GLOBAL

HEALTH

WATCH 4

AN ALTERNATIVE WORLD HEALTH REPORT

Praise for previous editions of *Global Health Watch*

'*Global Health Watch 3*, like the previous editions of the Watch, provides us with compelling evidence about all that is wrong with the governance of health care systems across the world. At the same time it also provides us with hope, in the many stories about what can be done and what is being done. The challenge before us is to act decisively on the evidence provided.' **Dr Halfdan Mahler, former director general of the World Health Organization**

'*Global Health Watch 3* provides the thorough and provoking overview of global health issues that we have come to expect from th series. The case studies of change in action provide powerful evidence that poverty and inequity are neither inevitable nor insurmountable, and my students are going to relish debating the feasibility of redesigning health and health care using the alternati blueprint suggested in the latter half of the book.' **Dr Jolene Skordis-Worrall, UCL Institute for Global Health**

'Since 2005, when the first edition of *Global Health Watch* was launched in Cuenca, Ecuador, each new edition has provided an entirely new and stirring account of creativity and courage from peoples and communities in all corners of the world, as they relentlessly struggle against the wide-ranging, criminal path of capitalism, rapaciously determined to cause ever more suffering and death. *GHW3*, surpassing its forerunners, masterfully addresses the relationship among health, health inequalities and their social determinants with exceptional scientific rigour, providing us with an indispensable reference for academics, activists, policy-makers leaders, government officials, and students. Each section in the book objectively describes and supports the facts, while also unmasking the underlying processes, laying out new paths, and evaluating proposals. Reading *GHW3* is a necessary step in understanding how challenging and urgent change is, but that it is increasingly necessary for the survival of our planet Earth.' **Dr Eduardo Espinoza, vice-minister for health of El Salvador**

'Excellent … I highly recommend this treasure trove, which is full of food for thought, to scholars and health workers alike.' **Dr Maria Isabel Rodriguez, rector of the University of El Salvador, 1999–2007**

'*Global Health Watch* confirms the failure of the UN, capitalism and liberal democracy. It also convinces us that we shall need a radically new manner of thinking if mankind is to survive.' **Dr Suwit Wibulpolprasert, senior adviser on disease control, Ministry of Public Health, Thailand**

'An important contribution to understand the overwhelming health problems and their relation to the globalised oppressive world economy.' **Asa Cristina Laurell, former secretary of health of Mexico City and secretary of health of the Legitimate Government of Mexico**

'An incisive socio-political critique of contemporary global health issues which focuses on determinants rather than diseases, enable the reader to unravel the complexity of global economic governance of health, and helps us understand why appalling health inequities persist across and within nations – a must-read for anyone involved or interested in public health.' **K. Srinath Reddy, president, Public Health Foundation of India**

'A very good reference for people working in areas affecting the health of populations. It deals with some of the most important issues in today's world. I highly recommend it.' **Vicente Navarro, editor-in-chief, *International Journal of Health Services***

'Combines academic analysis with a call to mobilize the health professional community to press for improvements in global health and justice. I hope it will be read by many health professionals in rich and poor countries alike.' **Professor Andy Haines, dean, London School of Hygiene and Tropical Medicine**

'It is very good to see issues of trade and globalization reflected prominently in a report aimed at health professionals. *Global Healt Watch* provides them with a resource to engage in debates about these non-clinical, structural determinants of poor health.' **Martin Khor, director, Third World Network**

'Governments and intergovernmental organizations have structured our social world so that half of humankind still lives in severe poverty. These global poor suffer vast health deficits. This greatest moral outrage of our time will continue until citizens reflect on i causes and firmly place the human rights of the global poor on the political agenda. Global Health Watch is a courageous and promising effort in this direction.' **Thomas Pogge, professorial research fellow, Centre for Applied Philosophy, Australian National University**

The Global Health Watch is a broad collaboration of public health experts, non-governmental organizations, civil society activists, community groups, health workers and academics. It was initiated by the People's Health Movement, Global Equity Gauge Alliance and Medact as a platform of resistance to the neoliberal dominance in health.

