

Chapter 13

From “Health for All” to “Health as Investment:” The Role of Economic Rationalities in the Transition from International to Global Health 1978–2013

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13.1 Introduction

The last 25 years have witnessed a dramatic shift in the terrain of world health. Usually characterized as a transition from “international” to “global” health, this shift has been accompanied by epidemiological, organizational, geopolitical and financial transformations. Even though global health has emerged as the dominant term for attempts to address matters of health and disease on a transnational scale, how it differs from earlier designations such as international health or tropical medicine remains underspecified (Anderson 2014; Banta 2001; Brown et al. 2006; Fried et al. 2010; Kleinman 2010; Koplan et al. 2009; Lakoff 2010; McGoey et al. 2011). Scholars have observed a number of features that have accompanied the rise of global health: the declining role of the World Health Organization (WHO) dating from the budget freezes of the 1980s, the relative ascendance of the World Bank in world health affairs, the proliferation of public private partnerships, Bill Gates-style philanthrocapitalism, and an emphasis on health threats that transcend national boundaries, i.e. HIV/AIDs, SARS, pandemic influenza and, more recently, the ebola virus (Brown et al. 2006; Chorev 2012; Kenny 2015; Lakoff and Collier 2008; McCarthy 2002; McCoy et al. 2009; Ruger 2005; Thomas and Weber 2004). In this paper I identify a less frequently observed feature: the rise of non-communicable diseases (NCDs) as a global health concern. NCDs, also known as “chronic” or “lifestyle” diseases,

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include conditions such as cardiovascular disease, cancer, respiratory disease and diabetes and share four common risk factors: tobacco use, physical inactivity, alcohol consumption and unhealthy diet. I argue that the current concern with NCDs, and the transition from international to global health more generally, coincides with the historical rise of economic rationalities in the field of world health over the last 25 years.

I begin by comparing two prominent moments in the history of world health – the 1978 Alma-Ata Declaration, in which the WHO reaffirmed its commitment to the goal of “health for all by the year 2000,” and the 2013 High Level Meeting of the UN General Assembly at which Non-communicable Diseases were declared to be a grave threat to the global economy. The contrast between these two moments illustrates the central question of this chapter: How did the dominant conceptualization of health shift from a legitimate end in itself to something that should be maximized in service to the economy?

I answer this question by locating the origins of global health in the structural and conceptual transformations of the field of world health that began immediately following the Alma-Ata conference. I then focus on the World Bank’s increasing involvement in world health affairs beginning in the late 1980s and culminating in the publication of the World Development Report 1993: Investing in Health. In addition to its widely criticized recommendations for health sector financing (emphasizing privatization of health care services), the Investing in Health report also introduced a new way of conceptualizing health using the disability adjusted life year (DALY) metric. One DALY is equivalent to a *year of healthy life* lost to either premature death or to disability. It represents an internationally standardized quantum of ill health used to measure the global incidence of health and disease and to perform cost-effective analyses on potential health care interventions. The shift from disease-specific mortality statistics to DALY calculations brought the global burden of NCDs into clear focus. However, the DALY method by which NCDs became a global health priority relies on a particular *economic* valuing of human life.¹ I situate the creation of the DALY metric with respect to the broader field of health economics, which itself emerged through the 1970s and 1980s. I argue that the DALY metric explains the rise of NCDs on the global health agenda and, more fundamentally, illustrates the rise economic rationalities in the field of global health over the last 25 years.

13.2 From “Health for All” to “Health as Investment”

In September 2011, the United Nations General Assembly convened a high-level meeting to address the prevention and control of non-communicable diseases (NCDs). It was only the second time in history that such a meeting had been devoted

¹My analysis builds on theoretical work in sociology and in science and technology studies concerned with processes of economization (Berman 2013; Çalışkan and Callon 2009; Fourcade 2009; Mitchell 2006; Murphy 2013b). Michelle Murphy’s work on the “economization of life” is particularly relevant here (Murphy 2013a).

