The Political Economy of Health Transitions in the Third World

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The health transition, according to some social scientists, can best be understood as a social or behavioral phenomenon (Caldwell 1990; Findley 1990). They have argued that the key determinants of shifting patterns of mortality are found in the behaviors and values of society. It seems unlikely, however, that the transformations in mortality and morbidity now underway in poor countries can be reduced to theories that focus solely on bringing people to technology, changing individual behaviors, or altering social values. These societies are now undergoing complex social changes, including processes of commercialization, medicalization, and internationalization. These processes, all shaped by the distribution of political and economic resources, are affecting developments in health.

The resulting transitions are not necessarily in healthy directions for all social groups. New social risks — including environmental hazards, factory production processes, and traffic accidents — create new patterns of morbidity and mortality. As Julio Frenk and his colleagues have argued, the health transition (at least in some countries) is not unidirectional, does not follow clearly separated stages, and produces a maldistribution of health among population groups — resulting in what they call a "protracted and polarized" transition (Frenk et al. 1991) (See also this volume). An explanation of such health transitions in poor countries needs to consider the distribution of political and economic resources at both the national and international levels. This chapter's central point, in short, is that an analysis of political economy is essential to understanding health transitions in the Third World.

The approach of political economy covers many forms of analysis, including both Marxist and non-Marxist varieties. In general, this
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Perspective seeks to identify systematic relationships between economic and political processes and the resulting impact on the distribution of resources within a particular community (local, national, or global). The approach can be used to explain political and economic phenomena (such as powerlessness or poverty) as well as other conditions (such as poor health or illiteracy). Different forms of political economy give precedence to economic or political factors as primary determinants. Some forms stress how power and political principles influence the behavior of markets; for example, how structure of the state affects national economic success or failure. Other forms emphasize how economic principles explain political actions; for example, how governmental decisions on policy result from rational economic calculations. The 1970s and 1980s witnessed a distinct analytic turn in the direction of political economy for the study of rich countries (Lange and Meadow 1985) and poor countries (Chilcote 1985) and for the processes of development (Bates 1988b).

In the study of Third World health conditions, the approach of political economy has lagged behind the subdiscipline of health economics. The technocratic appeal of economic techniques, such as cost-benefit analysis and cost-effectiveness analysis, makes health economics appear desirable to governments, corporations, and international agencies. The practical problems of pricing health services, for both public and private institutions, are assisted by economic models that estimate the likely financial consequences of different decisions. By contrast, the analyses of political economy can raise uncomfortable questions for those who sit in the seats of public and private power. This inherent tension with established institutions may be one reason for the relative underdevelopment of health political economy in comparison with health economics. While health economics helps define what and how much should be allocated for health problems, political economy helps explain why a particular allocation occurred and why the actual distribution diverged from the predicted one.

Despite these difficulties, a growing number of studies are appearing on the political economy of health in the Third World (and a substantial literature exists on the political economy of health for the United States). Critical analyses have been done of the health consequences of capitalist expansion in the Third World (Doyal and Pennell 1979; Elling 1981) and of the role of international agencies in advancing those processes (Navarro 1984). Case studies have analyzed the impact of political economy on health transitions in particular countries, such as India (Jeffrey 1988) and China (Sidel and Sidel 1973; Chen 1988). Studies of specific technologies and products have shown how political and economic forces, both domestic and international, shape the interaction of society and technology in producing good (and bad) health consequences in the Third World; these products include tobacco (Barry 1991), pharmaceuticals (Gereffi 1978; Lall and Bihle 1978; Reich 1987), and infant formula (Sethi et al. 1986). Analysts have also addressed the international transfer of specific organizational forms, such as for-profit hospitals operated by private multinational corporations, and the probable effects on health policy and access to health services in poor countries (Berliner and Regan 1987; Roemer 1987).