GLOBAL HEALTH WATCH 4

AN ALTERNATIVE WORLD HEALTH REPORT

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CONTENTS

BOXES, TABLES AND FIGURES

Boxes

Tables

Figures

IMAGES

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Amit Sengupta (on behalf of the *Global Health Watch 4* editorial group: Anne-Emanuelle Birn, Chia Bodini, David Legge, David McCoy, David Sanders, N. B. Sarojini and Amit Sengupta)

INTRODUCTION

The *Global Health Watch*, now in its fourth edition, is perceived widely as the definitive voice for a alternative discourse on health. It integrates rigorous analysis, alternative proposals and stories struggles and change to present a compelling case for the imperative to work for a radic transformation of the way we approach actions and policies on health. It was conceived in 2003 as collaborative effort by activists and academics from across the world, and is designed to questio present policies on health and to propose alternatives. *Global Health Watch 4* has been coordinated b six civil society organizations – the People's Health Movement, ALAMES, Health Actio International, Medico International, Third World Network and Medact.

Global Health Watch 4, like the preceding volumes published in 2005, 2008 and 2011, provide analysis of contemporary issues that impact on health. It provides policy analysis, debates technic issues, and provides perspectives on current global processes. The GHW does not limit itself to th 'health sector' but extends its scrutiny to all those areas that determine whether people are able to liv healthy and fulfilling lives. We hope the contents will be of use to a wide range of readers – activist academics, developmental agencies and policy-makers. *Global Health Watch 4* provides informatio and analysis, but it also takes sides. The analysis and alternatives that we present are embodied in vision of a society that is more just, more equal and more humane. Many of the stories that we inclu inspire hope that change can happen, and is actually happening in many parts of the world.

As in the case of the previous editions, the contents of *Global Health Watch 4* are divided into fiv interlinked sections. The section on the 'The Global political and economic architecture' locates th decisions and choices that impact on health in the present structure of global power relations an economic governance. The section 'Health systems: current issues and debates' looks at contempora debates on health systems in different parts of the world, to draw appropriate lessons and propo concrete actions. The third section, 'Beyond healthcare', engages with multiple social and structur determinants of health. The section on 'Watching' scrutinizes global processes and institutions whic have significant impact on global health. The final section foregrounds stories of action an resistance, from different parts of the world.

The global political and economic architecture

The section begins with a scrutiny of how and why neoliberal globalization has produced a glob health crisis. It traces its forty-year history, describes three phases of neoliberalism (structur adjustment, financialization and austerity) and examines how these phases have affected health. then looks at oppositional or countervailing forces to neoliberalism's orthodoxy, and discusses number of policy options and political strategies that public health activists might support or pursue.

It also provides evidence from post-crisis Europe as a clear reminder of the need to defend publ services. It is precisely at this juncture – when the economic crisis in Europe is eroding the livelihoo of millions of people – that public investment in education, healthcare and infrastructure is und attack.

The section further contends that the installation of several 'progressive' governments marks a ne phase of transformation in the Latin American region, which could have far-reaching glob repercussions. In each country, different power groups have emerged, giving rise to ne

contradictions and tensions. Concurrently, new forms of the 'welfare state' have started emergin based on social rights and citizenship. New ways of defining social inequalities and what is 'social good' are also emerging. Noteworthy, in this context, has been the rise of the idea of 'living wel (*vivir bien*) as a new paradigm, geared towards new forms of communal socialism.

The chapter 'After the Arab Spring' examines the aftermath of the spectacular fall of major Ara leaders in 2011. The uprising in the region was part of a revolutionary process against econom deprivation and political suffocation. The struggle for transformation in the region is now bei forced to contend with renewed attacks by global capital, on welfare and social services.

Health systems: current issues and debates

The chapter on 'Universal Health Coverage (UHC)' examines how existing public systems could b made truly universal. It argues that public systems need to be reclaimed by citizens, reformed in t interest of the people and made accountable. People's movements and organizations have much lose from the present drift legitimized by a particular discourse in the name of UHC. Historicall healthcare systems worldwide have been shaped by labour's fight for better conditions of living either through transformation of the capitalist system itself or through the extraction of better tern from the ruling classes. The fight for a just and equitable health system has to be part of the broad struggle for comprehensive rights and entitlements. To take this struggle forward, the domina interpretation of UHC today – weakening public systems and the pursuit of private profit – needs to b understood and questioned.

