are anaemic. Maternal anaemia is a 'pandemic' (James Commission).
- Sub-clinical vitamin-A deficiency affects 140-250 million pre-school children.
- Over 2 billion people are at risk of iodine deficiency, with over 740 million affected by goitre.
- Chronic dietary diseases are everywhere on the rise (the double burden).

Sources: UNICEF 1998, James *et al.*, 2000, ACC/SCN 2000.

Table 1

<b>Region</b>	<b>Prevalence of child under-nutrition (% of children under 5) (1992-98)</b>	<b>Share of population living on less than \$1 a day (%) (1996)</b>
East Asia & Pacific	22	15
Europe & Central Asia	<b>8</b>	5
Latin America & Caribbean	<b>8</b>	16
Middle East & N. Africa	<b>15</b>	2
South Asia	<b>51</b>	42
Sub-Saharan Africa	<b>33</b>	48

Source: World Bank, 2000

- i. A set of internationally agreed targets, the so-called International Development Targets (IDTs), of which the best-known is to reduce by half by 2015 the proportion of people living on less than US\$ 1 per day;
- ii. A consensus strategy for poverty reduction, summarised in the World Bank's World Development Report for 2000/1 (WDR 2000/1), 'Attacking Poverty';
- iii. A mechanism for operationalising the strategy at country level, through the preparation of Poverty Reduction Strategy Papers (PRSPs);
- iv. A 'technology' for implementing the PRSP strategy, and donor support for it, by agreeing a Medium Term Expenditure Framework (MTEF), and adopting Sector Wide Approaches (SWAPs);
- v. Supporting all of this with performance-based evaluation and reward, including performance-related pay for individuals and performance-related budgets for local authorities.

None of these elements are new in themselves, but the fact that they exist together is important and gives new impetus to poverty reduction efforts. Inevitably, there are both strengths and weaknesses to the approach. In particular, past experience with similar initiatives cautions against hubris.

The IDTs have proved to be extremely powerful as a tool for political mobilisation, and have helped to refocus and re-energise development co-operation. At the same time, they need to be used sensibly at the level of implementation. Used well, targets can guide and direct public administrations. Used badly, which is to say in an over-structured and deterministic way, they can be reductionist, distorting policy, and, if not met, disillusioning. They can also be expensive to monitor. The experience of NHS waiting list targets in the UK illustrates some of the political pit-falls.

The new strategy laid out in WDR 2000/1 emphasises a three-legged approach to poverty reduction, based on opportunity (meaning growth), empowerment, and security (Maxwell, 2001). Key features include:

- a strong foundation in participatory poverty assessments (the Voices of the Poor);
- a multi-dimensional model of poverty (including income, but also agency and self-esteem);
- recognising the importance of redistribution, both to foster growth and to increase the poverty-reducing impact of growth;
- caution on market liberalisation if the necessary institutional infrastructure is absent;
- a strong statement on the 'obligation' to protect the poor; and
- the introduction of a new social protection agenda.

All of this is important. Again, not much of it is new in itself, but the fact that the World Bank is promoting the new strategy gives it additional credibility and weight.

Why cavil? First, there are some topics that would have benefited from greater or more extended coverage, for example the issue of rights, both civil and political, and economic, social and cultural, which are not much discussed. Second, there is an issue about the affordability of the package, and about its coherence if not all of it can be afforded. If the menu is table d'hote, and everything is on the table, then the new strategy is very attractive. If, on the other hand, the menu is a la carte, then choices have to be made: how attractive the menu then is depends on what has to be left out.

PRSPs have been introduced as a requirement for debt relief under the Heavily Indebted Poor Countries (HIPC) initiative. They are designed to be country owned and led, based on a participatory process leading to a national consensus on poverty reduction, and with conditionality by donors strictly limited to the process not the outcome. They are not intended to be blueprints, but to evolve over time. All this is good, and PRSPs do offer a plausible alternative to the donor-imposed models of the past. The doubts are about how much room for manoeuvre countries really have, and some fear that the time pressure to deliver debt relief, though admirable in itself, will mean that PRSPs are rushed and of poor quality. There is also an interesting discussion to be had about a political model, which seems to suggest that a national consensus is feasible in as contested a field as poverty reduction.

MTEFs and SWAPs provide a rigorous basis for expenditure planning, and provide a neat technical solution to the chronic problem of poor donor co-ordination and excessive reliance on autonomous donor-funded projects (Brown *et al*, 2001). The problem here is that SWAPs appear to work much better in some sectors than others: health and education are two sectors where most expenditure is in the public sector and where public expenditure is the main vehicle for achieving change; nutrition and rural development are two sectors where these conditions do not hold. In these latter sectors, an emphasis on sectoral SWAPs may make it harder to achieve inter-ministerial co-ordination.

Finally, performance-based evaluation and reward are again attractive in theory and rather difficult to implement in practice. Of course, it is good to focus on outcomes not inputs, but causality is often very hard to establish, particularly when long and complex chains of causality are involved (as with good health and nutrition, for example).

None of these caveats should be taken to imply that there is not much to be pleased about in the new construction: the glass is certainly at least half full. However, the caveats are not trivial. They can be avoided by following some obvious rules (Box 3).

## Box 3

<b>Do's</b>	<b>Dont's</b>
Encourage a broad-based debate.	Assume consensus is possible.
Expect a strategic vision.	Expect to agree with all the vision.
Talk about the content.	Impose rigid conditionalities.
Reinforce government leadership.	Replicate international targets unthinkingly.
Invest in training and capacity.	Develop piecemeal plans.
Disburse quickly.	Make unrealistic demands for data.
Revise frequently.	Insist on the perfect plan before starting.
Build two-way accountability.	Set performance standards for one side only.

Source: Adapted from Maxwell and Conway, 2000

## **Making links between North and South**

How useful is any of this for health planners and researchers in the UK? A first step is to characterise thinking about poverty in the UK; a second is to look for interesting comparisons (the Smartie box); and the third is to ask about possible connections (Maxwell, 1998).

Thinking about poverty in the UK has evolved substantially since 1997. As found, for example, in 'Opportunity for All', but also in general government statements, it has some notable features (Maxwell and Kenway, 2000):

- A focus on multiple deprivation, broadly corresponding to a social exclusion model;
- a life cycle perspective, with analysis and intervention for children, adolescents, people of working age and the elderly;
- a focus on work for those who are able, and social security for those who are not;
- a whole raft of specific anti-poverty interventions, for example the New Deal measures for the unemployed or for communities;
- a strong emphasis on targets and performance standards, operationalised via Service Delivery Agreements (SDAs) and Public Service Agreements (PSAs) between the Treasury and individual ministries.

It is worth noting that macro-policy is given only a supporting role, underpinning growth and stability (though of course employment creation is at the heart of the strategy). Also, redistribution does not feature overtly, though 'redistribution by stealth' is said to be a government objective.

There are many points of connection here with the poverty agenda set out in the previous section: the IDT of halving poverty, for example, compares with the UK government objective of eliminating child poverty within twenty years. The core strategies of employment plus social protection have many similarities (and it could be argued that the league table approach adopted by the UK government has a parallel in some of what the WDR has to say about empowerment). There are connections to be made between SWAPs

and PSAs, and between performance-based rewards used in both contexts. This is good: there is obvious scope for sharing and lesson-learning.

More specifically, there are eight areas where health professionals in the UK might forage in the Smartie box and find inspiration from counterparts in the South:

- i. The idea of human development as a model, incorporating non-income aspects of poverty, but building more comprehensively on Amartya Sen's ideas about functioning and capability;
- ii. The use of participatory methods, to capture the voices of the poor, but also to foster real participation and ownership;
- iii. The rights-based approach, particularly for economic, social and cultural rights;
- iv. A more subtle model of political participation and the political process than is found in appeals for a national consensus on poverty reduction, and which certainly exists in the developing country literature;
- v. Experience of working with targets and performance standards, especially at the local level;
- vi. Understanding the benefits and limitations of Sector Wide Approaches;
- vii. Good experience of partnerships, particularly in the government to government aid context, but also, for example, in relations between non-government agencies (NGOs) and clients;
- viii. The role of the private sector in service delivery, not least in health.

If we want to go beyond the Smartie box, an interesting question is whether models of globalisation help to explain poverty (and ill-health) in both North and South: for example, do the problems of poorly educated young males in the UK find a counterpart in the South? Or, conversely, does the creation of more jobs in the South take jobs away from young males in the North?

This is not the place for a detailed analysis of the meanings and impacts of globalisation, but Box 4 lists a selection of hypotheses about globalisation and social welfare, which at least are worth discussion. Many of these indicate problems (for example, the alleged time squeeze on care resulting from greater female labour force participation), but it is important to emphasise the first point in Box 4, namely that globalisation can be good for growth, and therefore for poverty reduction. It is by no means self-evident that globalisation is bad for poor people. The challenge, rather, is to recognise the risks and the potential losers, and to put the mechanisms in place which enable the poor to share the benefits without undue exposure to the costs: no small task, it must be said, and one still fully to be taken up in international discourse.

## **Conclusion**

It does not follow from any of this that the right course of action is for all UK health specialists to start working on developing countries. A different strategy is proposed, in which specialists from both sides of the divide forge new partnerships and alliances. There is plenty of interesting material in the Smartie box. And there is work to do together on the benefits, costs and implications of globalisation.

#### Box 4

- Globalisation is good for growth.
  - But some benefit more than others (and some may lose).
  - So it may increase inequality.
  - And it certainly increases exposure to risk.
- Globalisation increases the time squeeze on care.
  - And it may lead to worse health and safety at work.
  - And undermine social stability.
- Furthermore, it is harder for states to raise revenue.
  - So there is a fiscal squeeze on public goods and social expenditure.
  - And a crisis in governance - power is moving up and down, away from nation states.

Source: Adapted from Norton *et al*, 2000

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# **EQUITY AND GLOBAL ECONOMIC AND HEALTH POLICIES: A NORTHERN NGO PERSPECTIVE**

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**Medact**

## **Introduction**

I will comment on the broader picture of international development policy, and will touch on four areas:

- i) the effectiveness of IMF/World Bank adjustment programmes;
- ii) the impact of globalisation on health;
- iii) so-called 'pro-poor' health policies;
- iv) evidence-based policy.

## **Economic policies**

Globally, despite signs of a drift away from both the Washington consensus style of economic policy-making and new mechanisms (such as the Poverty Reduction Strategy Papers) which potentially promote greater local ownership and design of policies, we still see that the adjustment paradigm of the World Bank and IMF dominates development economics.<sup>1</sup> Adjustment lending is set to increase over the next few years, and the policy recommendations that come with the loans affect all sectors in developing countries. There are a number of comments I would like to make about adjustment policies and their effects on health and equity.

(a) Firstly, adjustment overall does not appear to have been too successful in terms of income growth. Bill Easterley, the World Bank economist, has recently summed up a largely inconclusive literature pessimistically (Easterley, 2001). Looking at the 36 countries to which the IMF gave ten or more adjustment loans over the period from 1980 to 1998, he finds that the median growth rate of income per person in this group over the past two decades is zero. He also finds that the reforms have generally lowered the sensitivity of poverty to the aggregate growth rate, which is dangerous, he says, because this gives the poor less of a stake in overall good economic performance. He notes that this 'might increase the support of the poor for populist experiments at redistributing income'.

