Reclaiming the State : Advancing People's Health, Challenging Injustice

Speaking Notes for an Address Delivered at the International Conference on Equity in Health Organised by the International Society for Equity in Health, EQUINET, Health Systems Trust and the Global Equity Gauge Alliance, 10 – 12 June, 2004, Durban, South Africa.

By

Adebayo Olukoshi,
Executive Secretary,
CODESRIA,
BP 3304, Dakar,
Senegal.

Introduction:

*The accelerated processes of globalisation that have characterised the last decade and half in world history and the forces/interests that have emerged to dominate and propel them have brought to the fore, a broad range of issues and concerns that touch directly on global and local-level equity and justice both generally as they pertain to the developmental experience and more specifically as they are being played out in the social sectors of which health and education occupy a place of prime importance.

*Although, at one level, globalisation appears to promise a great deal of opportunity for progress and advancement, the process, in the way in which it has been shaped in the contemporary period has also been accompanied, at another level, by a sharpening of socio-economic disparities and inequalities among nations and within countries. Furthermore, even within specific social groups, an accelerated process of differentiation is taking place and overall, in most countries of the world, the social pyramid has grown much narrower at the top, thinner in the middle and broader at the base, suggesting that the main winners from globalisation represent a small and diminishing minority even as millions, including many who once formed part of or aspired for the middle class, have been pushed to the bottom of the social ladder into poverty and misery.

*At the same time, the promise which the greater international exchanges associated with the process of globalisation offers also contains the grains of vulnerability to the accelerated spread of diseases across frontiers propelled by the increased cross-border mobility of people. And yet, there is no corresponding globally structured capacity to respond to these vulnerabilities and the states on whom the challenge of managing global disease spread falls are of generally uneven capacity.

*A plethora of explanations have been advanced as to why the process of globalisation has not been accompanied by social gains and has, instead, resulted in the erosion of

some of the achievements recorded in an earlier phase of development. While some scholars point to the fact that the current experience of globalisation is driven by the narrow concerns of international financial investors with a strong short-term, speculative orientation that is inimical to the overall interests of the working poor and the real sectors of economies, others have suggested that the problems that have arisen are traceable directly to the neo-liberal ideological principles and doctrinal foundations on the basis of which the process of globalisation is being governed and which has resulted in the enthronement of a narrow and limiting market logic in the policy process. Furthermore, it has been suggested that the main thrust of the current phase of globalisation has been primarily economic, especially trade and investment to the neglect of social questions and

*There is clearly some truth in the various competing explanations which have been offered as to why the problem of inequality would seem to have worsened on the back of globalisation. But over and above these is the question of the state, particularly in the developing countries, and the erosion and delegitimation not only of its role in the developmental process but also the erosion of its broad policy planning and implementational capacities at the same time as the efforts at supplanting it with the private sector and/or non-governmental organizations have failed to live up to expectations. When this is taken together with the fact that in the African context, the free market orientation of policy premised on deflationary macro-economic principles has failed to deliver growth and has instead widened the boundaries of poverty, it is easy to begin to understand why the problems of inequality and injustice have worsened. It is here, in my view, that the problem ought to be located in the first place.

*In the rest of this presentation, I will attempt to develop my arguments further drawing on the African historical context, developments in the broad socio-economic and developmental experience of the African continent that affect the health sector/system, and developments within the health system itself that have served to heighten inequality and injustice.

The Making of the Post-Colonial African State and Social Policy:

*In spite of neo-liberalist revisionism which attempts an ideologically-loaded and self-serving re-interpretation to the contrary, the state, whether in developed or developing countries, played an important historical role as a social actor. Indeed, it will not be entirely inaccurate to suggest that the social function of the state was as critical to the constitution of the social contract as the quest for a secured territorial framework within which individuals and groups could exercise their livelihoods.

*The high point of the development of the social state came in the period immediately after the Second World War with emergence and spread of different variants of social democratic and welfare regimes in response both to popular domestic pressures by the working poor in Europe and as a direct response to the challenge of an ascendant socialism/communism most eloquently symbolized by the Bolshevik Revolution and its initial spread across Eastern Europe and Asia.

*The post-War context of the consolidation of the social state coincided with the period of late colonialism which also witnessed for the first time in the colonial experience, a deliberate and conscious investment of effort in the promotion of "development" which included greater attention to the promotion of infrastructure, the nurturing of local industrial processing and the expansion of health and educational facilities and expenditure.

*At independence, African states were, not surprisingly invested with broad-ranging social responsibilities which were integral to the anti-colonial social contract on the basis of which the nationalist politicians mobilized the populace for the independence struggle. Central to the contract was the promise of the expansion of social policy in a direction which will significantly improve the health and nutritional status of the populace, expand access to education and offer greater opportunities for employment. African countries succeeded in varying degrees in achieving the goals which they defined: in the period to 1980, the livelihood prospects of the populace were generally improved - life expectancy maintained an upward trend even as child and maternal mortality showed improvements.

*The expansionary economic policies which African governments pursued in the 1960s and 1970s had a great deal to do with the successes which they recorded. With growth rates averaging 5 to 7 per cent and star economic performers like Cote d'Ivioire and Kenya clocking up to 9 per cent average growth rates, it was possible to expand the social expenditure of the state particularly with regard to health and education. Policy was geared to promote the inclusiveness of marginal groups and subsidies were employed to improve the reach and coverage of the educational and health targets of the state.

*To be sure, the post-colonial model of social policy formulation and implementation was not without its problems and some of the problems were to become sources of dysfunctionality that eventually weakened the effectiveness of policy and, eventually, the onset of socio-economic crises. Still, in comparison to the poor growth records of the 1980s and 1990s, the 1960s and 1970s seemed like golden years. Moreover, there was a close correlation between the broadly Keynesian-inspired economic policies that were pursued and the social measures that were introduced.