The chapter on reforms in the UK's National Health Service (NHS) describes how the shift fro NHS to 'National Healthcare Market' was made possible through various failures of democracy a professional leadership and reflects on the implications of the downfall of the NHS. The scale of t threat to the NHS – coupled with the UK government's lack of a democratic mandate to end the NH and its propensity to misinform the public – suggests that we are in a situation where profession dissent is not just appropriate, but urgently required.

Countries in Latin America have been host to several 'experiments' designed to promote UH beginning with the health and social security reforms in Chile in the mid-1970s, carried out under t dictatorship of Pinochet. This trend continued with a wave of neoliberal reforms in most countries the continent during the 1990s. The most celebrated was the Colombian reform of 1993, which w recommended to other countries as a successful model. With the virtual collapse of the Colombia health system, its place has been taken by the Mexican health reform and its 'Popular Heal Insurance programme' (*Seguro Popular*). The chapter on Mexico discusses the supposed 'succe story' of *Seguro Popular* and challenges the mainstream discourse about its 'success'.

Brazil's successes, in rapidly rolling out primary-care services to cover the entire country and pioneering a model of social participation through its health councils, are discussed in the context existing challenges. The chapter reflects about the need to overcome structural barriers that preve the full implementation of reforms that would make the country's unified universal health syste (SUS) the dominant form of healthcare provision in Brazil.

The chapter on South Africa discusses the country's commitment to the introduction of a ta funded system with universal entitlements to comprehensive health services. The experience of Sou Africa could provide valuable lessons for other low- and middle-income countries (LMICs) that ha large private health sectors.

The discussion on Tunisia looks at the current situation in the country, foreshadowed by the valu of social justice and equity that were the underpinnings of the Tunisian revolution.

Community health workers (CHWs) were an important component of the original vision of universal health system based on the principles of primary healthcare (PHC). However, over the pa three decades CHW programmes have become bureaucratized and have lost the earlier intended focu on social mobilization. The chapter on CHWs looks at recent experiences from four countries – Braz India, Iran and South Africa – and argues that they demonstrate a number of commonalities. The mo important of these is the relatively weak focus on and arrangements for inter-sectoral action on soci and environmental determinants of health. The chapter discusses how CHW programmes ca contribute to shaping healthcare to the expectations and reality of the community the health tea serves.

In spite of some recent progress, the levels of maternal mortality and morbidity rema unacceptably high, and there are major inequities between and within countries. With a focus o Africa, the chapter on 'maternal mortality' discusses how universal access to reproductive and sexu health needs to be the cornerstone of programmes aimed at improving both maternal and women health.

The chapter on the 'health workforce crisis' details how the availability of a strong healt workforce, supported by public funds, is a prerequisite for strong, universal and quality heal systems. The current focus on UHC carries the potential threat of reducing the role of health worke to undertaking selective diagnosis and treatment, rather than addressing the health of people an communities in a comprehensive and integrated way, combining public health and individual clinic approaches. It critically analyses recent trends in the role of health workers geared towards concer of economic efficiency.

The final chapter in the section focuses on 'medical devices', a hitherto neglected area in publ health discourse. While the medical-device industry makes claims about how new devices (an technologies) can 'revolutionize' healthcare, there are too few independent studies that examine suc claims. The chapter argues for regulatory regimens based on better evidence as regards the cos effectiveness of medical technologies.

Beyond healthcare

The chapter on 'social protection' contests the mainstream discourse on development. It advocate for a transformative agenda where development implies an end to 'dual societies' engendered b neoliberal policies, and for a shift away from 'productivism' and an exclusively growth-oriente economy.

The rise in the incidence and prevalence of non-communicable diseases (NCDs) poses a comple challenge. The discussion on NCDs calls for vigilance to ensure that the agenda is not hijacked b very powerful interests who seek to profit from disease and suffering.