<sup>1</sup> Adjustment policies include:

- (a) stabilisation measures aimed at lowering inflation and the demand for imports, including devaluation, raising interest rates and cutting government expenditures, and
- (b) longer-term structural measures such as financial and trade liberalisation, freeing of prices, privatisation of state assets and tax reforms.

The usual position of the World Bank and the IMF when confronted with the negative evidence of the impact of adjustment is that this reflects the fact that although money for adjustment was lent, the countries did not comply with the correct policies. This seems a bit of a non-sequitur, but in some respects it is correct - countries often do not comply with the wishes of donors and lenders, particularly when they have to apply hard policies. Nevertheless, the argument is dubious for a number of reasons. For example, the indicators of a country's compliance are often flawed and underestimate the 'true' degree of compliance (Woodward, 1992). Also, and more importantly, there is in fact sometimes startlingly little evidence of the efficacy of the so-called 'correct' policies. I will return to this point later.

(b) My second point about adjustment is concerned with the impact of economic and health policies in developing countries. The question that I ask is: what do we know about how economic change affects health at the household level? If we look at the shifts in prices, incomes, and public and private social expenditures that follow economic change, we surprisingly find that twenty years after their widespread adoption, very little is known about the *economic* effects of adjustment programmes, let alone their health effects. The World Bank admitted as much in the aftermath of the East Asian crisis when it pointed to the lack of analysis of the distributional effects of economic change, or its effects on the social fabric (World Bank, 1998). Such a knowledge gap makes it difficult to comment, cross-nationally at least, on the impact of adjustment.

The implications of adjustment for health have often focussed unduly on the impact on health expenditure. Whilst important, we should also be looking at what impacts the shifts in incomes and prices associated with adjustment programmes are having on health.

For example a study of the effects of the 1994 devaluation of the CFA franc in Brazzaville, Congo, showed an increase in the prevalence of wasting and stunting amongst children, and a reduction in the mean body mass index of mothers, as households were forced to decrease their food expenditure (Martin-Prevel *et al.*, 2000). There was also a marked tendency to wean small children more quickly onto family foods and reduce the use of special transition foods that are usually prepared with meat or fish enrichment. The reason for this could be ascribed to the mother's desire both to save money and save time in preparation. Fewer gruels were prepared using imported flour, and more made from a local substitute which has a very low energy density and had a lower protein and micronutrient content than the imported versions. The number of ingredients added to local gruels to increase nutritional value also decreased and mothers added milk to gruel less often.

(c) A third area I would like to touch upon is the issue of the impact of globalisation on health and equity. Adjustment policies - particularly those related to trade and financial liberalisation - have given a major boost to the globalisation process. Again, evidence of the impact of globalisation on health and equity is limited, but what we do know should give us cause for deep concern. There has recently been a lot of debate in *The Economist* and elsewhere about whether globalisation has been accompanied by an increase in inequalities. Robert Wade's article looked at the world distribution of income - the gap between the world's richest 20% and world's poorest 20% - and argued that it was increasing: he puts this partly down to increasing liberalisation (Wade, 2001).

Giovanni Andrea Cornia has come at the question from a slightly different angle. Why, he asks, has income inequality increased *within* so many countries *simultaneously* over the last

twenty years? He points to trade liberalisation, which has tended to assist the import of high-tech equipment and thus privilege skilled workers over unskilled workers; financial liberalisation, which has tended to increase the financial returns to capital relative to the financial returns to labour; and inept privatisation and decollectivisation processes, which have seen assets owned by the public turned over to a private few. All this, he argues, has been exacerbated by a roll-back in the re-distributive role of the state in many countries (Cornia, 1999).

With these problems in mind it is worrying that so many in the health sector are not more concerned by the impacts of globalisation on health. Very few documents on globalisation and health produced in the UK mention the problems caused by financial liberalisation, or the Asian financial crisis, to my mind the globalisation crisis *par excellence*. However, this lack of concern only mirrors the attitude of Western governments and the international financial institutions to the lessons of Asia. UNCTAD's Trade and Development Report 2001 has again castigated policy-makers for ignoring the fact that 'excessive financial liberalisation is creating a world of systemic instability and recurrent crises' (UNCTAD, 2001).

All of us in the health sector have to pay more attention to the economic changes that globalisation is producing and their impact on people's livelihoods. This means attention to the health effects of changes in incomes, prices and household coping strategies as well as to our usual globalisation mantras about air-travel, infectious diseases and the positive health effects of the internet. It means lobbying for changes in global economic policies - hard, but not impossible, as the efforts of Jubilee 2000 have shown.

In the UK and the rest of Europe, pressures for such changes have arisen in response to the debate on health inequalities, with the Acheson Report calling for health inequality impact assessments of all government policies (Department of Health, 1998). Article 152 of the Amsterdam Treaty also mandates the European Commission to assess the health implications of all European policies. Despite some progress in responding to these calls, there is still a glaring need to take the recommendations to their logical end, which would be for governments to design economic policies that respond to equity and other social concerns. How useful health impact assessment can be in low-income countries, where civil services are often so brittle, is a moot question.

## **Health policies**

I want to turn now to the question of health policies and equity. Health expenditures are still a concern in much of sub-Saharan Africa (SSA) and the rest of the developing world. In SSA the median expenditure is \$6 *per capita* and the mean in the lowest income countries is around \$3 *per capita* (World Bank, 2000). Perhaps more worrying than these figures are the widespread signs of reversals in indicators of health system effectiveness, such as assisted delivery and immunisation rates, both inside and outside sub-Saharan Africa (Medact and Save the Children Fund, 2001).

Attention is presently focussed on the establishment of a global health fund to tackle three infectious diseases, but primarily HIV/AIDS. It is good to see health being put at the top of policy-makers' agenda. But I am also worried by the prospect of yet another funding instrument

for health. As G8 leaders look for quick results on these infectious diseases will we witness a re-verticalisation in the health field, unnecessary duplication of activities and a shift away from the need to create sustainable health systems? What will happen when donor priorities change in a few years time? It would seem far better to channel new money through national poverty reduction strategies and attempt to focus policy-makers' attentions on system-building.

Recent attempts at health system reform, including decentralisation and integration of health services (both laudable objectives) as well as shifts in the way services are financed, have not been terribly successful. From interviews (of stakeholders in the health reform process of five African countries) during a project that I am involved with, there was profound disillusionment with the process and the negative impacts the reforms were having on health service delivery. Too often reforms have taken a blue-print approach without proper acknowledgement of the difficult effects of the transition.

Of great concern is the widespread presence of user charges and a sense of helplessness at the problems of financing health services in low-income countries. One suggestion of dealing with the crisis, made by the World Bank and increasingly followed in donor rhetoric, is to focus public sector resources on the poor and primary health care services. The corollary of this approach, as the economist Maureen Mackintosh has observed, is 'the privatisation of secondary and tertiary care perceived as primarily serving the middle-class ... the *aim* is separate systems for the middle classes and those in formal employment' (Mackintosh, 2001). However, before committing ourselves to such a course of action for the sake of the poor, we would do well to remember the aphorism 'services for the poor are likely to be poor services'. Why is this? As the middle-class opt out of public services there will be less resources with which to maintain a service for the poor, and the poor have little political voice with which they can defend their interests and increase budgetary allocations. Amartya Sen has emphasised these type of dangers which arise from over-strict targeting (Sen, 1999).

Mackintosh poses the simple question in relation to the UK and Eastern and Southern Africa - why should we expect more equitable health policies when the economic context is one of deepening inequality (Mackintosh, 2001)? I suspect this is useful to keep in mind when we are trying to get past donor and government rhetoric on targeting resources towards the poor. Interestingly, Andrew Dillnot of the Institute of Fiscal Studies in the UK has recently raised a similar point with evidence of the greater take up of private pensions, health insurance and schooling by richer people in the UK, as inequalities in income have grown (Dillnot, 2001). People in power in the UK would do well to remember that inequalities do matter - for many reasons - but in this instance because their increase helps to undermine the social settlement by which the rich help the poor and the healthy help the sick.

I would like to make a brief comment about the role and treatment of personnel in the health sector. Evidence from the economically successful developing countries in East and South East Asia (Colclough, 1997) and the high-performing low-income countries, shows the need for active public sector wage policies which give good wages and incentives to health professionals and others in the sector. Public sector wages have collapsed to fractions of their earlier levels in many countries, leading to disenchantment and a decline in professional ethics as well as huge pressures on the lives of health (and other public sector) workers. The idea, propounded by the international financial institutions, that relative

income decline would have little effect on productivity has been shown to be dramatically wrong (van der Hoeven, 2000). We need more attention to be paid to these type of recurrent costs otherwise public sector decline will become even more of a self-fulfilling prophecy.

## **Evidence-based approaches**

I worry about the future shape of health services in developing countries, which face so much pressure for the privatisation of finance and provision. On the one hand it is essential for developing country governments to involve and regulate the private sector and to mould them into a comprehensive service framework. But current proposals in low-income countries seem not to be taking into account sufficiently longer-term objectives for health systems. In this sense we can quite easily see that the situation, left to itself, will develop along the lines of US-style health provision with high costs, quality concerns and lots of uninsured poor people. Global agreements such as the General Agreement on Trade in Services (GATS) may well help this trend along, insofar as they assist the development of the private sector role in provision and financing (Koivusalo, 1999).

The voluntary nature of the GATS agreement has been overemphasised, and one can quite easily imagine that ministers and senior civil servants in developing countries, used to partaking of private services themselves, will be keen to sign their countries up to commitments to open their service sectors to international health insurance and managed care companies.<sup>2</sup> Once these players are in they are difficult to get out. And once countries have signed up to the GATS agreement it is pretty much irrevocable.

Broadly speaking, developing countries should be travelling along the well-trodden route to European-style social and health care policies rather than the American route. This is what 40 years of evidence says works in health care. But as the health economist Robert Evans notes, the calls for privatisation in health keep on coming back, like 'intellectual zombies': they are ideas which are intellectually dead but which for some reason will not stay in their graves (Evans, 1999). One of the most important reasons for the zombie phenomenon is of course that vested interests want to make money out of a sector which commands a huge proportion of world GDP: pressures on health policy whether from managed care companies, the insurance industry, pharmaceutical companies or health professionals will always be there but they must be resisted.

It is worth noting that there is also a danger of the diversion of development or health sector funds into schemes that primarily benefit the private sector. A case in point are some of the tax-break and credit mechanisms being designed to make sure pharmaceutical companies start producing drugs for diseases that matter in developing countries. Whilst these types of incentives can be useful, the public sector should, as a matter of principle, be more stringent in the way it hands out intellectual property or data exclusivity rights to private companies that have used large amounts of public sector money, or that may have

<sup>2</sup> This is not to argue that all public servants are self-interested. However, problems could arise especially where civil servants in trade and other non-health departments are unaware of the effects of greater private sector involvement in the financing and provision of health care.

made a commercial success from breakthroughs made in public sector research institutions. Often, this type of *quid pro quo* simply is not considered by public sector representatives.

Another area where evidence is ignored is in the debates about how improvement occurs. The World Bank has dismissed 'Health for All' as rhetorical (Peters *et al.*, 1999), and many perceive a shift away from Health for All in the World Health Report 2000 on health systems (WHO, 2000; Hakkinen and Ollila, 2000; Navarro, 2000; Almeida C, *et al.*, 2001). Recently UNICEF sponsored a review of the high achievers in low-income countries (Jolly and Mehrotra, 1998). How come countries such as Cuba, Sri Lanka, Costa Rica, Barbados, Malaysia and China were defying their levels of GDP to post life expectancy levels on a par with those in the developed world? The report argues that the evidence from these countries shows that in fact what works best is comprehensive primary health care: tackling causes of ill-health outside the health sector, reducing inequalities and concentrating on system building are the broad outlines of the successful approach.