to a topic related to health, the first having been in response to the HIV/AIDS pandemic a decade earlier. Unlike the earlier meeting, at which the vast majority of the burden of HIV/AIDS was acknowledged to fall on the countries of Sub-Saharan Africa, the 2011 summit presented the threat posed by NCDs as universal (United Nations General Assembly 2001). Far from the diseases of affluence that cancers, diabetes, and hypertension were once portrayed to be, NCDs had by late 2011 come to occupy a central place on the global health agenda. The precise *kind* of threat that NCDs were seen to present was not limited to the domain of health: the UN Resolution adopted by the General Assembly declared that “the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century” and that “non-communicable diseases are a threat to the economies of many Member States” (United Nations General Assembly 2012). A report by the World Health Organization (WHO) and the World Economic Forum (WEF) published to coincide with the UN NCD summit similarly warned that “The economic consequences of NCDs are staggering” with projected losses to low and middle income countries surpassing 4% of their annual output (“From Burden to ‘Best Buys:’ Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries” 2011, 3). Another report projected that the cost of NCDs to the global economy would exceed US\$30 trillion over the next 20 years (Bloom et al. 2011, 5). By contrast, the cost of implementing a range of “best buy” interventions to prevent NCDs was low. The report continued: “[...] the return on this investment will be many millions of avoided premature deaths [...] and] many billions of dollars of additional output” (2011, 3). NCDs are here positioned by the UN, by the WHO and by the WEF as a threat to both the health of the population and as a threat to the economy. Conversely, strategies to combat NCDs are imaged as a solid investment in health and in economic growth with an expected yield of positive future returns.

Just twenty-five earlier, in 1978, the World Health Organization celebrated the thirtieth anniversary of its founding with a conference on primary health care at Alma-Ata in the Soviet Union. There, the famous Alma-Ata declaration was made in which the WHO reaffirmed that “health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right.” “[T]he attainment of the highest possible level of health,” the declaration continued, “is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” (“Declaration of Alma-Ata” 1978). Famously, the WHO committed itself to the goal of achieving “health for all by the year 2000.” In contrast to the UN NCD Declaration in 2013, this earlier declaration positioned health as both a human right and as a “most important world-wide social goal” – one that the resources of the economic sector must be harnessed to support.

How did the conceptualization of health that underpins world health efforts transition from an end-in-itself to a means towards economic growth? What prompted the transition from “health for all” to “health as investment?” Put differently, what explains the *economization* of global health over the past 25 years?

13.3 World Health and the World Bank

Throughout the 1980s the field of international health was beset by a number of tensions: debate over comprehensive vs selective primary health care, vertical vs horizontal approaches to health interventions, and budgetary crisis as well as crises of legitimacy at the World Health Organization. Although the conference at Alma-Ata represented a high point in the history of the WHO, it also marked the beginning of a long, slow decline in the organization's prominence. After Alma-Ata, the goal of "health for all" came to be seen by influential parties such as the United States Government, UNICEF and the Rockefeller Foundation as overly ambitious and unrealistic (Birn et al. 2009; Brown et al. 2006; Cueto 2004). Without disavowing the *goal* of health for all, they began to advocate a different means by which to accomplish it. As opposed to what was now termed "Comprehensive Primary Health Care" (CPHC), these actors articulated a vision of "Selective Primary Health Care" (SPHC) emphasizing specific, low cost technical interventions that were limited in scope and easy to monitor and evaluate (Balabanova et al. 2013; Walsh and Warren 1979). Specifically, SPHC advocated a four-pronged approach to reducing child mortality known by the acronym GOBI: Growth monitoring (to ensure early detecting of childhood malnutrition), Oral Rehydration Solutions (for diarrheal diseases), Breastfeeding (for improved infant survival and natural family planning) and Immunization against certain communicable diseases. While successful in improving child survival the SPHC approach drew criticism from advocates of a broader-based *comprehensive* primary health care approach. The growing tension between advocates of SPHC and CPHC caused considerable tension at the WHO.

Against this backdrop, the World Bank "moved confidently into the vacuum created by an increasingly ineffective WHO" (Brown et al. 2006, 86). Although the Bank's initial interest in health extended only to population control, by the early 1980s the newly founded Population, Health and Nutrition Department began lending for stand-alone health programs on the rationale that enhanced health and nutrition would lead to increased economic growth (World Bank 1980). However, with World Bank money came their associated structural adjustment policies, which, in the domain of health focused on more efficient use of available resources and an increased role for the private sector in financing health services – all in service of promoting health for economic growth. While this approach drew much criticism from those who opposed privatization of the health sector, it did not stem the influence of the Bank and by 1990 World Bank lending for health surpassed the entire WHO budget (Brown et al. 2006). From the late 1980s to the late 1990s, Bank lending for health, nutrition and population projects grew sevenfold – with a growing proportion of these loans made with the explicit intention of reforming the structure of health systems (Fair 2008).²