Two case studies (located in India and the Pacific Islands) individually and together illustrate th complex and dynamic global food and nutrition crisis. They are presented as stark reminders of th urgency of eliminating the 'double burden of nutrition' (under-nutrition and obesity), and of the cle and distressing explications of its national and global social, economic and political contexts. The underline the fact that this human crisis cannot be addressed without confronting and changing i social determinants.

The section also advocates that policy, law and guidelines on gender-based violence mu incorporate a comprehensive health system response. Elimination of gender-based violence requir action at various levels, including steps to address societal issues related to power and dominanc access to resources and entitlements, among others.

The sanitation crisis is rapidly escalating, with a growing and urbanizing poor population in LMIC and a scarcity of fresh water and infrastructure. We discuss the embracing of a new strategy, terme 'Community Led Total Sanitation' (CLTS), by powerful international agencies and NGOs. Th chapter argues that the strategy may be demeaning and represent a 'victim-blaming' approach to basic health issue and human right.

The evidence demonstrating the causal relationship between exposure to mining hazards ar adverse health outcomes is denied and suppressed by industry advocates. The same is true of the hug contribution of the mining industry to a high burden of disease. The chapter on 'extractive industrie contends, through an examination of several case studies, that current global governance structures a grossly inadequate in the face of the tremendous power imbalances that exist between communiti and mining companies.

Watching

The discussion on the World Health Organization (WHO) is located in the roots of the global healt crisis in the contemporary regime of economic globalization. It argues for a theory of global (healt governance that goes beyond simply listing those international institutions that deal with heal issues. An expanded theory of global governance, it is contended, should also recognize imperialis and big-power bullying; acknowledge the historic competition between the nation-state and th transnational corporation as the principal agent of governance; and contextualize governance with the emerging class relations between the transnational capitalist class, the diverse national midd classes and the more dispersed, excluded and marginalized classes of both the periphery and th metropolis. The chapter describes how the WHO is under continuing pressure to retreat to a pure technical role and to withdraw from any effective engagement with the political and econom dynamics that characterize the global health crisis.

Non-governmental organizations (NGOs) have been remarkably flexible in adapting to changin global power relations. A critical analysis of the role that NGOs play today, entitled 'A new "busines model" for NGOs?', identifies some of the 'red lines' that are beginning to be defined quite sharply i relation to the activities of NGOs.

The chapter contends that 'pragmatism' guides many NGOs today as the current hegemon discourse abhors utopian thinking by demanding realism. Consequently, as NGOs becom increasingly beholden to donor funding, they are being overtaken by the agenda set by donors.

Public policy-making is being influenced on a global level by private actors, accountable only their board members. We discuss the mounting evidence that clearly points to a clear nexus betwee different private actors – private foundations, consulting and accounting firms, private industry ar global public–private partnerships. The precise role of this complex nexus in subverting public polic it is argued, needs to be examined systematically.

The Trade Related Intellectual Property Rights (TRIPS) agreement harmonized laws that prote intellectual property (IP) in all countries and thus forced LMICs to allow patents on medicine irrespective of the domestic situation. However, at the insistence of many LMICs, the TRIP agreement incorporated a number of 'health safeguards' designed to mitigate the adverse impact of strong patent regime in LMICs. The discussion on 'The TRIPS agreement: two decades of faile promises' takes stock of the experience of using the 'health safeguards' in the TRIPS agreement, ar examines a number of emerging trends in the global trade environment that act as barriers medicines access.

The analysis of the Haitian cholera epidemic contends that the popular consciousness of th

epidemic, in donor countries, has been based on a fabricated narrative which has centred on the plig of the refugees affected by the January 2010 earthquake. This narrative is not only misleading, misses out on the political context in which the epidemic took place. Haiti's story and its prese plight need, instead, to be principally viewed in the context of how the country's political system ar economy have been systematically undermined by its imperial neighbour.

Evidence is also presented to show that the World Bank's International Finance Corporation (IFC through its Health in Africa initiative, works at odds with the commitment from the Bank's leadersh to universal and equitable health coverage. While the initiative has failed to mobilize its target lev of investment, of particular concern is the lack of focus on the poor. The Bank's response to the mi term evaluation of the initiative does nothing to reassure critics that the IFC is genuinely committe to a pro-poor, evidence-based approach.