I mentioned earlier that the World Bank's list of 'correct economic policies', such as trade and financial liberalisation, often had very little evidence to back them up. Trade liberalisation is a case in point. Much of the evidence that trade liberalisation lifts people out of poverty comes from a few sources with methodologies that often leave much to be desired (Rodriquez and Rodrik, 1998). The biggest problem at the moment, as the economist Dani Rodrik has noted, is that the impetus to trade liberalisation and globalisation in general has replaced the idea of broader development strategy, and moves administrative capabilities and political capital away from urgent development priorities such as education, public health, industrial capacity and social cohesion (Rodrik, 2001).

## Conclusion

The main thrust of this paper has been that there needs to be much more research in several fields relating to health and development. These include the effects of economic policies on health and how health care can be financed equitably in low-income countries. However, existing evidence exists about what constitutes effective action and should not be ignored on ideological grounds - the costs to society would be too high.

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# **THE PEOPLE'S HEALTH ASSEMBLY: A POPULAR RESPONSE TO HEALTH INEQUITIES**

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## **Introduction**

The People's Health Assembly (PHA) met in Dhaka from 4-8 December 2000 and brought together 1,495 delegates from 92 countries for five days of intense discussion, culminating in the adoption of the People's Charter for Health.

The PHA was the manifestation of a groundswell of people's social movements and health initiatives across five continents over several decades. It sought to stir global consciousness about the large gaps in health care that remain at the turn of the millennium, when the world boasts of riches, knowledge and technology as never before. It was a reminder to international bodies, national governments, the public health community and academia of the forgotten pledges and declarations made at Alma Ata towards attaining Health for All by 2000 AD through using the primary health care approach.

The PHA remembered the plethora of goals, objectives, targets, measurable indicators, inputs, outputs, outcomes and expected impacts with respect to the unfulfilled promises made in 1978. It provided a forum to share the successes, struggles and experiences of numerous groups working in partnership with people to improve health and health care. It took cognisance of political and social processes that influence, support and resist or oppose movements towards a more equitable, just, humane and democratic approach to health and health care. It also brought together analyses from different countries and different streams of thought, concerning the present health situation and the prevailing trends in health policy. But, most importantly, it provided a space to hear the unheard. This was an assembly with a difference. People affected by health inequities, health workers, health professionals, and citizens in support, came together as one people. There were a variety of languages, cultures and issues, but a central solidarity and shared experience was evident, along with a spirit of listening and learning. The PHA was an effort to build a globalisation from below, a globalisation of people in solidarity and in resistance to certain current trends. It demonstrated the powerful agency of affected people in addressing health inequities.

## **The process**

Early dreams of the PHA began around 1985, with growing evidence of a lack of commitment to the primary health care approach, particularly with respect to important components such as community participation, intersectional coordination, and the value basis of social justice. In 1998 a network of organisations launched the PHA process. The G-8 of the PHA included the Asian Community Health Action Network (ACHAN), Consumer International, the Dag Hammarskjold Foundation, Gonoshasthya Kendra, Health Action International, the International People's Health Council, the Third World Network



and the Women's Global Network for Reproductive Rights. There were preparatory activities, such as meetings and networking in several countries. In Asia, these included India, Bangladesh, Nepal, Philippines, Japan, Cambodia and China.

## **The Indian mobilisation**

The people's campaign towards *Health for All - Now* was initiated in India in late 1999. It built on the strengths of the various groupings that have been alive and active over the past three decades. These included people's science movements, the voluntary health sector, the women's movement, the National Alliance of People's Movements and various issue-based groups. Eighteen national networks came together for the first time for the *Jan Swasthya Sabha*, forming the G-18 of the PHA in India. It was the involvement of the non-health movements in the Indian PHA that gave it vibrancy and tremendous reach, with the health groups including some key academics who provided core support.

A national training workshop was held on 7 April 1999 for core groups from different states, and at that time the campaign was formally launched. The set of five booklets prepared as background to the main themes of the campaign, included:

- i. What globalisation does to people's health.
- ii. Whatever happened to Health for All by 2000 AD?
- iii. Making life worth living.
- iv. A world where we matter.
- v. Confronting the commercialisation of health care.

These were creatively illustrated, translated and published into several Indian languages and very widely used.

A range and variety of activities resulted in tremendous grass-root mobilisation. These included state training workshops, district meetings, people's health inquiries and audits, Kalajathah, folk theatre, health songs and popular theatre (which travelled from village to village in some areas), block level seminars, 250 district conventions, policy dialogues on issues such as socially relevant health personnel education etc., seventeen state conventions, and five people's health trains that converged from different parts of the country to Kolkata for the *Jana Swasthya Sabhe* (National Health Assembly) at the end of November 2000.

Over 2,000 delegates spent two days participating in parallel workshops, plenaries, exhibitions, a march for health joined by about 25,000 citizens, a public rally and cultural programmes. The Indian People's Health Charter was adopted. It reiterated the need for comprehensive primary health care under state auspice with adequate financial support, and active community involvement with the government health sector being accountable to elected local bodies (the panchayati raj institutions). It stressed the need:

- i. for legal and social mechanisms to regulate standards in the private medical/health sector;
- ii. to curb privatisation of the public health sector;
- iii. to support indigenous folk and home-based healing systems and traditions.

It highlighted the need for an adequate response to the large burden of communicable and non-communicable diseases, mental health problems, and health problems for women, children, workers, the elderly and the disabled, in a societal context. It also called for:

- i. a restriction of industries that promote addictions and unhealthy life-styles;
- ii. a rational drug policy;
- iii. transparency and decentralisation of decision making.

Moreover, the Charter opposed current neo-liberal economic policies that were causing growing unemployment and rising prices of pharmaceuticals, diagnostics and health services.

A representative group of over 300 people from India participated in the global PHA that was held in Dhaka soon after.

### **The PHA and the People's Health Charter adopted in Dhaka**

The global PHA was inaugurated with a call for Health for All to be a major part of the international development agenda. It was widely felt that current processes of globalisation, liberalisation and privatisation were resulting in adverse effects on the livelihoods, health and well-being of a substantial proportion of people. Specific effects on the health sector, such as a shrinkage of the public sector, privatisation, user fees, and rising drug prices, all further reduced access to care for the poor. This has resulted in greater home care with an increased burden of work for women and children. Infant mortality rates are stagnating or worsening. Deteriorating economic conditions have exposed young people, particularly girls, to greater risks of HIV/AIDS, sexually transmitted diseases and TB. There has also been an increase in stress and mental health effects. The biomedical techno-managerial approach has been gaining greater policy predominance, linked as it is to industry and business, at the cost of the social, societal and humane paradigm of health and health care.

World Bank policies, the WTO and, in particular, the impact of the Trade Related Aspects of Intellectual Property Rights (TRIPs) agreement on access to essential medicines came in for much criticism at the global PHA. A session on 'The World Bank faces the people' provided a forum for a lengthy and heated debate, punctuated by democratic protests. Unfair trade practices, aid-related conditionalities, militarisation, and the commodification and commercialisation of health and health care were strongly critiqued.

Conspicuous by their absence at the PHA were the UNICEF, who were co-organisers of the Alma Ata Conference with the WHO. Also, the WHO was represented by only lower profile staff. This was despite invitations and adequate notice. Interestingly, WHO thought it fit to have 'Safe Blood' as the theme for World Health Day in the year 2000. Organisational interests and directions were apparently distant from the real health concerns of people.

The People's Charter for Health, endorsed by the delegates after a highly participatory process, highlights that 'health is a social, economic and political issue and above all a fundamental human right' (People's Health Assembly, 2000). The Charter speaks of a vision of 'equity, ecologically sustainable development and peace'. It encourages 'people to develop their own solutions and to hold accountable local authorities, national governments,

international organisations and corporations'. It stresses the need to 'tackle the broader determinants of health ...; to tackle environmental challenges; to tackle war, violence and conflict; and finally to make the health sector more people oriented ... democratic and accountable'.

### **Post PHA follow-up**

The People's Charter for Health has been translated into at least 35 languages. Some countries have taken it to their parliaments. There are active processes to set up a People's Health Watch. In India, World Health Day (7 April 2001) was renamed People's Health Day, with the PHA being renamed as the People's Health Campaign (*The Jan Swasthya Abhiyan*). National committees have held meetings and made plans, and PHA-related work is being integrated with ongoing health activities. A fruitful dialogue has been held with the WHO at their request and they have initiated measures for an institutional link with civil society groupings. Overall, the movement by people for Health for All has been strengthened and continues to grow. But will it sustain and withstand the powerful lobbies and interests that have different aims? Will we be there to observe and critique or to actively participate?

### **Reference**

People's Health Assembly. People's Charter for Health. Dhaka: PHA, 2000 (website: [www.phamovement.org](http://www.phamovement.org)).

## **HIV/AIDS: IMPROVING ACCESS TO TREATMENT AND THE IMPACT OF INTERPRETATIONS OF THE TRIPS AGREEMENT ON DRUG PRICING IN SOUTHERN AFRICA**

**Ben Jackson**  
**Action for Southern Africa**

### **Scale and impact of the disease in Southern Africa**

Twenty-four million people in Africa are now thought to be infected with HIV, and approximately one-third of the global total with HIV live in Southern Africa. It is estimated that there will now be 2-3 million AIDS deaths in Africa each year. Moreover, there is a knock-on impact on other infectious disease issues: for example, the incidence of TB is increasing, both within the population infected by HIV and, as a result, within the non-HIV infected population.

All this has had a huge impact on health care services, right down to the primary care level. Moreover, there has been a major economic impact through the loss of workforce, skills and livelihoods, significant in that the disease tends to disproportionately affect the economically active.

### **The importance of increasing affordable access to treatment**

In developed countries, in huge contrast to the situation in Africa, treatments have revolutionised the life expectancy and life quality of people with HIV. Therefore, their ability to continue their economically productive lives is relatively unimpeded, and they tend to require relatively few hospital inpatient services. In Africa and other developing countries, the 'mainstream' development orthodoxy has been that drug treatment cannot be a significant part of the strategy: prevention must remain the only real approach.

Apart from the political morality of this apparent acceptance of total inequality in access to life chances, the development orthodoxy fails to take on board the unique scale and economic development impact of HIV/AIDS. The orthodoxy also appears to overlook the fact that prevention strategies will be stronger if they operate alongside treatment.

Treatment should occupy a much stronger place within an integrated strategy, which would include prevention, the strengthening of health care systems to deliver primary and other care, support for palliative care and efforts towards developing a vaccine. Development strategies must increasingly take on board the costs of not treating the disease.

### **Cost as a key obstacle of access to treatment**

The patenting of key drugs - for example, anti-retrovirals and those used in the treatment of opportunistic infections - is a major reason that such drugs are prohibitively expensive in

poor countries. A patent effectively confers a monopoly on the sale of the drug. With no effective market competition (other than from other types of patented drugs), prices are inevitably high.