These studies on the political economy of health transitions in the Third World have implicitly or explicitly adopted one of two broad normative approaches. The first stresses the positive role of government intervention, and the second emphasizes the importance of market forces. These two approaches reflect a broader intellectual division in political economy (Lindblom 1977), what Charles Wolf (1988) called the choice between the "imperfect alternatives" of governments or markets. Although advocates of these two approaches to good health do not always portray themselves in tension, they in fact pull in quite opposite directions. This lack of self-awareness is due in part to a deficiency in the political analysis of health systems. In this chapter, I use political analysis to critically review these two approaches and to identify problems with each perspective. I also argue that political analysis is essential to an understanding of health policy making and to efforts that seek to shape health transitions in the Third World.

The government intervention school advocates activist health policy to achieve advances in health conditions in poor countries. According to this school, government intervention is necessary to correct the market's allocation of health resources, biased toward the more powerful and wealthy groups in society, through technology selection, geographic location, and access criteria. Some members of this school propose that a government with the proper commitment, with "political will," can achieve good health for the entire population. For example, a conference sponsored by the Rockefeller Foundation in 1985 on "good health at low cost" (Halstead et al. 1985) concluded that "a sustained political commitment to universal health and well-being" was the major factor responsible for health success in countries with low per capita incomes.
more vulnerable groups in society. This distribution might be carried out through the direct delivery of services, through government-owned and operated facilities or through other means (such as national health insurance) to assure adequate access to affordable health resources. The strategy is based on the assumptions that governments possess the knowledge and capability to improve health conditions in society and that market imperfections require government intervention. In many countries, the constitution specifies health as a basic right and mandates government action to provide and protect this right. The simplest version of this argument states that government intervention improves health in poor countries when there exists “political will.” In short, if national leaders only exercised their political will, then health transitions would occur in a positive direction. This formulation, however, has multiple problems.

The Concept of Political Will: At a broad level of generality, the call for political will strikes a chord of common sense. What self-respecting public health professional would disagree with the need for political leaders to be committed to good health? — especially if commitment means increased budgetary allocations to the health sector. But what does political will really mean as a necessary condition to get good health at low cost? And which political conditions produce the “will” that leads to good (or at least better) health in poor countries? Is political will the same regardless of regime type? What role does ideology play in the adoption of political commitment to equity and good health? Are some forms of the state more likely to produce good health than others? The invocation of “political will” rarely provides answers to such questions.

But the conceptual ambiguity of political will has not stopped its use. The phrase appears frequently as an “op-ed” concept, often in articles opposite the editorial page in newspapers and with little systematic explanation. One example was the call for new public policies that could solve the problems of homelessness: “We know what needs to be done: what is lacking is the political will to do it” (Swanson 1989). The “failure of political will” has also been noted, in passing, as a reason for government’s not implementing public policies on the export of hazardous substances (Jasanoff 1985:143). Others have called for making political will “more than a slogan,” as did the authors of a study of antipoverty policies in the Third World (Lewis et al. 1988:25). Clear definitions of political will, however, are difficult to find. More com-
monly, the flag of political will is waved along with a tone of moral exhortation.

While the notion of political will may seem intuitively obvious to some observers, others have criticized it as an analytic concept. Lynn M. Morgan (1989) argued that efforts to explain Costa Rica’s experience with primary health care, through the concept of political will, end up being misguided, superficial, and unhelpful. She questioned whether political will ever existed in Costa Rica and showed how use of that phrase has masked both domestic and international political processes. Along similar lines, Paul B. Vitta attacked the notion that African countries “simply” need political will in order to enact effective technology policies, “as though all it requires is the pure act of a polity changing its ‘mind’ from one state to another” (n.d.). More generally, Pranab Bardhan noted that chronic failures of policy implementation in the Third World are often ascribed to “a lack of ‘political will’ (whatever that means) or a lack of ‘social discipline’” (1988:55). Other analysts have similarly criticized the pattern of blaming failure of policy implementation on a lack of political will. Merilee S. Grindle and John W. Thomas, for example, consider the term a “catch-all culprit” that has “little analytic content,” adding that “its very vagueness expresses the lack of knowledge of specific detail” (1991:122-124).