Finally, we analyse the growing trend of clinical trials being 'offshored' to LMICs. Case studie presented in the chapter, reflect common trends in the preferred destinations of offshored clinic trials: weak regulatory systems and vulnerable populations that constitute a pliant pool of clinical tri subjects. The gross rights and ethical violations that are taking place reflect a nexus betwe multinational pharmaceutical companies, domestic regulatory agencies, pliant doctors leading clinic trials and regulatory agencies in the North.

Resistance, actions and change

Three chapters in this section narrate the changing dynamics in Latin American countries that hav witnessed significant social and political changes in the past decade. In Bolivia the concept of 'livi well' (*vivir bien*) is contributing to the dismantling of colonial and neoliberal legacies of the past. Salvador is embarking on a challenging process to ensure the irreversibility of the achievements ma after the installation of a 'left' government in 2009. Venezuela faces the onslaught from the imperi US government and its allies in the country (the oligarchy, private media, the Catholic Churc hierarchy, political parties now led by neo-fascist groups, etc.). The three countries represent differe kinds of experiments, each in their own way attempting to chart a course that challenges and rejec the neoliberal framework. This contestation is being played out in the health sector as well, wi entrenched neoliberal ideas being questioned and replaced by 'communitarian' approaches.

The analysis on two other countries in the region – Colombia and Peru – represents a contrast. both these countries, neoliberal hegemony is being challenged by popular movements. The tw chapters narrate how such contestation is apparent in the struggles against reforms to the heal system.

The global economic crisis has had a deep impact on people's lives in large parts of Europe. W carry vignettes, in this section, of the waves of protests and resistance movements that have starte sweeping large parts of the continent. These target the austerity packages being imposed by th 'Troika' – the European Commission, the International Monetary Fund (IMF) and the Europea Central Bank – and also the EU–US negotiations for a new free trade agreement (the Transatlant Trade and Investment Partnership, or TTIP). A linked case study narrates the story of Halkidiki – of community in Greece that has collectively risen up in protest against a mining project.

We also focus, in this section, on the Right to Food (RTF) campaign in India. Over these years th RTF campaign has expanded into a wide network with members across the country representin different groups, including agricultural workers' unions, women's rights groups, Dalit rights group single women's networks, child rights organizations, those working with construction worker migrant workers, homeless populations, etc. These groups have come together in the belief th

‘everyone has a fundamental right to be free from hunger and that the primary responsibility f guaranteeing basic entitlements rests with the state’.

Finally the section foregrounds the story of the ‘Aboriginal community-controlled health servic in Australia’. This movement has been one of the key vehicles through which the Aborigin community has been able to engage in the struggle for health. This struggle combines collecti actions to access healthcare with those that address the social determinants of health.

Towards a shared narrative for change

We acknowledge that a single volume cannot encompass the wide range of issues that have bearing on health in different parts of the world. Each community, country, region and continent ha its own specificities, all of which need to be addressed. However, we do hope that the contents *Global Health Watch 4* will stimulate readers to reflect more concretely about what needs to chang how things can be done differently, and how people can be at the centre of bringing about desire change. Above all, this volume is ‘work in progress’ towards the development of a shared narrativ located in a vision of equity and justice, and imbued with the urgency that the present global heal crisis demands. Many of the ideas that are explored in this book are further detailed on the website the Global Health Watch (www.ghwatch.org). Readers are invited to visit the website and contribu their own perspectives, so as to enrich this narrative that we seek to develop.

THE GLOBAL POLITICAL AND ECONOMIC ARCHITECTURE

A1 | THE HEALTH CRISES OF NEOLIBERAL GLOBALIZATION

Introduction

The global economy has had a turbulent time over the past six years, creating greater inequities health and in its social determinants. The Great Financial Crisis (GFC) began in 2007 and ha deepened by 2008, sparking unprecedented public bailouts and stimulus spending by many of th world's richest and most powerful governments. This impressively rapid mobilization of publ money forestalled a Great Depression but not a Great Recession (Box A1.1) from which much of th world has yet to recover. This period of powerful state intervention into the market econom however, was very brief, and was quickly followed by the 'austerity agenda' adopted in most of th world's countries. Austerity was argued as being essential for reducing government debt, much o which was caused by the unregulated greed of global financial institutions that necessitated cost public rescues. Many are now questioning not only the health costs of austerity, but also its econom necessity. As the director-general of UNCTAD complained in that agency's 2011 report: 'Those wh support fiscal tightening argue that it is indispensable for restoring the confidence of financi markets, which is perceived as key to economic recovery. This is despite the almost univers recognition that the crisis was the result of financial market failure in the first place' (UNCTA 2011).

