THE ROLE OF THE WORLD BANK IN INTERNATIONAL HEALTH: RENEWED COMMITMENT AND PARTNERSHIP

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The article by the de Beyer et al. Examines the role of the World Bank in health sector financing and reform in low and middle income countries. During the nineties the Bank has emerged as the single largest financier of health programs in developing countries which are part of the structural adjustment program (SAP). The prominent role of the Bank in health programs during the nineties is partly a result of the negative impact that SAP had on the health outcomes among vulnerable sections in the early adjusting countries. This trend was strongly criticised by several international agencies like UNICEF, WHO and NORAD. The experiences of the early adjusting countries amply demonstrated the negative impact of adjustment on health outcomes. This prompted UNICEF to emphasise the need for investments in the social sector and called for structural adjustment with social sectors and called for structural adjustment with a human face (Cornia et al., 1988). These developments prompted the Bank to shift from across-the-board privatisation to a "Selective state intervention" in health care, as articulate in the World Development Report 1993 (WDR 93).

Lending to the health sector during the nineties has been tied to reforms, both financial and structural. The policy package for health policy reforms as put forward by this paper and the World Development Report (WDR) is applicable to a number of developing countries with varied histories and levels of development. These blanket policy prescriptions are not grounded in the specific history, experiences and problems of a particular country. This therefore raised important questions regarding the feasibility of these recommendations for countries with varied experiences. Since these loans are tied to macro-economic adjustment policies, most countries are unable to negotiate the attendant conditionalities as equal partners with the Bank.

In the Indian context, it is apparent that the Bank's policy has distorted priorities as far as the communicable disease programs are concerned. Excessive importance has been given to AIDS and a vertical approach is once again being advocated, which in the past has failed. During the early nineties, the Bank allocated more for AIDS and tuberculosis than malaria or other diseases. The loan for tuberculosis also involved a policy shift from an integrated National Tuberculosis Program which relies on expensive second-line drugs for the treatment of tuberculosis (Banerji, 1995).

Both in the WDR 93 and in this paper the schism between preventive and curative services is all too apparent. The emphasis is on selective interventions, which are deemed to be cost-effective. Methodologies like DALYs are then used to justify the selective interventions in nutrition and disease control programmes. Recently, there has been some debate on the limitations of DALYs and the assumptions upon which it is based (Barker and Green, 1996). The nature of interventions being suggested of disease control are through vertical programming which fragments any effort for unified planning at the level of the community. The approach of the Bank is to have state-support preventive services at the primary level, and for curative services at the secondary and tertiary levels to be left to the private sector. This kind of approach goes against the principles of primary health care which stresses the importance of an integrated approach to health services and recognises the link between socio-economic development and health outcomes. This approach, which was accepted in Alma- Ata scarcely two decades back, is still extremely relevant and a cost-effective strategy for developing countries. The Bank, on the other hand, places a great deal of faith in health services for improvement in health status.

The focus of this paper is on the public-private mix in medical care and specific inventions, which will provide better value for money, invested. The authorise review the experiences of some African and Eastern European counties where the Bank has guided reforms in the health sector. Some recent studies suggest that reforms in many of these countries have been far from successful and that issues like equity, quality and efficiency do not necessarily improve when health services are taken over by the private sector. This paper has only looked at health services and does not comment on other aspects like wages and rising food prices which have a negative impact on health status, especially of the poor.

Even within the discourse on health services, the concept of universal access is no longer important. The focus is much more on what is the optimum combination of the public and private sectors. In the Indian context, a large section of the population is dependent on public health services. While it is true that private practitioners are utilised for a variety of minor aliments, this is more due to lack of adequate expansion of the public sector. A national survey revealed that in a majority of the states, public hospitals are being in a majority of the states, public hospitals are being utilised for any conditions requiring hospitalisation. This is partly due to the uneven penetration of private services across regions. Private services are largely restricted to urban areas and ricer states, hence the public sector becomes an important provider of services in the rest of the contra (Baru, 1994). The need for investments in the public sector becomes crucial for ensuring universal access since the private sector is important and needs to be tackled. However, these reforms have to be addressed within the context of the specific country. In India, there has been considerable debate on regulating the private sector, and the sociopolitical constraints for lacks of action are well know.

Regulation of the private sector has to take into account the heterogeneity, uneven penetration and quality of services. Mere regulation of the private sector does not automatically solve the problem of unequal access to services. The American experience has clearly shown that a highly regulated private sector does not ensure equal access. Over time it has marginalised the elderly, poor and minorities from availing of health care when they need it the most. When market failure in health services is being so actively discussed in the West and there is a strong push towards greater state intervention, why should developing countries cut back on public services?

This brings us to an important ethical issue regarding the responsibility and accountability that lending institutions should have when they are in a position to dictate policy changes. The Bank's role is restricted to giving loans with policy advice without any responsibility for its outcomes. The experiences of various countries are then used to modify or abandon certain policy directions in different sectors. It is the negative experiences of privatisation in the early adjusting countries that led to a shift in the Bank's position on the role of the state in the social sectors. These "experiments" are costless to the Bank but it is the countries where the reforms have been initiated who have paid a price. During the eighties the Bank strongly advocated the introduction of user fees in Sub-Saharan Africa as means for recovery. After a few years studies that the Bank claimed it would (Creese, 1990). Subsequently, the Bank toned down its advocacy for introducing user fees.

It would have been useful if some of the data from studies on health sector reform were presented in this paper. This important for evaluating the impact that reforms could have in other countries. The "Experimental approach" that the Bank adopts is all too clear and developing countries are essential laboratories where new strategies can be tried since the cost of failures will be borne by the respective countries. The Bank has expanded its operations in the health sector with bilateral and UN agencies buying into its programmes. As suggested in this paper, the Bank is going to play a more active role in defining the agenda for health sector reform in developing countries. There is clearly a need for questioning many of the assumptions and directions of these reforms as suggested by the Bank in countries, which are part of this process.

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