The changing structural organization of international health coincided with a shift in the field's conceptualization of its primary targets due to "health transition." A pre-transitional environment dominated by high fertility and high mortality was seen to be giving way to a low mortality, low fertility environment (Frenk et al. 1989). While the

² During the late 1970s, fewer than 10% of World Bank Population, Health and Nutrition loans included "systemic" objectives. By the late 1990s, this number had risen to well over 50% (Fair 2008, 10).

health transition held general implications for the orientation of the world health agenda – away from population control and towards diseases of old-age, for example – the precise consequences of the transition for the global incidence of disease and for the exact interventions necessary to curb its spread were unknown. This knowledge deficit presented a two-fold problem for the Bank. First, while the Bank was interested in helping to reform health systems to provide a package of “essential health services” it was unclear to which diseases these services should be targeted. Second, in the absence of systematic estimates of the global burden of disease, statistics on disease prevalence were frequently provided by disease-specific advocates. These numbers were viewed with deep suspicion by World Bank health experts (Jamison et al. 1993; Murray and Lopez 1996; World Bank 1993). The Bank thus undertook a wide-reaching Health Sector Priorities Review which yielded a constellation of studies – most significantly the Disease Control Priorities Project (DCPP) (Jamison et al. 1993) and the Global Burden of Disease Study (GBD) (Murray and Lopez 1996). Results from both of these projects served as background to the landmark *World Development Report 1993: Investing in Health* (World Bank 1993), the publication of which is frequently cited as a watershed moment in the transition from international to global health. Importantly for my purposes, the *World Development Report 1993* (WDR 1993) also introduced the Disability Adjusted Life Year metric.

13.4 The DALY Metric

The architects of the DALY metric devised their new method for measuring the global burden of disease in order to account for the “full loss of healthy life” due to disease, death and disability on a global scale and to determine global health priorities according to cost-benefit analyses (Lopez 2005). Previous attempts to gauge the relative importance of different diseases used mortality statistics, disease prevalence rates, or risk of death calculations to determine the *number* of deaths due to various diseases (Feachem et al. 1992). The DALY metric, in contrast, sought to account also for the *burden* of diseases and conditions that may not be fatal, but by virtue of their duration and disabling effects contributed to economic “losses” in the form of diminished productivity and strain on health systems.³ The DALY metric thus used “life-years” as a smaller and more commensurable unit than calculations made in terms of individual human lives.⁴

In its simplest presentation the DALY metric expresses “years of life lost to premature death and years lived with a disability of specified severity and duration” (Murray and Lopez 1996b, 7).

$$\text{DALYs} = \text{YLL} + \text{YLD}$$

³ Ayo Wahlberg and Nikolas Rose have analyzed the DALY metric and disease *burden* concept as part of a longer history of what they call the “governmentalization of living” (Wahlberg and Rose 2015).

⁴ While not the focus of the present paper, it is important to note also that by disaggregating lives into “life years”, the DALY metric also provided a unit-measure with which to perform cost effectiveness analyses without appearing to put a dollar value on individual human lives.

However, a more technical description can be found in the WDR 1993, which explains that the DALY metric “measures the present value of the future stream of disability-free life lost as a result of death, disease, or injury” (World Bank 1993, 27). This measurement is made using a number of econometric techniques. I focus on two: age weighting and discounting.⁵

13.4.1 Age Weighting

Age weighting gives different value to years of life lost at different stages of the life course. It was incorporated into the DALY metric by “consensus judgment” in order to reflect the idea that “most societies attach more importance to a year of life lived by a young or middle-aged adult than to a year of life lived by a child or an elderly person” (World Bank 1993, 26 & 213). However, even if life was held to have the same *intrinsic* value at every age, one might still “attach greater importance to years of productive adult life” because of the importance of adults as “net producers” i.e. for their increased human capital and resulting contribution to economic growth (Murray and Lopez 1996). As a result of age weighting, the relative value of life rises steeply from zero at birth to its peak at age 25 before falling gradually with advancing age. The precise values used for DALY calculations were chosen so that the total number of DALYs is the same as though uniform age weights had been used (World Bank 1993, 213). But age weighting redistributes DALYs away from the early and later years and concentrate them on the middle, economically productive years of life – i.e. those years most critical to the Bank’s priority of economic growth.