Yet political will remains an attractive phrase. The conference sponsored by the Rockefeller Foundation in 1985 on “good health at low cost” successfully established the concept of “political and social will” as a necessary element in efforts by poor countries to improve their health conditions. The conference publication has become a basic reference in discussions of the health transition, and the conclusive phrase on “will” has percolated into international discourse. For instance, a report on health research strategy for the World Health Organization used the felicitous Rockefeller phrase without citing its source. While noting problems of incomplete conclusions, the WHO report stated that “in a Third World country which seeks to progress rapidly, an essential requirement, and in a sense the starting point, is the political and social will to bring about improvement” (WHO 1988:5).

Papers in the Rockefeller volume suggested two ways to operationalize the concept of political will. One operational indicator might be government legislation for social welfare. Patricia Rosenfield used “historical commitment to health as a social goal” as an indicator of political will. She assessed this factor by determining whether there existed early legislation, early government welfare policy, early medical systems, or Christian missionary influences. But it is unclear which aspect is most important: the historical length of the commitment (how long ago or how early in the development process legislation was adopted) or the intensity of the commitment (the degree of implementation or the level of resources invested in the program). Moreover, governments might exhibit an historical commitment to health, but without producing good or better health. Perhaps historical commitment represents a necessary but not sufficient condition.

Another way to operationalize the concept might be through an analysis of per capita health expenditure. Countries with comparatively high expenditure would be considered to show relatively high levels of political will. In his essay in the Rockefeller volume, Dean Jamison demonstrated that China came out with 25 percent above its expected per capita health expenditure for its GDP, in a comparison with 19 countries in 1975 with per capita GDP under $2,000 (Jamison 1985:31-32). China’s higher than expected health expenditure, for its level of per capita income, could be interpreted as reflecting a greater than normal degree of political will. This finding, however, creates some problems for the Rockefeller volume’s main theme of “low cost.”

Indeed, “good health at low cost” may be the wrong phrase, since the three other cases in the Rockefeller volume also showed comparatively high government expenditure on health (Joseph 1985:226). The critical question may be how to maximize public and private expenditures on health despite extremely limited resources due to poverty. Perhaps the volume should have been titled “good health despite extreme poverty,” or the phrase used in Costa Rica, “health without wealth” (Morgan 1989).

In conditions of extreme poverty, the allocation of scarce government funds to health compared to other sectors could provide an indication of political will. This concept of a discrete government decision to do x rather than y fits well with conventional political analysis. One problem, however, is that a government decision to invest in health facilities rather than road construction, for example, could be interpreted by transportation advocates as illustrating a lack of political will.

Neither of these two approaches to political will is particularly persuasive. In the Rockefeller volume, the conceptual ambiguity of “political will,” as with “low cost,” may result partly from the format. Conference publications often suffer from uneven analysis. The Rockefeller volume lacked an introductory essay to pull together the individual
efforts and critically reflect on the concepts and contributions. Although a central answer to the conference question (when does a society obtain good health at low cost?) focused on political commitment, the volume included little systematic analysis of political factors. Even at the end of the volume, the causal chain between political will and health outcomes remained cloudy. To be analytically useful, the concept of political will requires at least a clear definition.

Davidson R. Gwaltkin (1979) used the concept of political will with more analytic care to explain India’s aggressive pursuit of family planning in 1976. He employed the concept to mean that leaders, in pursuit of their goals, introduce incentives and sanctions to change the political costs and benefits associated with specific policies for lower-level political officials and civil servants. Gwaltkin showed how the “application of political will” to family planning, as previously advocated by critics of the government in this area, produced coercion and chaos (1979:31). But his analysis tended to stress policy goals more than political goals; he understated the extent to which India’s focus on family planning in 1976-77 belonged to Sanjay Gandhi’s political strategy to extend personal and party power. Raising the political costs and benefits of implementing family planning achieved the policy objectives in some regions, but it also created a huge reservoir of opposition that contributed to Mrs. Gandhi’s electoral defeat in 1977. The focus on family planning failed not only because it neglected other development measures and “the larger end of human well-being” (1979:51), but also because it miscalculated the political costs and benefits.