The Onset of Economic Crisis and the Age of Orthodox Structural Adjustmnent:

*The onset of the African economic crisis at the beginning of the 1980s and the orthodox structural adjustment crisis management and reform framework which was adopted triggered attacks on the social policies of the post-colonial state. While for most African governments, the immediate, almost instinctive response which they had to the crisis in their economies was to curb social expenditures as the core of the austerity measures which they adopted, this attack on the social sectors was carried further and transformed into a dogma in the context of IMF/World Bank structural adjustment which had a

deflationary, market-oriented thrust that saw and treated the post-colonial state as the problem and not a part of the solution.

*The economic crisis management and reform strategy promoted by the IMF and the World Bank drew heavily from an ascendant global neo-liberalism which was one-sidedly anti-state and which was committed to "freeing" the forces of the market under the banner of "getting prices right", curbing inflation, and promoting the private and/or non-state sector. The consequences of this crisis management strategy were many and devastating from the point of view of the health sector and the health status of the average Africa.

*Apart from the extension of and sustenance of the cuts in the social expenditure of the state as part of the bid to curb budget deficits, tame inflation and cut "overbloated" post-colonial governments down to size, several other measures were adopted which had adverse consequences for the generality of the populace. Some of the measures introduced include:

i) Cost recovery/user fees;
ii) The elimination of subsidies whether gradually or through a shock approach;
iii) The freezing of personnel wages and salaries and in public sector employment opportunities;
iv) The retrenchment of public health sector staff;
v) The freezing of all major (new) public health sector investments; and
vi) The promotion of market-oriented health sector reforms, including privatization and the application of new public sector management systems.

*The shift in the structure of incentives which the structural adjustment framework represented and which consisted of efforts at shifting the locus of developmental activities away from the state to market also triggered a brain drain from the social sectors generally and the public health system in particular even as freshly qualified health personnel roamed the streets in many countries unable to find gainful employment.

*The brain drain from the public health system was multidirectional – into private health provisioning, to greener pastures abroad, etc. – and it had the consequence of further weakening capacity in the sector and, therefore, the social function of the state. The brain drain also fed into, as much as it was reinforced by the degradation of the public health infrastructure and the collapse of professionalism.

*The immediate post-colonial health system definitely had many problems but there was also a clear vision which underpinned it and which sought to improve livelihood and well-being. During the crisis and adjustment years, this vision was lost and the alternative that seemed to replace it was preoccupied primarily with winning the battle to roll back the frontiers of the state and enthrone the market. Little initial attention was paid to ways in which the health gains that had been recorded in the lead up to and immediately after independence could be safeguarded. The consequence was that a chaotic situation

prevailed in many countries in which the public health system was in a state of collapse and mired in all-round shortages of personnel, equipment and medicaments while the private/non-governmental health system such as it existed proved to be inadequate in many ways even as its services were priced beyond the reach of the working poor. Not surprising, health-seeking behaviour began to shift in the direction of self-diagnosis and treatment, and in the reinvention/rediscovery of traditional forms of health provisioning, including faith-healing.

*The decline which was registered in the health status of the average African was dramatic and alarming: diseases which were previously under control or which were well on the way to elimination resurfaced while life expectancy suffered reversals as maternal and infant mortality grew at the same time as the nutritional status of many households declined. The wider framework of economic reform and structural adjustment which was being pursued had clearly taken a toll on the health sector and combined with developments in the health system itself to send alarm bells ringing. Across Africa and the rest of the world, the case began to be made for adjustment with a human face.

*The pleas for the modulation of economic reforms in order to give adjustment a human face led to the introduction of a series of interventions which came under the rubric of the social dimensions of adjustment. They included social safety nets, various funds targeting poor households, and programmes for the mitigation of the social costs of economic reform. Various initiatives designed to alleviate poverty were also introduced. Overall, most of these programmes failed to achieve the objectives for which they introduced and there is no greater evidence of this than the worsening of the problems of growing exclusion that they were supposed to help tackle. The reasons for the failure of these interventions are many and examples from field-based research across Africa can be cited for each of them.

*The shallowness of the interventions was brought in sharp relief by the outbreak of the HIV/AIDS pandemic which the social dimensions of adjustment were simply unable to address and which accelerated at a time when the capacity of the state and of the public health system had been severely eroded.

Beyond Structural Adjustment and Towards the Social State:

*One of the fundamental lessons from the failure of the social dimensions of structural adjustment to have an effect, and a factor which is equally relevant for the PRSPs which have been put in place across Africa during the last two years, is that no progressive policy of social advancement can be successful if it is treated as a residual category to serve targeting needs even as the “serious” business of macro-economic policy-making is carried on without a clear social objective in mind. To be truly effective, social policy must be an integral part of macro-economic policy-making, not a residual add-on. This can only be done if there is a conscious effort to avoid the decoupling of social policy from macro-economic policy formulation as has happened over the last two decades. Such an approach will require, as necessary, the harmonization of economic policies and

instruments with the goal of social renewal and advancement built on foundations of equity and justice.

*For macro-economic policy-making to succeed in advancing the frontiers of social policy in a manner that is equitable, just and inclusive, it would also require to generate growth without which it will not be possible to expand expenditure. The tragedy for Africa is that the structural adjustment years were characterized by a policy orthodoxy which, by its deflationary logic, stifled growth. The quest for a social state will necessarily, therefore, all involve a revisiting of the macro-economic fundamentals that inform policy with a view to effecting a radical shift from a growth-retarding orthodoxy to a growth-promoting heterodoxy. In sum, the rebirth of a social state in Africa will also simultaneously involve a re-thinking of policy in a direction that could promote what some have conceptualized as developmental democracies on the continent.