However, cheaper generic versions of many of these drugs are available. For example, until recent 'voluntary' price reductions by the companies, branded fluconazole cost about \$20 a shot in South Africa, where as a Thai-made generic costs about 30 cents.

## **Balancing drug patent protection and public health needs**

Weighing the benefits of patents as an incentive to the research and development of drugs versus making or importing cheaper alternatives to increase access to them is not a new debate. There always has to be a balance in terms of protecting the overall public good - otherwise we would, for example, have 100 year-patents.

In order to maintain this balance, many developed countries have operated systems of:

- i. compulsory licensing (where the state grants another manufacturer the right to produce generic alternatives of patented drugs on the grounds of public health, competition policy/anti-monopolistic behaviour, national emergency etc. - subject, of course, to an ordered system and proper medical safety);
- ii. parallel importing (the import of branded drugs from the country where they are marketed at the cheapest price).

## **Internationalising patent protection: drug companies, TRIPs and developing countries**

Brazil is an example of a country that has used such methods as compulsory licensing and parallel importing to radically improve access to treatment and health performance in a range of areas, including HIV/AIDS. However, the large pharmaceutical companies have lobbied hard to secure support for the strengthening and internationalising of patent 'rights', both through advocating the tightening of international trade rules via the WTO TRIPs agreement, and by bilateral pressure through direct (e.g. via legal action) and indirect (e.g. via efforts to get the US and EU to bear down on recalcitrant developing countries like South Africa) means.

The companies have supplemented this huge lobbying effort with a positive public face, by offering voluntary deals to reduced price or even free drugs. However, these offers are not sustainable or systematic solutions, and do not replace the need for developing countries to have legally-protected international rights to achieve affordable drug prices via methods such as compulsory licensing and parallel imports.

## **The South African court case and its wider implications**

The South African case illustrated the inordinate and multiple pressure on developing countries from both lobbying by western governments and from the companies' direct legal bid to block the implementation of the 1997 Medicines Act, which would have produced a well-ordered system for the use of generics.

A huge international campaign caused the drug companies to terminate its legal action. However, the battle continues with the companies and Western governments (including that of the UK) continuing to ignore the request of African and other developing countries for a clarification of the TRIPs rules concerning the rights of developing countries to pass pharmaceutical-related legislation. It is time that the request for this clarification be heeded.

# **EQUITY IN HEALTH IN AN UNEQUAL WORLD: NATIONAL AND INTERNATIONAL RESPONSIBILITIES**

**Gerald Bloom**

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## **Persistence of structural inequalities**

Fifty years ago the world was recovering from a destructive war and many countries were emerging from colonialism. There was widespread optimism about the possibilities of substantially reducing inequalities between countries and between social groups within countries. During the immediate post-colonial period many governments promised access to health care on the basis of need. People had high expectations.

In a recent article in *The Economist*, Robert Wade claims that economic inequalities have grown over the past twenty years. This claim is disputed. However, no one denies that major inequalities persist. The experience of the past fifty years demonstrates the difficulties involved in trying to overcome deeply entrenched structural inequalities. The aim of this paper is to contribute to the search for realistic strategies for enhancing health equity in this context. These strategies have to avoid both fatalistic conservatism and unrealistic utopianism. Either can result in costly failures.

## **What can we learn from China?**

There are several reasons why China's experience is important for analysts of international health equity. First, there is the size of its population. Second, there is China's past influence on international health policies. Third, there is the opportunity to learn how radical social and economic transformations have affected health and health services.

From the 1950s to the 1970s China made great progress in reducing the burden of excess illness and premature death. This was largely because almost everyone had a means of earning a living. The health sector contributed by organising mass public health campaigns and providing access to basic health services at an affordable cost. China's success influenced the adoption of primary health care as the international health development strategy.

There were substantial differences between urban and rural health services, even when government policy was strongly egalitarian. Employees of government or state-owned enterprises were entitled to free health care. Peasants had to pay for many services, though these services were inexpensive. Also, many people were covered by local insurance that reimbursed a share of the cost of medical care.

China has been in transition to a market economy for 20 years. Its economy has grown rapidly and fewer people live in poverty. However, inequalities have risen between regions and between households in a locality, and these changes have affected health services in a number of ways.

Government health budgets have risen much less than health worker incomes and most health facilities depend largely on user charges. There are strong incentives for these facilities to encourage people to use more drugs and diagnostic tests, and consequently health care has become much more costly.

Residents of rapidly growing areas have access to sophisticated medical care. However, a growing number of urban residents do not have health insurance, and so the government has made the reform of the urban health system a high priority. Rural health services are experiencing serious problems, as local governments provide little funding. The best health workers have moved to the cities. Health facilities compete for patients to finance salaries, and there has been a shift in emphasis from prevention to curative care. Rural people find it increasingly difficult to pay for medical care. Major illness is now an important precursor of household poverty.

China is in a new and difficult phase of the transition to a market economy. The government needs to maintain support and/or consent amongst key social groups. Reform of the social sector has lagged behind economic development, and there is an increasing recognition that the national government must act to balance the interests of different localities and different social groups in terms of age, employment status and so forth.

The government faces the following policy challenges in formulating its health development strategy:

- i. The transition strategy has depended heavily on the devolution of government financial management. Local administrations have powerful incentives to encourage economic growth and provide benefits for the local population. However, governments in poor localities face serious financial constraints and they cannot fund even basic services.
- ii. The growing inequalities have created problems such as the movement of the most qualified health workers to the cities, the rise in the cost of health care relative to the income of the poor and expectations created by the development of sophisticated hospitals in urban areas.
- iii. The national government has limited control over local administrations and there is less political control over health workers than before. Certain stakeholders have a disproportionate influence in some localities. This is manifested in the health sector, for example, by overstuffed health facilities, which give higher priority to revenue generation than to meeting priority needs.

The government has three major policy instruments to address these challenges:

- i. Control of public sector finance. There is an increasing recognition that the richer areas will have to transfer more tax revenue to poor localities. The government will have to convince local authorities and residents of the richer areas that this measure is necessary. Also, fiscal transfers will have to be designed so they do not reduce the pressure on recipient localities to reduce overstaffing and increase the provision of benefits to the population. This will probably involve some kind of agreement between national and local governments to co-finance basic services.



- ii. Reform of institutions and regulations. The growing inequalities pose difficult problems for the design of a national regulatory framework. The government is considering the introduction of professional regulation and drug controls to improve the quality and safety of health services. However, legal restrictions on the right of less qualified staff to practise or dispense drugs could increase the cost of care to the poor and reduce their access to services. The regulatory framework will have to take into account the needs of different population groups.
- iii. Provision of information to stakeholders. The government is exploring new strategies for making health service providers accountable to the community. This includes the involvement of elected village committees and the dissemination of basic medical knowledge and information on the performance of local service providers. These developments are new and have mostly taken place in the context of large rural reform and development projects.

### **Towards international public health law**

I will conclude with a few thoughts about international responsibilities for global health equity. Most discussions about health equity focus on individual countries. For example, the government is increasing public health expenditure to improve health equity in the UK. One consequence may be an increase in international inequality. This highlights difficult questions regarding the balance between reducing local and global health inequality.

We need to move beyond statements of belief in health equity towards a clearer identification of who is responsible for what. The international community can have little influence over how countries manage their health system in the context of large national and international inequalities. There are no grounds for advocating lower levels of health benefit for workers in low and middle-income countries than for their British counterparts. This is a national economic and political issue. However, there are arguments for some form of international public health law that could include the following:

- i. International agreement on minimum standards of provision of high priority health services, where access to these services would be a right. The agencies responsible for financing these services would be identified through agreements between the international community, national and local governments to a form of international fiscal transfers, and there would be sanctions for failing to meet obligations.
- ii. The recognition of the need to balance the interests of different stakeholders in the international regulation of the health sector. For example, there are potentially large gains from the establishment of international standards for drug and equipment quality and professional qualifications. However, high standards may exclude the poor from access to effective and affordable services.
- iii. The creation of minimum standards of public health information that would provide people with information on health needs and the performance of health providers, including inequalities in health and access to health services between social groups.

It will be difficult to reach international agreement on this kind of arrangement, but an important first step is to recognise the difficult issues involved in implementing equity-enhancing health development. This would provide a starting point for serious negotiations.

# **EQUITY AND HEALTH: THE IMPACT OF ECONOMIC SANCTIONS**

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## **Introduction**

To sanction a country is to interrupt communications, diplomacy, and/or economic relations. Sanctions have become especially common in the last decade, since the end of the cold war has reduced the strategic interests of major powers to take a direct part in local or regional conflicts.

Trade sanctions may increase suffering or death among civilians, particularly among the most disadvantaged or vulnerable population groups. This paper examines evidence of the impact of economic sanctions on health, health services, and well-being in affected countries. In particular, it examines adaptations in those countries which either contributed to or further worsened the external threats to health brought on by economic sanctions, with particular reference to underlying and crisis-driven changes in economic equity within Cuba, Yugoslavia, Haiti, and Iraq.

## **Country case studies**

### **Introduction**

#### *Cuba*

In the 1980s Cuba was one of only a few developing countries with infant, child, and maternal mortality rates approaching those of developed countries. The other 'good outcome' countries - China, Costa Rica, Kerala state in India, and Sri Lanka - had both good health outcomes and moderate to high rates of economic growth. Cuba, by contrast, has experienced nearly uninterrupted improvements in health outcomes despite economic stagnation during much of the 1960-1990 period, and rapid economic decline in the 1990s.

Cuba has been under economic sanctions from the US since 1961. During detente in the 1980s sanctions were relaxed, permitting Cuba to purchase goods from US companies from third countries. In 1992, the US embargo was made more stringent with the passage of the Cuban Democracy Act. All US subsidiary trade, including trade in food and medicines, has since been prohibited. Ships from other countries are not allowed to dock at US ports for 6 months after visiting Cuba, even if their cargoes are humanitarian goods. Pressure is being applied on other countries to stop trading with or providing humanitarian goods to Cuba. Although embargo legislation since World War II has usually included exemptions for humanitarian goods, the 1992 embargo legislation on Cuba does not permit sales of food and requires unprecedented onsite verification for the donation of medical supplies. The legislation does not state that Cuba cannot purchase medicines from US companies or their

foreign subsidiaries; however, such licence requests have usually been delayed or denied. Despite criticism from most US allies, and a slight loosening following papal intervention in 1998, sanctions continue at present.

### *Haiti*

Haiti has been the poorest country in the Western hemisphere for most of its two centuries of post-colonial history. When Jean-Bertrand Aristide became the country's first elected president in February 1991, half of the labour force was unemployed, half of all adults were illiterate, and a third of the people lacked access to modern health services. A military coup ousted Aristide in September 1991; sanctions were initiated by the US and the Organization of American States (OAS), a regional body of the UN, in October 1991. Initial sanctions froze Haitian government assets in the US and prohibited payments to the *de facto* regime. Later sanctions included the prohibition of most imports to or exports from Haiti (with the exception of humanitarian goods), restriction of commercial flights, and a freeze on arms and oil shipments. Sanctions were lifted in 1994 after a US/OAS military contingent enforced the Governor's island accords, which led to a reestablishment of the elected government. During sanctions, NGOs and governments provided essential functions outside of government structures in order to avoid legitimising the *de facto* military regime. Many good staff left government employment at that time, never to return. This has left Haiti with a legacy of weakened infrastructure from which it has only partly recovered.