The lack of specificity for the concept of political will could be precisely its source of popularity. Politicians and journalists may think in terms of “political will” and find it a convenient slogan for criticism of opponents. But a phrase from public discourse does not necessarily produce a concept with analytic power. A better approach to assessing when government intervention is likely to occur and succeed would be to draw from a political economy model and apply a form of political cost/benefit analysis (Majone 1975). This approach would stress political feasibility rather than political will (May 1986). As discussed below, the value of this analysis would depend on an appropriate selection of cases, a full assessment of trade-offs, an analysis of political regime characteristics, and an understanding of the dominant political and economic interests.

Selection of Cases: Comparative analysis of public policy requires care in the selection of cases and the justification of choices (Przeworski and Teune 1970). A comparative study without an adequate explanation of how the cases were chosen should be treated with caution, as should any conclusions from the study.

The selection of the four case studies in the Rockefeller volume presumably resulted from an assessment of societies that have achieved good health at low cost. Yet nowhere does the volume provide a coherent justification for this four-some. Two sentences in the editors’ preface address the process of selection: “In absolute dollar expenditures, the health gains of China, Kerala State, Sri Lanka and Costa Rica were achieved at relatively modest cost. Each of the success stories described has evolved, with one exception, in countries with unusually low gross domestic product per capita” (Halstead et al. 1985:5). This brief mention begs three questions.

First, what about other similar cases? One left-out case is Cuba, which has per capita income midway between Sri Lanka and Costa Rica, with similar life expectancy of over 70 years at birth (Jamison 1985:22). The conference apparently included Cuba in its initial program but then dropped the case before the meeting. Yet no explanation for Cuba’s exclusion appears in the volume. The case of Cuba could have provided an important perspective on the political processes of allocating scarce resources to the health sector and the anticipated political benefits in the domestic and international spheres.

Cuba’s concerted strategy to become a “world medical power,” in the words of Fidel Castro, has generated both material and symbolic benefits (Feinsilver 1989). While not among the world’s leaders in biomedical research, Cuba has achieved health indicators similar to those of rich countries and has provided substantial medical assistance and services to other nations, especially in Africa. According to one assessment, these activities have created “legitimacy, prestige, and influence” for Cuba in both domestic and international spheres (Feinsilver 1989:26). The case of Cuba demonstrates that health can be considered not only as an end in itself but also as a means to other political and economic goals.

Another unanswered question is the inclusion of Kerala State among the case studies. Kerala’s fame as an overachiever in health within India deserves recognition. But are the conclusions of analysis at the subnational level of government applicable in other contexts for national governments? For example, is political commitment at a subnational level the
same as that at a national level? Also, do similar overachieving regions (with distinctive political traditions as found in Kerala) exist in other large and complex poor countries, like China?

One paper in the Rockefeller volume on Kerala State did follow appropriate principles of comparison by focusing on two subnational governments. Moni Nag (1985) compared the impact of social and economic development on mortality in Kerala with that in West Bengal. These two Indian states have similar standards of living and share an emphasis on education and a leftist political orientation, but have diverged historically in their mortality rates. A subsequent study by Nag (1989) pursued these differences for the two states and concluded that Kerala had stronger sociopolitical movements in rural areas and had political parties more oriented toward rural mobilization. These factors gave rise to rural Kerala's greater political awareness, which contributed to more health facilities and their better utilization in rural Kerala than in West Bengal. In his concluding paragraph, Nag noted that his conclusions at the subnational level supported the findings of another analyst on political processes at the national level in developing countries. While not addressing the differences directly, Nag seemed to recognize that such generalization took him out on an analytical limb.