13.4.2 Discounting

The DALY metric also incorporates a discount rate (of 3%) such that future years of healthy life are valued at progressively lower levels into the future. This reflects what the GBD authors saw as a general societal preference for immediate gains: “[...] societies typically prefer to have a given amount of consumption today rather than tomorrow” (World Bank 1993, 213). However, the inclusion of this purportedly “typical” social value also has considerable consequences for the distribution of DALYs. Like age weighting, discounting results in the relatively greater valuing of economically productive middle years of life because the future years of life lost from

⁵Other components of the DALY metric include the severity weights that are used for calculating the impact of disability and the use of a global standardized life expectancy. Disability weights have been debated extensively in the scientific literature (Anand and Hanson 1997; Anand et al. 2004). I discuss both of these additional components of the DALY metric in my forthcoming dissertation. For my purposes here, it is important simply to note that economic productivity is also central to the determination of disability weights in so far as the ability to perform in one’s occupation is a key feature of the disability weighting scale.

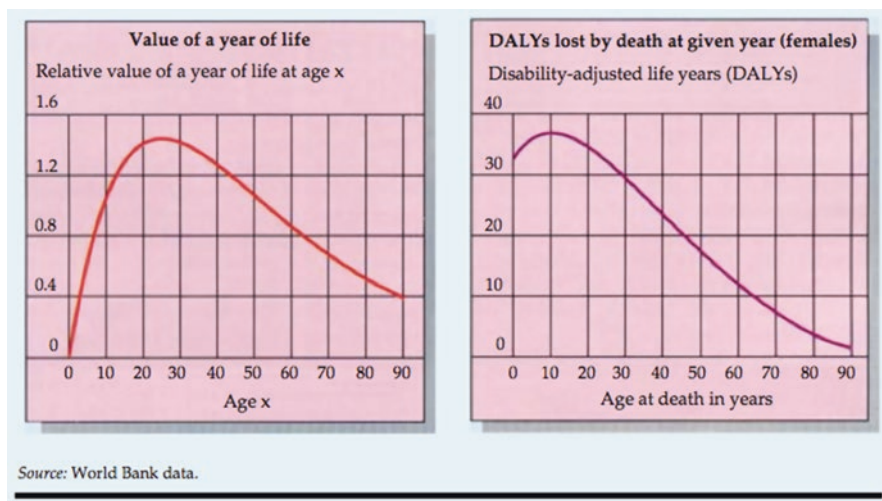


Fig. 13.1 Age weighting and resulting DALYs lost from early death (Reproduced from World Bank 1993, 26)

childhood deaths is discounted over a longer period. The contribution of childhood deaths to the global burden of disease is thus given relatively less *numerical* significance. As the GBD authors acknowledge “[...] higher discount rates reduce the importance of premature deaths at young ages in relation to those at older ages” (WDR 214).

The incorporation of age weighting and discounting functions into the DALY metric minimizes the contribution of childhood deaths to the global burden of disease and puts relatively greater value on the middle economically productive years of life – precisely those years deemed most important by the Bank for increasing economic growth. Figure 13.1 illustrates the age weighting function and the combined impact of age weighting and discounting on the resulting DALYs lost to death at different ages across the life course.

The relatively greater weighting of the middle, economically productive years of life in DALY calculations reflects a central tenet of the field of health economics as it has developed since the 1970s and 1980s: the conceptualization of health as a form of human capital.

13.4.3 Health as Human Capital

Each of the technical dimensions of the DALY metrics is underpinned by a general conceptualization of health as a form of “human capital” – a Nobel-prize winning approach within the field of economics developed by the Chicago School’s Theodore Schultz and Gary Becker (Becker 1962; Schultz 1961). Although human capital theory met with resistance and controversy upon its initial introduction and

development in the 1950s and 1960s, by the 1990s, it had become a central tenet of both micro and macro economic theory and key to the rapid expansion of the field of economics through so-called economic imperialism (Becker 1992; Fourcade 2006; Fourcade-Gourinchas 2001; Mitchell 2006).