### *Iraq*

Sanctions began on all items imported to Iraq except medicines on 6 August 1990. Following the Gulf war in January and February 1991, sanctions were reaffirmed by the UN. Starting 3 April 1991, Iraq was again permitted to import food in addition to medicine. In fact, little of either commodity was imported. To address Iraq's humanitarian needs, the UN Security Council passed Resolution 706 in August 1991 authorising limited sales of Iraqi oil to pay for imports of food and medicine. In 1995 the Security Council again authorised sales of oil for the purchase of humanitarian goods. The government of Iraq, citing sovereignty concerns and betting that the Security Council would end sanctions before stockpiled goods ran out, approved the plan (UNSCR 986) only in 1996, and the first deliveries of humanitarian goods began in 1997. Since a 1991 post-Gulf war uprising in the three predominantly Kurdish governorates of northern Iraq, the UN has directly administered this territory along with local administration composed predominantly of two rival Kurdish parties. The fifteen governorates of central and southern Iraq are under the exclusive administration of the Iraqi government, headed by Saddam Hussein. With evidence of humanitarian crises throughout the nine years of sanctions, the UN Security Council, under an initiative developed by Canada and Brazil in January 1999, voted to carry out a comprehensive field evaluation of its oil for food programme by March 1999. Political manoeuvring among Security Council member states prevented a team from being fielded to collect original information. The Humanitarian Panel Report was a compromise document produced by staff at headquarters, drawing upon existing UN reports.

### *Yugoslavia*

Sanctions against the government of Yugoslavia were initiated by the US, the EU, and the UN from 1991 to 1993. The UN sanctions ended in 1995 while lessor restrictions on credits, travel, and trade by the EU and US continued on Serbia, the main republic of the Federal Republic of Yugoslavia (FRY) until January 2001 (after October 2000, elections led to the end of the government of Slobodan Milosevic). The measures, ranging from a visa ban to trade and arms embargoes, were established first to discourage warfare, then to bring compliance with the Dayton Peace Accords of 1995, and finally to oppose the actions of the Milosevic government in Kosovo. Between 1993 and 1999, more than half of Serbia's population became poor, unemployed, refugeeed or displaced. Beginning in December 1993, the World Food Programme (WFP) distributed food to 200,000-700,000 people a month, while the Red Cross provided food, shelter materials and clothes to 100,000 local and 200,000 displaced people. In all, humanitarian assistance to Serbia in the 1990s probably totalled between US \$5bn and \$10bn. In *per capita* terms, this level of assistance was probably unmatched in any other recent crisis.

### **Macro-level impacts**

#### *Cuba*

Cuba's gross national product declined by 35% from 1989 to 1994. While it is impossible to quantify the amount of economic decline due to each source, it is widely thought that the embargo was of lesser importance than the loss of trade and aid relations with the Soviet block. There is a high degree of social equity in Cuba; the ratio of income among the highest 20% compared to the lowest 20%, at 2 to 3 times difference, is among the lowest in the world. Through 1994, this gap declined further as the economic crisis reduced income broadly, while housing, education, rationed food, and health care were public access goods not acquired through market mechanisms. The economy grew by about 15% from 1994 to 1999. This growth was predominantly in non-traditional sectors, including tourism and the export of Cuban vaccines and other new medical products. Growth since 1994 has been associated with the emergence of a social gap between those with income in dollars and those with income in only pesos. This growing gap has been aggressively attacked by the government through legal changes and expansion of the taxation authority.

Despite the profound economic setback, infant, child and maternal health outcomes have continued to improve. Infant deaths, for example, reached an all time low of 7.1 per 1000 live births in 1998. Despite a shortage of available calories, the percentage of all births which were below 2,500 grams reached an all time low of 6.7% in that same year. More than 99% of all births occurred in health institutions and an all time low of 47 maternal deaths occurred per 100,000 births. Infant mortality in Cuba is about as low, and life expectancy at birth is nearly as high, as in developed countries despite *per capita* incomes 90-95% lower. Some of the factors associated with these good outcomes are a strong family doctor programme, food rationing, routine monitoring of weight among pregnant women and young children, medical surveillance of pregnancies, long-range investments in general education, a high degree of social unity regarding child health, and wide public education on public health issues. Most important of all, instead of losing ground in monitoring health and well-being,

Cuba greatly improved its health information systems. Since the tightening of the embargo, Cuban authorities are thus able to make far more timely, efficient decisions on the use of very scarce resources.

### *Haiti*

Although downward trends in both industrial and agricultural output existed in Haiti since 1986, the rate of decline accelerated from 1991 to 1994. In the five years between 1986 and 1991, assembly industry employment declined 8%; between 1991 and 1994, employment in this sector plunged by 80%. The embargo on Haitian exports was associated with the loss of 29,780 jobs in Haiti's garment, electronic, sports and toy assembly industries. Similarly, since the early 1980s, agricultural production declined at an average rate of 1% per year. Had the same trend continued, between 1991 and 1994, output would have declined a further 5%. Instead it fell 20% - four times faster. Data are not available on the distribution of income in Haiti, but it is widely believed that the military and traditional elites have one of the highest concentrations of wealth in the world amidst a general population predominantly in poverty. This concentration grew at least in relative terms during sanctions as most of the poor became poorer during that period of economic decline.

Despite the difficulties of sanctions in Haiti, widespread famine was avoided, epidemics were contained and at least minimal social services were maintained. Though a humanitarian disaster was averted, economic decline and social dislocation were not. During the three years that sanctions were in force, *per capita* GNP declined by \$120, or 30%; over the same period, the international community (mainly the US government) provided Haiti humanitarian assistance totalling an estimated \$250 million, or \$35 *per capita*. This offset by less than a third the income lost through economic sanctions. Around 15% of this assistance was provided through the UN system; the bulk of the remainder was provided by the US Government, which contributed close to \$190 million over the three years of *la crise*. Although this represents an enormous sum of humanitarian assistance to Haiti, in comparison, the US Coast Guard's seizure, processing, detention and transport of Haitian boat people between 1993 and 1994 alone cost \$250 million, while the 1994/1995 military intervention, at \$2 billion, cost eight times more than the three years of humanitarian assistance.

### *Iraq*

In 1990, prior to sanctions and the Gulf war, Iraq produced about 3 million barrels of oil a day and exported 2.5 million. This generated export earnings of \$19 billion a year to the government, providing 95% of the funds for the national budget and 64% of the country's gross domestic product. Iraq's legal foreign trade was cut by an estimated 90% by sanctions. Illegal oil sales have been reported repeatedly, using an overland route to Turkey and Syria and via sea and land to Iran, but it has never been credibly suggested that these sales amounted to more than a small fraction of pre-sanction exports. In the first eight years of the embargo, Iraq estimates that it lost \$120 billion in foreign exchange earnings. During this time Iraq received about \$1 billion in humanitarian donations. Those donations were declining and have nearly disappeared since the Oil for Food programme (OFF) started to provide Iraqi-funded humanitarian goods in 1997.

*Per capita* income is estimated to have declined by an average of 75% from 1990-1993. It continued to decline, slowing in subsequent years. The gap between those with high and low incomes grew during these years. Representative household surveys in 1988 and 1993 showed that high earners lost half of their income, average earners lost two-thirds of their income, and low earners, representing two-thirds of all families, lost more than three-quarters of their income.

Oil sales from the OFF program generated more than \$20 billion. Goods purchased with these funds amounted to a little over half of this total, representing \$12-\$15 per person per month. More goods are being imported to Iraq under OFF even than during the years of highest imports prior to sanctions. These commodity imports are not accompanied by similar investments in human capacity, such as communications, transport, or education.

### *Yugoslavia*

The impact of sanctions on the Serbian economy in Yugoslavia was less severe than:

- i. the succession of 4 of the 6 republics of the former FRY;
- ii. central government mismanagement; and
- iii. the destruction inflicted by NATO bombings in 1999.

Loopholes and inadequate enforcement of sanctions also mitigated their impact. Nonetheless, they were severe enough to retard economic recovery. The cost of fuel increased three-fold, crippling the energy sector and leading to frequent power cuts and fuel shortages, leaving many homes without heat. The regime politicised energy supplies by making less coal and oil available to communities that voted against the Milosevic government in 1996. In turn, the EU supplied 34 opposition communities in its 'energy for democracy' programme. This confusion of political and humanitarian criteria obscured the human rights-related objectives of sanctions.

### **Impact of sanctions on health and health care**

#### *Cuba*

Only during the worst years of the economic decline and retooling of the health system were poor health outcomes recorded. Total mortality per 1,000 inhabitants in Cuba rose from 6.4 in 1989 to 7.2 in 1994. The increase was almost entirely due to a 15% rise in mortality among those aged 65 years and older, accounting for 7,500 excess deaths. From 1992 to 1993 alone, the death rate for influenza and pneumonia, tuberculosis, diarrhoea, suicide, unintentional injuries, asthma, and heart disease each rose by at least 10% among this older population, presumably because some of those with chronic diseases requiring daily medication or laboratory support did not get needed goods. In all other age groups, mortality rates remained stable or declined.

Maternal mortality among Cubans rose sharply in 1993-1994 from formerly low levels. Extraordinary efforts to provide extra food rations to pregnant women and revamp birthing procedures rapidly reversed the trend toward rising mortality. Infant mortality in Cuba, long among the lowest in Latin America, did not rise but failed to continue declining during

those same years. Subsequent efforts to improve maternal nutrition and conditions for delivery led to continued declines in infant mortality starting in 1996.

Cuba was largely successful in protecting those population groups which are usually the most vulnerable: women and children. In doing this, and with high quality, comprehensive information systems, it became clear that other groups emerged as especially vulnerable. These included the elderly and adult men, especially those lacking sources of dollar income.

Poor nutrition and deteriorating housing and sanitary conditions in Cuba were associated with a rising incidence of tuberculosis, from 5.5 per 100,000 in 1990 to 15.3 per 100,000 in 1994. Cuba had a serious housing shortage in the 1980s and has built virtually no residential housing since. Consequently, 15% of the country's housing stock is in poor condition, including 1,000 homes that collapsed in Havana in 1994 and 4,000 more that are in a precarious state today. Medication shortages were associated with a 48% increase in tuberculosis deaths from 1992 to 1993, and from 1989 to 1993, these conditions were also associated with a 67% increase in deaths due to infections and parasitic diseases (from 8.3 to 13.9 per 100,000 population) and a 77% increase in deaths due to influenza and pneumonia (from 23.0 to 40.7 per 100,000 population).

Lack of fats formerly imported from the Soviet Union resulted in a severe shortage in soap and soap products. Yearly *per capita* soap distributed via rationing in 1993 and 1994 amounted to four small bars. Soap substitutes are made with caustic soda and other chemicals not normally found in the home. These chemicals cause burns and poisonings, which were extremely rare before 1989. From 1989 to 1993, deaths from unintentional poisonings jumped from 0.4 to 1.1 per 100,000 population.

### *Haiti*

In 1990, a third of rural inhabitants had access to potable water. Prior to the coup, average calorie consumption was 80% to 90% of recommended levels. Less than 5% of babies in the Capital were exclusively breast fed. Access to professional health services and hospitals was far poorer than in Cuba or Iraq. Indeed, much of the population had only occasional access to health services at best. Few useful health information systems existed, and many of these were NGO-based and had little coordination with the government and its services.