A third issue not addressed in the Rockefeller volume was the strategy of analysis implicit in the selection of cases. One might learn just as much from a comparative analysis of cases of poor health at high cost. Consideration of several countries with high per capita incomes but poor health performances (such as some oil-rich nations) might help illuminate the nature of political commitment in different national contexts. Exploring government failures could help explain the limits of government expenditure in improving health conditions, especially how the strategies and efficiencies of health expenditures relate to political benefits. This analysis could also provide a more critical view of calls for political will.

Trade-offs: Intervention by governments to improve health can also have trade-offs, with both political and economic consequences. The advocates of government intervention rarely address the potential trade-offs of specific public programs or of broader social changes toward greater equity. A reallocation of resources to improve the health conditions of one group can impose economic as well as political costs on other parts of society. That reallocation can occur across ethnic, class, or geographic lines. Deciding whether those trade-offs are justified depends on a broader vision of social justice. Knowing a society's limits in tolerating increased costs for particular groups requires a good understanding of political economy.

The economic trade-offs of government interventions to reallocate resources to improve health take many forms. Government efforts to improve equity may be accompanied by losses in efficiency. The allocation of resources to primary health care, for example, could improve the access of poor people to health facilities, but at the same time could reduce overall productivity, especially if the supply system is unable to provide rural health workers with adequate materials. The efficiency losses of government interventions in the market and the problems of implementation are well portrayed by the advocates of market forces (as discussed below). But advocates of government intervention tend to underestimate possible contributions of the market in allocating resources to improve health (Reich 1987).

Economic trade-offs also arise in the reallocation of resources from the hospital sector to primary health care and from urban to rural sectors, which are considered key elements in achieving good health in poor countries (Segall 1983). In most poor countries, the bias in development favors the urban sector, through policies on agricultural and food prices, food subsidies, and foreign exchange and trade (Lipton 1977). Reversing this urban flow of resources would impose increased costs on urban residents, for example, through higher food prices, or in the health sector, through higher costs or reduced availability of health services. W. Henry Mosley concluded, "This gets back to a political commitment to equity" (1985:244). While true, the statement does not help us understand when that political commitment can be implemented, or what kind of political regime can withstand the pressures of the economic trade-offs imposed on the urban sector.

The case of China poses the issues of political trade-offs. China's health advances have depended on a strategy of mass mobilization in national campaigns that were centrally initiated and organized. From the 1950s through the 1980s, China averaged four or five health campaigns a year (Jamison 1985:26). To an important degree, this strategy belongs to China's post-1949 authoritarian state with its emphasis on central control and mass mobilization. In short, the improvements in national health may have depended on the limitations in political liberty (and their costs for certain groups in the population). The national campaigns of mass mobilization for health improvement bear striking and troubling
resemblance to the destructive campaigns of the Cultural Revolution. The effectiveness of China’s health campaigns may have required the repressive national political economy. If so, could political and economic liberalization in China contribute to a slowdown in health advances? More broadly, to what extent are health improvements and democracy incompatible in China?

Political commitment to equity thus is not costless. The reallocation of social resources through revolutionary processes, in particular, can impose substantial costs in the restriction of personal freedoms and the loss of lives. Yet analyses of China’s health achievements rarely consider the health costs of social revolution or else mention them only briefly in passing (Chen 1988:297). The experiences of the Soviet Union, with its history of gulags, illustrate similar problems, although the costs imposed in that country are more readily admitted and the health achievements are not held up today as an international model for replication.

Finally, an ideological commitment to equity may be a necessary component for government intervention to improve health (Caldwell 1986; Reich 1988b), but it rarely is sufficient. The Soviet Union provides a striking example of how political commitment to social equity through government intervention in health can fall short of the original ideals and hopes for socialized medicine. The mortality increases and quality problems in the Soviet health system are well recognized today (Davis and Peshbach 1980; Eberstadt 1988:11-33). As Mark G. Field (1990) observed, the Soviet health system illustrates how noble purpose combined with flawed execution to produce mixed results. Elsewhere as well, recommendations for government intervention and political commitment, which ignore the vast obstacles to implementation and the potential problems of centralized control, are unlikely to achieve the desired results.

