Adjustment with a human face

Disinvesting in health: the World Bank's prescriptions for health. *Editor Mohan Rao. Sage Publications, New Delhi, 1999. 232 pp.*

What does structural adjustment have to do with medical ethics?

The specifics of any given medical ethical dilemma are often influenced by much larger forces. For example, the doctor-patient relationship has become a commercial transaction because of growing privatisation. Medical costs can be determined by how much a person or institution 'needs' to recover expenses, or make a good living -- as well as the patient's need for treatment and the other available options. The kidney transplant racket could not have happened without the availability of advanced medical technology -- and a desperately poor population waiting to be exploited.

Structural adjustment

Since 1991, the International Monetary Fund has insisted, as a condition of extending a loan to tide over India's foreign exchange crisis,, that India introduce certain financial changes, which it claims will make its economy more dynamic and able to repay its loans. This structural adjustment programme (SAP) demands that the borrowing country opens up the economies to foreign investment, and give local industries the flexiblity to hire, fire, and shut down at will. Public sector enterprises should be turned over to the private sector to make them more efficient. Various public subsidies should be removed.

In 1993, the World Bank's *World Development Report: Investing in Health (WDR)* presented a set of recomendations on the government's involvement in health services, that was a natural sequel to the SAP: the government should be restricted to providing a package of 'essential interventions' – family planning, and treatment for STDs and TB – while leaving the rest of health care to the private and voluntary sectors. Public hospitals should introduce 'user-fees' to recover costs.

The papers published in the book under review were presented at a seminar organised by the Centre for Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University. The authors – political scientists, health economists, public health specialists and activists – provide an analysis and critique of the WDR's recommendations on various fronts. Some of the papers present a political, economic and historical context: the beneficiaries of structural adjustment, the character of the Indian welfare state, and the history of the various shifts in the government's commitment from comprehensive primary health care to 'selective primary health care'to the WDR's recommendations.

Health consequences

Others demonstrate the health consequences of the SAP, and the WDR's recommendations, on the poor, and especially women. Mohan Rao uses data on mortality, employment and health expenditures to suggest that structural adjustment has adversely affected infant mortality rates, a sensitive indicator of a community's health. Socioeconomic development, not technological interventions, determine people's health. K Seetha Prabhu's paper on health financing links the growing private sector and shrinking public sector in health care to increasing economic inequality and the poor's increased vulnerability.

TN Krishnan uses data collected in the 42nd round of the National Sample Survey on morbidity and utilisation of health services to look at the effect of reducing public expenditures on access to health care. People's expenditure on health services -- and the burden this involves -- are highest where the public infrastructure is least developed. The burden of treatment is higher for the poor, for whom the cost of health care can intensify their poverty, and deter them from seeking treatment.

Do private services work?

Can private hospitals and voluntary organisations replace the public sector? Since private organisations go where they can make a profit, they are bound to bypass parts of the country where no money is to be made. And unlike public services, voluntary organisations are not legally obliged to serve all areas, nor are they answerable to anyone. Indeed, Rama Baru analyses interstate variations in the structure and utilisation of health services to find that the public sector is the major provider of curative services in the country.

In fact, the public sector has played a critical role in building the country's health infrastructure, as Amit Sen Gupta illustrates, using the example of the Indian pharmaceutical industry which was developed by the public sector to meet the country's needs for bulk drug formulation, forcing multinationals to bring their prices down.

Efficiency or ethics?

The principles to determine whetherthe government should finance a service are laid out in the WDR. Essentially, it argues that people will pay for a service if it benefits them specifically; they're unlikely to shell out for mosquito eradication programmes but they **will** pay for curative health services. So let them pay -- it's more efficient. Besides the question of whether this is really a more efficient practice, one should also consider A K Shiva Kumar's argument that this principle cannot dominate decisions on allocating, providing and financing health care. Ethics and equality are equally important. Just because the private sector provides a lot of health care, it doesn't mean people spend this money willingly. Health expenditure is now acknowledged as a leading cause of indebtedness among the poor.

These papers challenge many widely accepted concepts: that the private sector is more efficient than the public sector, that social goals can be met through competition, that efficiency is a reasonable measure to determine health policy, and so on.

This collection of papers is essential reading for doctors searching for an overall perspective explaining the changes in today's health care scene. changes which ineveitably affect the ethical choices they face.

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