This recent tumultuous period is foreshadowed by a forty-year-old uncontrolled experiment neoliberal globalization. The past forty years have seen a particular ideology, neoliberalism, domina the norms or rules by which globalization has expanded. There are differing definitions neoliberalism, but they distil to the same thing: a belief that free markets, sovereign individuals, fr trade, strong property rights and minimal government interference are the best recipe for enhancin human well-being. This belief, an extension of classical economic and political liberalism, was fir promulgated by the Austrian economist Friedrich von Hayek in the 1940s. Hayek argued that th economy is too complex for governments to regulate, so markets should be allowed to regula themselves through the 'rational' choices of hundreds of millions of individual producers an consumers. Two other economists of the same era, collaborators of John Maynard Keynes, expresse this somewhat differently as a belief that 'the nastiest of men for the nastiest of motives will someho work for the benefit of all' (Robinson and Guillebaud 1941). The late Scottish-Australian heal economist Gavin Mooney wrote in his last book: 'The best outcome in terms of bringing about re change would be to see an end to neo-liberalism. So many of the problems that beset societies toda and their populations' health can be placed at its door …' (Mooney 2012).

Box A1.1 Depression or recession?

There is no standard agreement on the difference between a depression and a recession, apart from the fact that a depression has a longer and more severe contraction in economic activity (usually measured by a decline in GDP approaching 10 per cent), usually accompanied by a sharp rise in unemployment rates.

This chapter takes up Mooney's argument, and examines how and why neoliberal globalization ha produced a global health crisis. It traces its forty-year history, describes three phases of neoliberalis (structural adjustment, financialization, and austerity), and examines how these phases have affecte health. It then looks at oppositional or countervailing forces to neoliberalism's orthodoxy, an discusses a number of policy options and political strategies that public health activists might suppo or pursue to make globalization work for, or at least not against, greater equity in 'health for all'.

From Neoliberalism 1.0 to Neoliberalism 3.0: an abbreviated history

Neoliberalism 1.0: structural adjustment Although neoliberalism's key tenets were defined by Haye before the Second World War, Keynesian economics, with its emphasis on state intervention an regulation of private markets, held sway during the post-war reconstruction period and throughou much of the following three decades. The Cold War and the bipolar world provided decolonizin countries with options to experiment with mixed economies and with assigning a strong role for th state in economic planning and management. Neoliberalism's dominance in political and economi decision-making began to emerge only in the early 1970s. This was a decade marked by an increasin pace of economic recessions, oil embargoes and oil-price shocks that quadrupled the cost capitalism's crude energy source. To help write off its Vietnam War debts and to stimulate it domestic economy, the USA in 1971 permanently unpegged the US dollar from the gold standar This set financial exchanges adrift, allowing money to be made through currency speculation an entrenching the US dollar as the world's 'reserve currency' held by the central banks of governmen and other financial institutions 'in reserve' as a means of paying off international debt obligations an of stabilizing the value of their own currency when needed. Two years later, the 1973 military coup i Chile gave the neoliberal economic disciples of Hayek and Milton Friedman their first experiment laboratory. In quick succession, Britain's Margaret Thatcher, the USA's Ronald Reagan an Germany's Helmut Kohl joined Chile's Augusto Pinochet in ushering in neoliberalism 1.0. Althoug not yet a globally dominant discourse, the key tenet of Neoliberalism 1.0 was a belief that any form state enterprise or service provision was 'second best' to private markets.