Becker defined human capital as those “activities that influence future real income through the imbedding of resources in people” including the knowledge, skills, dispositions and health that are embodied in people that make them economically productive (1962, 9). Some of the ways to invest in one’s human capital, Becker argued “include schooling, on-the-job training, medical care, vitamin consumption, and acquiring information about the economic system” (1962, 9). These investments vary in their relative effects on earnings, that is, in their relative return on investment. “But all improve the physical and mental abilities of people and thereby raise real income prospects” (Becker 1962, 9).

While Becker acknowledged the importance of health as a form of human capital, the concept was more fully theorized by Becker’s student Michael Grossman (Grossman 1972, 2004). He conceptualized health as something consumers demand for two reasons. First, as a consumption commodity it “enters into their preference functions,” that is, people prefer a state of health over a state of ill health. Second, and importantly for the argument here, health is conceptualized as an investment commodity because it “determines the total amount of time available for market and nonmarket activities [... such that] an increase in the stock of health reduces the time lost from these activities [i.e. time away from market and non-market activities]” (Grossman 1972, 225). Investing in one’s health extends the *duration* of possible participation in market and non-market activity and maximizes the term over which investment in one’s human capital can be realized.

The DALY metric was designed for the purposes of carrying out cost-benefit analyses of potential health interventions so as to design economically rational health systems. But more than just facilitating cost-benefit analyses, the DALY metric accomplishes an *economization of health* by imagining health as a form of human capital.

13.5 NDCs on the Global Health Agenda

Because of the higher valuing of economically productive middle years of life in DALY calculations, disease of middle age – notably NCDs – achieved greater prominence in the Global Burden of Disease (GBD) results (Murray and Lopez 1996, World Bank 1993). Before the introduction of the DALY metric, the then-current most comprehensive study of adult health worldwide concluded that “mortality from non-communicable diseases declines as overall mortality declines” (Feachem et al. 1992, 94). This suggested that as countries’ death rates declined as they entered “health transition” so too would NCDs. However, after the introduction of the DALY metric just a few years later, the GBD would report that NCDs represented the single largest category of DALYs lost worldwide – greater than either communicable diseases or injuries (Murray and Lopez 1996). Furthermore, it would predict that by 2020 NCDs would account for more than 70% of deaths in

developing regions (Murray and Lopez 1996). At the same time, the Disease Control Priorities Project (DCPP), also sponsored by the World Bank, would make a strong case for cost effectiveness of health interventions designed to mitigate NCD risks – notably those directed towards personal behavior change (Jamison et al. 1993).

The introduction of the DALY metric by the World Bank’s World Development Report 1993: *Investing in health* brought NCDs into clear focus on the global health agenda. And this focus was further institutionalized in the early 2000s when the WHO officially adopted the DALY metric for purposes of disease quantification and cost-effectiveness analyses for purposes of priority setting (World Health Organization 2000). By September 2011, NCDs had come to occupy such a central position on the global health agenda as to warrant a UN High Level Summit meeting – only the second such meeting in the history of the UN.

13.6 Conclusion

The creation of the DALY metric by the World Bank in the early 1990s brought NCDs firmly onto the global health agenda. However, as this paper has suggested, the DALY logic by which NCDs became a global health priority depends on a vision of health as a form of human capital and as a site of investment. This can be seen in some of the more technical dimensions of the DALY metric, age weighting and discounting, for example. The political implications of the DALY metric – the redistribution of DALYs away from childhood disease and diseases of old age and towards the middle, economically productive years of life – are frequently obscured by the apparent objectivity of the numbers produced by DALY calculations. Yet these implications remain inseparable from the rising prominence of the World Bank in world health affairs since the late 1980s, its efforts to restructure health systems according to cost effectiveness, and its greater valuing of the economically productive middle years of life so as to prioritize health for economic growth.

More generally, the creation of the DALY metric and concomitant rise of NCDs as a global health priority coincides with the broader shift from international health to global health that has occurred over the last 25 years. The causes and consequences of this shift have only recently begun to receive sustained scholarly attention (Anderson 2014; Lakoff 2010; McGoey et al. 2011; Wahlberg and Rose 2015). But in this paper, I have suggested that this transition may productively be understood in relationship to the rise of economic rationalities in the field of world health. In contrast to a post-war vision of health as a human right and social good – a vision that came to be enshrined in the Alta Ata declaration of 1978 – the contemporary era of global health conceptualizes health as a form of human capital and as a site of investment. The transition from “health for all” to “health as investment,” then, can be understood in relation to the economization of world health at the dawn of the twenty first century.

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