The 1994/1995 USAID-financed Demographic and Health Survey (DHS) found that between 1987 and 1994 the mortality of children one through four years of age rose from 56 per thousand to 61 per thousand. This higher rate last occurred 17 years earlier, in 1977. During the same period, infant mortality declined 38%, from 101 to 74 per 1,000. Average life expectancy for Haitians decreased by 2.4 years during the crisis and in 1994 stood at 54.4 years.

Much of the increased mortality among one through four year olds was due to a measles epidemic from June 1991 to November 1993. The Immunization Programme Technical Committee (Comite PEV), composed of representatives of PAHO/WHO, UNICEF, bilateral donors (notably USAID and the French Cooperation), Haitian and international health NGOs, as well as representatives of the Ministry of Public Health, debated whether a measles campaign should be launched under the *de facto* regime. The Aristide government argued that the security situation did not permit large crowds to assemble around health posts as there was a risk they would be attacked by military forces. In addition, a large scale



campaign would have to use state structures and thus lend legitimacy to the *de facto* government.

### *Iraq*

Iraq had invested heavily in health and education services in the 15 years prior to the embargo. Iraq in 1990 had one of the most advanced systems of curative medical care services in the middle east. Information systems and public health services, however, were less advanced and have since deteriorated a great deal. Starting in March 1991, reports of an impending humanitarian disaster were common.

Diarrhoea and war-related mortality rose steeply in Iraq during and following the Gulf war and post-war insurrection in 1991. Starting in 1991, decreased access to food and increased risk of respiratory and diarrhoeal infections led to a marked increase in malnutrition among those reaching twelve months of age, when the protections offered by breast feeding have waned and risks from poor weaning practices rise. Those unprotected by breast feeding were at far greater risk. Although the prevalence of breast feeding was high, supplementary bottle feeding was also high and rising during sanctions. Few infants were exclusively breast fed during the first six months, and the introduction of complementary semi-solid foods failed to reach a third of children aged six to nine months. Malnutrition among women giving birth led to a high rate of low weight births and high perinatal mortality. Without significant improvements in sanitation, food sources, or medical care, many of the children with acute malnutrition after weaning became chronically malnourished as toddlers. They were at increased risk of serious disease and death, especially from measles, diarrhoea, and respiratory infections. Throughout Iraq, grain and meat production fell, purchasing power and educational achievement declined, and the energy, water, medical, and transportation infrastructure deteriorated. These changes left all Iraqis at greater risk of poor health outcomes. This risk was greatest among those in rural areas, and those with lower income and educational levels.

Information presented on the level of excess mortality has been confusing and contradictory. In 1993, the Iraqi government reported that sanctions caused a greatly increased number of deaths. It provided data showing a rapid rise in mortality among under five-year-olds, up from 592 per month in 1989 (all figures are per 100,000 children) to 2,289 per month in 1991 and 4,409 per month in early 1994. These data were derived from hospital-based death reports; they represented an unknown but changing proportion of all deaths and cannot be considered reliable indicators of mortality change. Others argue that Iraqi mortality data has been falsely elevated.

Two studies in 1999 established more reliable estimates of changes in mortality among children under age five. The first study estimated under five mortality at  $80 \pm 7$  per 1,000 live births; the more definitive UNICEF study estimated mortality at 131 per 1,000 live births. These studies confirmed beyond any reasonable doubt that a grave and sustained rise in mortality had occurred in Iraq.

### *Yugoslavia*

The gradual rise in importance of the private sector in Yugoslavia during the 1990s in all areas, including education and health, weakened the social fabric, encouraged disrespect for

social norms, and created inefficiencies and imbalances in the economy. Until the 1990s, the state provided cradle-to-grave social benefits, including a well-developed health care system with few user fees. By the end of the 1990s, most medicines and medical procedures were purchased privately, leaving some refugees and other vulnerable groups at a distinct disadvantage. Survival depended increasingly on political or family connections, charitable help from humanitarian organisations or black-marketsteering. Drug use, domestic violence, and the proportion of young people reporting psychological or emotional trauma rose.

The impact of external sanctions was magnified by the Milosevic government, which imposed its own internal measures to limit access and increase profits for government-related importers. Thus, while essential drugs including insulin and basic antibiotics were in short supply, a smuggler's market meant that 'luxury' products like Viagra were widely available. The government's internal controls on access to, and the price of, goods - including humanitarian goods - were perhaps as important as the international limits imposed by sanctions. These restrictions allowed access to basic entitlements and opportunities to be abused, thus worsening economic and social discrimination. Rather than responding to the needs of vulnerable groups, sanctions thus contributed to vulnerability among women, those living on pensions, those not well connected politically, and those earning only salaries in the formal sector of the economy.

Strong central government control was, however, associated with the maintenance of a strong social safety net for traditional disadvantaged groups. Before the crisis, the income gap between the highest and lowest 20% of income earners was a modest 4-5 times. This relationship changed little during sanctions in the 1990s, in part because 'in kind' rather than cash income was maintained at around 10% of all income for all income groups.

## **Discussion**

It is telling that although enough calories were available in Haiti and Iraq during sanctions, child nutrition suffered. While rationing can promote equity in distributing food to households, the long chain of events from arrival at the house to absorption of nutrients by a young child can be affected by changes in access to fuel for cooking, water quality and quantity, the mother's educational level, breast-feeding, child-rearing habits, and health education for child nutrition. If women must spend more time in income seeking or income-substitution activities, less time and attention will be available for child care and feeding during the critical weaning months, resulting in increased nutritional vulnerability. This has been accentuated in Iraq, where the government has insisted on rationing infant formula, and breast feeding has declined.

Cuba's approach to the economic crisis has been based on the dual policies of equity and priority for vulnerable groups. The government was already skilled at rationing food and other scarce goods prior to 1989. It has since used mass media and workplaces to promote the use of bicycles in place of cars, animals in place of tractors and trucks (for which fuel and parts are lacking), and the consumption of vegetable-based foods in place of scarce animal protein. In hospitals, rooming-in and other baby-friendly changes have been stressed to further promote exclusive breast-feeding. Eighty percent of all births now occur in such baby-friendly hospitals, and the prevalence of breast-feeding at the time of

postpartum discharge has risen from 63% in 1990 to 97% in 1994. Clinics, hospitals, and day care centres have helped popularise the use of herbal medicines to replace scarce pharmaceuticals. The distribution of food, clothing, and other scarce goods to target groups, including women, the elderly, and children, is facilitated via social service institutions, workplaces, pre-school facilities, and maternity homes. The number of children in pre-school facilities doubled, and the use of maternity homes among those waiting to give birth rose by 26% from 1988 to 1993. The weighing of pregnant women and young children to monitor weight gain has become routine. These weighing appointments provide opportunities to educate mothers about nutrition, and are used to involve the health system in assuring nutritional supplementation when needed.

### **Policy issues**

The sanctions that have the greatest impact on the health of the general population can be expected to be those which are multilateral and comprehensive, occur in countries with heavy import dependence, are implemented rapidly, and occur along with other economic and social blows to a country. Iraq has all these characteristics, and is thus especially vulnerable. Haiti stands out for the deep disruptions which occurred among families both during, and after sanctions. The US aggressively tried to replace essential goods with humanitarian assistance. No other sanctioned country has received as much as a third of lost income in humanitarian assistance. It is thus a sobering thought that Haiti has not yet recovered; indeed, years after sanctions ended, economic, social, and political processes stimulated by sanctions continue to deepen a crisis which appears to be becoming permanent in that country.

Infant mortality has declined in some embargoed countries even during periods of severe resource shortages. This has occurred when scarce resources were distributed more efficiently, when health and national leaders mobilise child health actions, and when the social and political emergency moves parents to special actions. Cuba, for example, moved from about half to more than 90% breast feeding during the first three months when leaders showed that breast feeding would make up for lost formula imports. Similarly, a campaign to boil water before drinking gained support when it was broadcast that the embargo resulted in a lack of chlorine to treat water supplies.

In other countries, campaigns promoting growth monitoring of children and pregnant women, vaccinations, the promotion of herbal medicines, and community participation in peri-domestic sanitation to reduce malaria and dengue transmission have been successful under the special conditions of externally-imposed resources shortage caused by embargoes. In Iraq, the development of community-based child nutrition and community development programmes have been stimulated in recent years. All of these basic health measures would have been beneficial prior to the embargo but were stimulated by a collective sense of emergency and the recognition of an opportunity to respond.

Political scientists argue that embargoes can be counter-productive when a population 'rallies round the flag' to identify with the nation's leaders in the presence of a foreign threat. This social solidarity can, however, be built on by humanitarians to stimulate locally integrated development and health activities which may benefit the country long

after the embargo has ended. To do so, NGOs must develop close working relations with nationals working in humanitarian affairs and recognise a country's and a people's strengths and resources, even when their weaknesses and disadvantages are most apparent at the time.

Cuba has demonstrated the most effective responses in maintaining essential services and priority goods during sanctions. The hundreds of thousands of excess deaths among under five year olds in Iraq occurred, in part, because of food shortages, inadequate breast feeding and inappropriate weaning, failure to boil water and treat children early and aggressively when they had diarrhoea and acute respiratory infections. Yet Cuba, with less calories available, has far less malnutrition, far fewer low weight births, and rates of death from infectious conditions which are similar to those of developed countries. Though the conditions for the practice of curative medicine have deteriorated markedly in recent years, from a public health point of view the Cuban experience since the tightening of the US sanctions in 1992 is an important humanitarian success.

Such forward-looking approaches require creativity, leadership, and a recognition of the underlying strengths of a society. Awareness of a decline in importing capacity is often acute during sanctions; recognition and utilisation of existent valuable human and material resources is often less apparent.

### **Equity-related comparisons**

The above cases demonstrate several important lessons for the broader assessment of the relationship of equity to health. First, it is dramatically clear that those societies with higher levels of economic equity prior to the sanctions-related crisis fare much better during the years of crisis. The income gap between high earners and low earners is only one expression of equity, but a valid one according to my observation.

Those countries with higher levels of 'economic solidarity'<sup>5</sup> under normal conditions are far better equipped to deal with shortages during a crisis. There is a perceptible commonality of values in these countries, where sharing among those better off and worse off within families and neighbourhoods occurs with greater frequency than in those societies with less equity.

There is also the opportunity to engage in country-wide discussion about priority vulnerable groups and the common need to support them. This may occur among neighbours in the street, where collections are taken up for those short of food if, for example, they are elderly and live alone.

The most exciting issue for research deals with the role of government in redressing imbalances and focusing the society on priority groups. In some countries, government has been quite active in using development indicators, technicians, and the service delivery infrastructure to deal with the special needs created by the shortages.

In the case of Yugoslavia, the government seems to have done many of the 'right' things unintentionally. By providing some of the legally mandated benefits with preference to groups that might have destabilised the regime, and in order to maintain stability between various social groups, resources were effectively redistributed throughout the 1990s in a way that supported both those associated with the governing party and the rural and urban poor. The government of Iraq was far less successful at

balancing the interests of social groups, where privileged groups got far more benefit from government policies.

In all the countries with sanctions, professionals and the middle class suffered with economic decline. The more effective governments nonetheless recognised the resources that these groups represented, and made more extensive or creative use of existing human capacity in education or health when other resources were limited due to sanctions and economic decline.