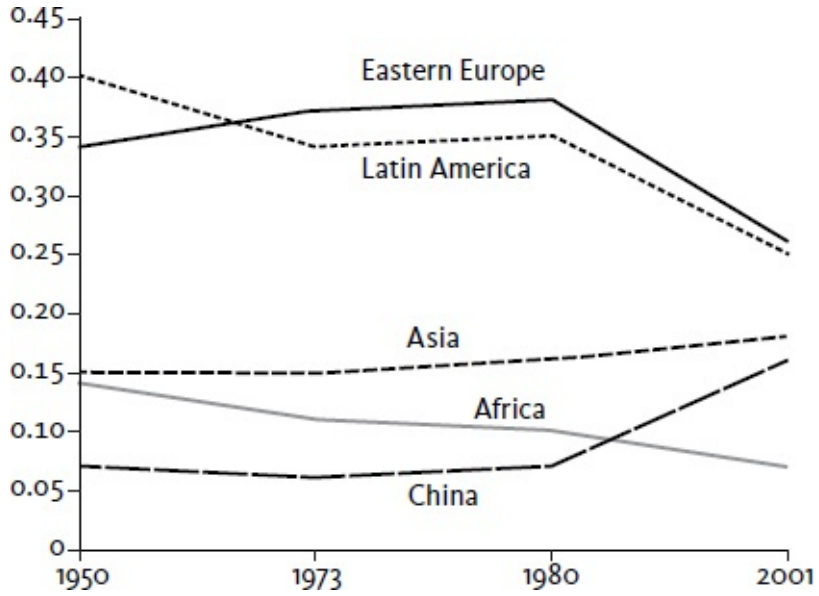
Image A1.1 Children at a garbage dump in Rio: global poverty and inequality have risen (Camila Giugliani)

THE RISE OF NEOLIBERALISM 1.0 Neoliberalism 1.0 began its rapid ascent during the 1980s. This decade brought us the developing-world debt crisis, a result of oil-price shocks that had led many developing countries to borrow heavily to continue their post-colonial path to industrialization. First World bank flush with new 'petrodollars' lent indiscriminately, often to governments that were known or suspected to engage in corruption or misappropriation. Developing-world debt worsened dramatically when US-led monetary policy to control inflation led to huge increases in interest rates, rising from 1 per cent in 1979 to over 20 per cent in 1981. As the international debts of developing countries became due for refinancing, the super-high interest rates caused debt-servicing costs to skyrocket and debt loads to accelerate. Fearing sovereign defaults by heavily indebted countries (threatened first by Mexico) and an ensuing international financial crisis, the World Bank and the International Monetary Fund (IMF) stepped in with emergency loans and grants to keep the worst-affected nations afloat. Countries accepting these loans had to agree to several 'structural adjustment' conditionalities that embodied neoliberal economic principles, later codified as the 'Washington Consensus', named after the location of the head offices of the World Bank and the IMF. These conditionalities included:

- Privatization of state assets, in part to help governments pay off international loans;
- Deregulation, to enable rapid private-sector-led economic growth;
- Tax reform to attract foreign investment through lower corporate and marginal rates, or ta holidays, for foreign investments;
- Public deficit (the shortfall between revenues and expenditures in any single fiscal year) and de (the total accumulated amount owed to creditors), in part to help governments pay off internation loans; and

- Rapid liberalization of trade and financial markets on the theory that liberalization leads economic growth (which it does sometimes but not always).

The health and social policy consequences of Neoliberalism 1.0 have been well documente notably in Africa and Latin America, the two regions most affected by international debt obligatio and most constrained by World Bank and IMF emergency loan conditionalities (Breman and Shelt 2001; SAPRIN 2004). These regions not only failed to grow economically (Figure A1.1), they al experienced severe retrenchments in public spending, upheavals in their domestic labour markets, a increased wealth inequalities within their borders. Central to structural adjustment was a reduction social protection spending by governments, which subsequent analyses found to be the main cause increases in poverty and inequality in the affected countries (UN Habitat 2003). Since poverty a inequality are the two greatest risk conditions for preventable disease, it is not surprising th structural adjustment led to a slowdown or reversal of health gains, particularly affecting the poo rural populations, women and children (SAPRIN 2004).



A1.1 GDP per capita in developing regions relative to that in the developed world, 1950–2001 (*source*: UN DESA 2006)