The identification and addressing of vulnerable groups has a reverse corollary as well - some groups are identified as less needy, less vulnerable, or less deserving in times of crisis when others become the focus of social attention. Among these are the elderly, who are often sacrificed to focus on priority needs among children, women, or the poor. In all the countries examined, not only did mortality increase among the elderly during sanctions, but this increase and other needs and problems among the elderly went largely unaddressed.

What will happen in these countries after the crises end? Sanctions against Yugoslavia ended early in 2001 and the country is to receive more than a billion dollars in credits toward redevelopment. The Cuban economy has grown at about 4% a year since the mid-1990s and the US embargo has been slightly relaxed. Both of these countries appear to be on track for economic and social development.

Sanctions in Haiti left that country with continuing political instability and economic decline. Despite access to very high levels of funding for medical commodities and food imports through the Oil for Food programme, the crisis in health and education levels in Iraq have only slowly been attenuated. Thus, it would appear that the lack of equity going into the crisis period is associated not only with worse crisis conditions but also slower and less effective recovery.

All four governments instituted or extended the rationing of food and other priority items under sanctions. This has been an effective means of assuring a more equitable distribution of scarce goods. Government policies in most countries can be further refined, even in low-equity environments, to improve social inclusion, appeal to widely held common values, utilise existing resources more effectively, and thus more actively and effectively manage the crises. In other words, even in countries with poor equity, the actions of the government in time of crisis can improve equity. This will create better conditions for a quicker and more effective recovery.

## **Conclusions**

To strengthen public health systems in light of the above, there is a need to identify how societies set priorities on resource utilisation and distribution in times of crisis. Where economic and social equity is high, many heavy decisions are already being made. For others, some of the lessons from the high-equity societies include the need to:

- i. document problems of commodity access to widen the definition of what may be considered 'essential humanitarian goods';
- ii. focus issues from the commodity inputs to the process of their distribution, assurance of access by vulnerable populations, and effectiveness of their use;

- iii. concentrate evaluation to indicators sensitive to changes in well-being of individuals and groups, rather than reporting only on clinical health or nutrition measures;
- iv. move the debate from culpability for lack of access to goods to maintaining and improving the physical and human infrastructure for the delivery of services, evaluating the humanitarian impact, and assuring conditions for post-crisis recovery.

Improved policy will require expanding information on vulnerable groups, more valid measures and appropriate methods to define the impact of sanctions on them, and more potent advocacy to show how innocents have been damaged and how and why they should be protected.

# **SIMMERING INEQUITIES: ADDRESSING POST-CONFLICT PRIORITIES BEFORE THEY BOIL OVER**

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## **Introduction**

This paper highlights the particular needs of countries emerging from major periods of conflict. It briefly draws attention to the ways in which the international community typically supports 'post'-conflict countries, and draws attention to the inadequate attention given to reducing inequalities between groups within such settings. It argues that allowing inequities to simmer will lead to them boiling over, and suggests that intense efforts to remove the causes of conflict between groups should be a cornerstone for post-conflict activity.

## **Objectives**

The paper seeks to:

- a) highlight the common problems facing countries emerging from conflict;
- b) identify the common responses and forms of support offered by the international community;
- c) critique current practice; and
- d) suggest some elements of a more appropriate response.

It is salutary to note that initiatives such as the Marshall Plan, and even the UK's NHS, grew out of periods of conflict. In post-war Britain new social structures, such as the NHS, were established to deal with needs in all parts of the community; this can be contrasted with other experiences in recent decades where opportunities to be radical in promoting equity have been missed. In Zimbabwe, the post-liberation state and the international community (and in particular Britain) failed to ensure that a more equitable land distribution system, which broadened land ownership and control by the Black population, was established soon after independence. Recent efforts by so-called veterans to violently seize land from white farmers are a telling reflection of a failure to act much earlier to promote equity.

In the Palestinian territories, lost momentum and inadequate payback following the signing of the Oslo accords has led to an ongoing cycle of violence. Failures of leadership on both the Israeli and Palestinian parts has ensured that ongoing inequities and violence are neither addressed nor resolved, and continue to provide a focus for local and international terrorism.

The United Nations Interim Administration in Kosovo has tolerated, and perhaps, therefore, indirectly sanctioned, the inequitable distribution of services to the different

ethnic groups in the territory. While all United Nations policy proposals clearly articulate the importance of ensuring equal access to services regardless of the user's community, services in the immediate aftermath of the NATO strikes on Serbia to free-up Kosovo were fragmented and unequal between groups. Early attention to redressing such inequalities were limited, and may indirectly have reinforced differences between groups, thus contributing to ongoing tensions.

Failure to address such inequities may feed into cycles of ongoing violence. The international community has a crucial role to play in countries emerging from major periods of instability and conflict: it should make every effort to ensure that post-war activities, support and resources do not reinforce inequities and directly or indirectly contribute to grievances between groups.

## **Background**

The last decade has seen a number of wars starting, many continuing, and some ending, with the slow re-establishment of livelihoods and governance in countries such as East Timor, Mozambique, Cambodia, El Salvador, Rwanda and Bosnia. All these countries have been through tumultuous experiences as a result of instability, conflict and violence, with some populations within them also experiencing genocide and repression.

In the aftermath of major periods of conflict, often accompanied by peace agreements and/or a change in government, the United Nations and the international community are significant players in shaping future systems. The UN, alongside other donors, such as bilateral organisations and non-governmental organisations, provides a channel for funding, resources and policy advice.

In the health sector, post-conflict environments are seen as presenting opportunities not only to re-establish the pre-conflict health system, but to reform the nature of the state and the services it provides. In some situations this seems to operate as a euphemism for introducing market mechanisms within the health and social sectors more generally, a feature which has some explanatory power when examining post-war policies in such countries as Mozambique, Cambodia, Bosnia and Kosovo.

## **Typical role of the international community**

Over the last decade, the international community has directed its efforts around post-conflict health system recovery through a relatively narrow range of channels. The emphasis has been placed upon reconstruction, rehabilitation and reform.

Reconstruction has been seen as important given the high levels of destruction occurring in many conflicts. Not only do health services get affected but they may be specifically targeted in many current conflicts. As such, reconstructing destroyed health centres and hospitals may appear logical, but also may be problematic if the levels of recurrent cost support are insufficient to maintain this re-establishment of services.

Rehabilitation, both physical and mental, is often prioritised, and considerable resources are poured into trauma counselling services. This has value, but also limitations, in that devoting attention to re-establishing livelihoods and social structures, and providing a safe



environment in which communities can reconnect with one another, may be far more important than providing western-style counselling services.

Reform measures are also often promoted with a view to establishing a more efficient and effective health care system. In some situations this also implies accepting a range of policy measures which may be promoted by the World Bank and key bilateral donors, whereas developing a mandate for change and ensuring that such reforms are locally owned and driven may be overlooked.

The international community has a high level of influence, but given the multiplicity of donors and their differing agendas and priorities in such fragmented states, it may be difficult to ensure that they coordinate with one another and contribute to establishing a policy framework which both the emerging government and all donors and NGOs can accept.

In these disrupted settings, and before the local governing authority is able to exert its influence, there may be a wide range of projects with much fewer sustainable and comprehensive programmes. In addition, activities may take the form of vertical programmes in which a single focus, whether it be on immunisation or reproductive health or malaria (for example), may be promoted in the absence of ensuring that linkages across services focused on different health problems, are established.

## **Understanding policy choice**

The choices which donors make in such settings may be entirely understandable. They relate to ensuring visibility for their investments, protecting them by segmenting them off into vertical programmes which have their own personnel, management and accounting structures, promoting a perceived 'return to normality', with a strong emphasis on short-term responses which seek to leave something behind. The focus on projects results from attempts to reduce the complexity of donor investments and reduce the risks associated with such investments. The emphasis on reform and liberalisation reflects donor attempts to seize opportunities to influence future health systems and the nature of the state.

## **Problems with current approaches**

Some of the problems associated with typical donor responses have been described above. Others are that the usual post-conflict responses tend to have an unrealistic assessment of what is sustainable rather than having a long-term vision in mind. Sustainability is crucially limited in fragmented, unstable countries. However, failing to invest at all, because sustainability cannot be guaranteed, may undermine governance and the reestablishment of lives and livelihoods. A long-term perspective is required. While on the one hand it is important to keep sustainability in mind, it may be very limiting if the time horizon is immediate, as the resources available in a struggling emerging state may be very limited indeed. Indirectly this therefore means that the communities in such settings would be condemned to receiving very limited inputs, especially when they are most needed. It may be more sensible to seek to obtain longer-term donor commitments so that some support

for a period of 5-10 years is mobilised, although current donor funding systems tend not to facilitate this.

One of the common problems in post-conflict settings is inadequate attention to the particular political sensitivities which are present. Many countries that have been embroiled in conflict have been through horrific experiences, and communities on both sides understandably recall the atrocities in great detail, while commentary about the much greater times in which communities lived harmoniously together is suppressed. Understanding the fragility and political sensitivities present in the aftermath of conflict is necessary if future systems are going to reduce the likelihood of further violence erupting. Reducing inequities between communities, and redressing those which have contributed to tensions between groups, is thus an important part of moving forward.

Some commentators suggest that countries emerging from conflict are just the same as any other resource-poor and constrained countries. The arguments presented above, however, suggest that not only are there additional needs which result from conflict, but there are qualitatively different circumstances notably around political instability, lack of legitimacy of interim authorities, high levels of suspicion and jockeying for positions, alongside considerable levels of anger and hurt, and accompanied by new funds from major donors seeking to influence political and economic outcomes.

## **Towards more appropriate international assistance**

Many suggestions for improving the international support to post-conflict countries have been raised above. Particularly important is to balance historical concerns with efficiency with much greater attention to equity. Placing country personnel at the centre of efforts to redress inequities and to develop new systems is also important. Some mechanisms, such as Sector Wide Approaches (SWAPs), may offer opportunities to influence how donors and new governments work together in countries emerging from conflict. The establishment of resource centres to support policy development and to exchange ideas, experiences and tools between countries emerging from conflict has also been articulated and deserves attention.

Appropriate social sector policies can assist in building the peace - through reducing inequities and ensuring that all communities have access to basic educational and health services. Achieving this requires longer term vision and substantial investment; but we need to recognise and respond to these needs, as happened after the Second World War, rather than ignore these challenges and the resources required to address them. There is clearly also place for innovation and experimentation, and in some settings novel approaches to addressing needs have been employed. In East Timor, for example, the emerging Ministry of Health felt that it was unable to provide services for all. However, it was in a position to contract non-governmental organisations to identify needs, develop a health plan for districts, deliver services and contribute to policy-making and capacity building. The extent to which this innovative response succeeded in its objectives demands study, so that lessons can be learned and shared with others. The international community, and the academic community in particular, can play an important role in networking, evaluating, researching and contextualising experience so that good practice can be identified and lessons learned and shared.

## **Conclusions**

Numerous analyses have suggested, and in some cases demonstrated, that inequities between groups may contribute to the occurrence of violent political conflict. In countries and territories which have recently emerged from major periods of instability and conflict, a narrow window of opportunity may exist in which historical inequities can be addressed with the political and economic support of the international community. However, the international community often seems to have other priorities - notably those of reform, reducing the size of the state, and promoting efficiency in public expenditure. The time horizon is often short-term, and investments may focus on high profile areas such as reconstruction of infrastructure, despite many other important needs in re-establishing systems and livelihoods. This contribution seeks to draw attention to the important but understated investments that need to take place to reduce inequities between communities, and to put in place systems and frameworks which will give priority to addressing real needs in different groups. Failure to cool down tensions will ensure that they continue to simmer and either boil over, or explode.

# **HEALTH AND INEQUALITIES IN NORTHERN IRELAND: DEFINING THE PROBLEM AND POSSIBLE SOLUTIONS**

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## **Background**

Northern Ireland (NI) has traditionally had the highest unemployment rates of any UK region. In 1995 it was about 13% higher than the EU average (Focus of Northern Ireland, 1997). The difference between NI and GB employment rates is explained fully by the much greater levels of long-term unemployment here (Gorecki, 1995). GDP *per capita* in NI is about 83% of the UK average. For those in employment the average wages are about 10% lower than the national average.

Despite these signs of relative disadvantage there has been a paucity of research into health inequalities in NI compared to other parts of the UK. Campbell (1993) has suggested that this has been 'an unfashionable area for researchers', and the London Health Economics Consortium (1995), have observed that '... taken on its own, the extent to which the current body of research into health inequalities in NI can provide a basis for policy development is limited.' The aim of this paper is to briefly describe the relationship between disadvantage and ill health in NI, to outline some NI specific problems (the 'Troubles' and the 'two communities'), and finally to describe some of the policy initiatives aimed at reducing these inequalities in health.

## **Inequalities in health**

What limited research there is shows that the general relationship between material deprivation and ill health in NI mirrors that found in the rest of the UK. Men in affluent areas can, on average, expect to live 6.6 years longer than their peers in the more deprived areas; women can expect to live 4.1 years longer (Campbell, 1999). Those living in the most deprived areas have about 60-80% more heart and respiratory disease and strokes, a two-fold excess of accidents and a three-fold excess of lung cancer (EHSSB Public Health Matters, 1994). Many children born to poorer families in Northern Ireland fail to reach their full physical and mental potential. They have higher rates of accidents, are 15 times more likely to die as a result of a house fire and are four times as likely to die before the age of 20. Suicide rates among those aged 15-24 are almost three times higher in the lowest income groups.

Deprivation, however, has a greater impact on general health than is reflected in the mortality differentials. Not only do affluent populations live longer, but they also spend a greater proportion of their longer lives in good health. The 1997 NI Health and Social Wellbeing Survey shows that those in the poorest households are about 2.5 times as likely as

the most affluent households to have suffered from a recent bout of ill health, or to describe their health over the last year as poor (O'Reilly and Browne, 2001). They are also 3-4 times as likely to complain of a longstanding illness and 6-7 times as likely to have a disability. The incidence of dental caries is also much higher in poorer areas. The likelihood of multiple disadvantage increases with age and if appropriate indicators of deprivation are used, inequalities in health at these ages are also found (O'Reilly, in press).

The well attested associations between lower socio-economic standing and adverse lifestyle factors such as smoking, excess alcohol consumption and a diet that is orientated more towards fatty foods than to fresh fruit and vegetables are also found in NI (O'Reilly, 1999). However, it is important that these are considered within the context of people's lives rather than as evidence of fickle self-indulgence. Other aspects of the lives of people in poorer households are less frequently noted or quantified; for example, significantly higher levels of stressors and poorer levels of social support (O'Reilly, 2001). They endure higher levels of crime and worry about serious legal or financial problems or about the health of family members and have greater levels of concerns about parenting. It is therefore not surprising that people in poorer households are 3-4 times as likely as those in the more affluent households to be on 'medicine for their nerves'.

## **The troubles'**

One obvious difference between NI and the rest of the UK is the civil disturbance, colloquially known as the 'Troubles', that the people have endured for the last 30 years. During this time more than 3,600 people have been killed (Fay *et al*, 1997; McKittrick *et al*, 1999) and thousands more injured or traumatised. The Troubles show a definite socio-economic gradient with the greatest effects concentrated in more disadvantaged areas (Fay *et al*, 1997) and amongst poorer people (O'Reilly, 2000). This heightened anxiety and worry may be a contributory factor in explaining why levels of mental ill health are higher here than in other parts of the UK. Yet over the years there has been relatively little study of the impact of the Troubles on the health of the public (Froggatt, 1999) and it has never featured in any of the Director of Public Health annual reports.

The death toll from the Troubles may have abated somewhat in recent years but the health impact in terms of 'knee-cappings', punishment beatings and other associated criminality continues. Indeed, in many areas, particularly the more deprived areas, drug-related crime has belatedly emerged to replace or coexist and compound the misery associated with the Troubles.

## **The two communities**

An almost constant feature of the NI political and social landscape is the tension arising from the differences between the Catholics and Protestants who live here (known locally as the 'two communities'). Almost 42% of the population are Catholic and 54% are Protestant (Northern Ireland Statistics and Research Agency, 1997). Forty-one percent of the population are living in electoral wards that have more than 90% of one religion and 60% in wards with more than 80% of one religion (The Northern Ireland Census, 1993), making for

a very segregated society. Protestants tend to be in the majority in the east and north of the region, while Catholics predominate in the south and west. Consequentially any geographically-based government initiative will naturally tend to favour one side over the other.

There are significant differences between the two communities. For example, Catholics tend to have higher birth rates, giving them a younger age profile and larger average households (Northern Ireland Statistics and Research Agency, 1997). They are also, on average, more economically deprived than their Protestant peers with substantially higher levels of unemployment (Labour Force Survey Religion Report, 1994), a greater dependency on social security benefits, and lower average household income levels (Family Expenditure Survey, 1995). They are over represented in deprived areas with higher mortality and long-term illness rates (O'Reilly and Stevenson, 1998) and exhibit poorer health when measured on a range of health indicators, though these health differentials are (statistically) explained by differences in socio-economic status between the communities (O'Reilly and Stevenson, 1998; O'Reilly and Browne, 2001).

Many of the current administrative structures in NI have their origin in a 1968 report into the Troubles (Elliot, 2000), which concluded that much of the Catholic grievances relating to manipulation of the electoral boundaries and discrimination in local authority housing (one of the key issues to spark the Troubles in 1969) '...had a substantial foundation in fact'. Centralisation of administrative functions followed, with a series of legislation to ensure fairness and equality, a process that continues to the present.

## **Possible solutions**

The introduction of initiatives and policies aimed at reducing inequalities in health has been a gradual process, with more concerted and targeted approaches in recent years, most notably following the change of government in 1997. Box 1 shows some of the most notable initiatives aimed at reducing social and health inequalities in NI.

### **Box 1**

1991:	Launch of Targeting Social Need (TSN)
1992-1997:	Regional strategy ... Targeting Health & Social Need (THSN)
1997-2000:	Health & Wellbeing into the new millennium
1998:	New-TSN to incorporate Promoting Social Inclusion April - Belfast Agreement June - Assembly elections November - The Northern Ireland Act... Equality schemes
1999:	December - Appointment of ministers
2000:	Health of the Public in Northern Ireland: Report of Chief Medical Officer
2001:	Investing for Health (consultation document) Target setting for Investing for Health

In 1991, we saw the launch of the TSN (Targeting Social Need) policy. This was provoked by research evidence showing significant differences in the socio-economic profiles of the

Catholic and Protestant communities. The aims of TSN (Quirk and McLaughlin, 1996) were 'to tackle disadvantage by diverting resources and efforts towards individuals, groups and areas objectively defined as being in greatest need ... and while not discriminating in favour of one community and against the other ... it should also lead to the erosion of socio-economic differences between the two communities over time'.

In the third regional strategy (1992-1997) TSN became translated into THSN (Targeting Health & Social Need). Its aims were to 'to minimise inequalities in population health and social wellbeing and in the need for and access to health and social care in NI', but it was not until the later 1997-2000 regional strategies (DHSS, 1997a; DHSS, 1997b) that guidance on its application became explicit. There is now a regional action plan in place to support and coordinate THSN with a steering group established at the Department of Health, Social Services and Public Safety (DHSSPS) to advise on specific actions. As Labour was transformed into New Labour, in 1998 TSN was re-launched as New-TSN, and while the rest of the UK embraced the principle of social exclusion we espoused social inclusion (DHSS, 1998). As a sign of the importance given to equality issues in NI they were placed under the Offices of the First and Deputy First Ministers.

For the first time in NI, the 1999 Chief Medical Officer's Report majored on inequalities in health, though the tackling of these inequalities was definitely placed in the political arena: 'Health is a matter of politics as much as individual personal practice, and when major inequalities in health exist then health is inescapably a matter for the assembly' (Campbell, 1999).

The year 2000 saw a review of the public health function in NI, culminating in the publication of *Investing in Health* (DHSS, 2000), in which inequalities in health formed a major theme. The consultation period for this report is now finishing and the DHSSPS is in the process of drawing up health inequality targets, though there is an acknowledgement that the utility of such an exercise is questionable (McKee and Bergman, 2000; La Parra and Alvarez, 2001). While the English targets have focused primarily on health outcomes, we hope that the NI targets will focus heavily on the intermediate processes, such as poverty and educational attainment, which perpetuate the cycles of socio-economic disadvantage that generate and sustain health inequalities. It remains to be seen whether the political will exists to recognise and act upon these factors, although some initiatives, such as redistributive tax policies, are not within the powers of the NI Assembly.

I now want to say a little about Equality Schemes. Section 75 of the 1998 NI Act 'requires public authorities to have due consideration to the need to promote equality of opportunity between nine different groups (see Box 2)'. This new equality legislation encompasses the ideas of Policy Appraisal and Fair Treatment (PAFT) (Osborne *et al*, 1996) but goes much further. Public authorities must now prepare Equality Schemes (stating how they propose to fulfil their new duties) for approval by the Equality Commission and then undertake an Equality Impact Assessment of all their existing and proposed policies. To date only a handful of the latter have been carried out and it is uncertain what the effects of this legislation will be in the longer term. It undoubtedly has the potential to greatly enhance the planning process by getting public authorities to meaningfully engage with parts of the population whose views would not, previously, have been so obviously canvassed. It also has

Box 2

Religious belief:	Protestants, Catholics, other belief, and no belief.
Political opinion:	Unionists generally, Nationalists generally, members/supporters of any political party.
Racial group:	As defined by the Race Relations Order.
'Men and women':	Men, women, and trans-gendered people.
Marital status:	Married, unmarried, divorced or separated or widowed.
Age:	Policy depend but generally children under 18; people aged 18-65; over 65.
Persons with a disability:	As defined by Disability Discrimination Act.
Persons with dependents:	Persons with primary responsibility for the care of a child, a person with disability or a dependent elderly person.
Sexual orientation:	Heterosexuals, bisexuals, gays, and lesbians.

the immediate effect of focusing attention on the primary aims of policies and on the need for their justification, especially when balancing issues of efficiency against the additional costs to society or sub-sections thereof.

The downside is that it may also lead to stagnation and 'paralysis by analysis'. Reviewing all existing and proposed policies will be a mammoth task and the requirement to quantify any differential impact on all of the various subgroups (Box 2) will be onerous considering the paucity of such classificatory variables in most routine data systems. Many of the smaller interest groups are already pleading consultation fatigue. While the objectives of the equality legislation are laudable, it also needs to be shown that Equality Impact Assessments can themselves have a useful impact. It could be argued that the PAFT initiative, which predates these by about five years, produced few tangible benefits or changes. The new equality legislation, as with all other initiatives to reduce inequalities, will require rigorous evaluation.

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