The Nature of Political Regimes: Political scientists have compared regimes for quite some time in efforts to determine whether one type is “better” than others for social welfare. Studies in the 1960s and 1970s sought to relate regime characteristics, such as civil versus military, to differences in public policy or economic performance. The analyses generally concluded that other variables (such as socioeconomic factors) provided greater explanatory power (Bossert 1983). Since the late 1970s, however, studies have moved beyond the simple distinction between civil and military regimes to find more complex sources of variations in political regimes that affect the adoption and implementation of public policies in the Third World (Stepan 1978; Cleaves 1980).

The impact of regime type on health remains relatively unexplored. One analysis of the causes of sickness and well-being for nations ignored regime type almost completely (Sagan 1987). In the Rockefeller volume, only Patricia L. Rosenfield (1985) attempted a direct comparison of political regimes. She noted that the “political economic orientations vary both between the examples and over time within each situation.” In conclusion, she stated, “On the basis of these four examples, no single political or economic approach can claim greater facility in creating conditions conducive to the improvement of health” (Rosenfield 1985:175). More concerted analysis of political regimes is needed to improve our understanding of government intervention.

Thomas John Bossert has analyzed the impact of regime characteristics on health policy as the dependent variable (rather than on health outcomes as done in the Rockefeller volume). He examined the adoption and implementation of primary health care policies in four Central American countries (Guatemala, Honduras, Costa Rica, and Nicaragua), and considered regime characteristics along four dimensions: strength of the state, stability, ideology, and democracy. Bossert explained the logic of relating these four dimensions to primary health care policy in the following hypotheses (1983:426):

Strong regimes will have the capacity to adopt and fund innovative health programs because they will be able to extract sufficient resources and distribute those resources to non-dominant sectors of society. Stable regimes will be most able to implement these policies because they allow more continuity in the bureaucracy. Progressive regimes will pursue more social welfare policies. Democratic regimes will give more voice to lower class beneficiaries and therefore be more responsive to their demands.

Bossert’s study did not find any simple relationships between one dimension of regime characteristics and the adoption of primary health care policies. Both stable (Costa Rica) and unstable (Guatemala and Honduras) regimes adopted the policy, as did reformist (Costa Rica and Sandinista Nicaragua) and status quo (Guatemala and Honduras) regimes. But he did identify several complex “contingent” relationships among the variables (1983:426). Status quo regimes that are threatened with instability have a greater incentive to adopt these policies, as an
effort to coopt potential rural support to opposition. "In a status quo regime, instability may be an incentive to adopt minor reforms. The status quo regime that was unstable — Guatemala — was one of the first in the world to adopt the reforms" (1983:436). Without that threat, stable regimes (like pre-1975 Somoza Nicaragua) have little incentive to adopt such reforms.

Bossert reached similarly complex conclusions about implementation, although single dimensions of regime characteristics tended to show greater influence on these processes. Weak and unstable regimes (Honduras and Guatemala) showed a lack of centralization and integration, two important variables for successful implementation, in contrast to the strong and stable regime of Costa Rica. Bossert suggested that weak and unstable regimes may not design policies that can be effectively implemented because of the potential threat that a successful program would pose to political and economic elites. Moreover, when weak states do design primary health care policies they are more likely to depend on foreign funding (such as Guatemala), in contrast to strong states (Costa Rica) that can allocate national resources to rural areas.

Bossert's overall conclusion stressed the importance of regime analysis. "At the very least, this study suggests that advocates of policy changes take into account regime characteristics when they design strategies for the adoption and the implementation of preferred policies" (1983:439). The nature of the political regime will affect the public policies for health, and thereby (presumably) will influence health outcomes. Bossert's analysis also suggests that in addition to the regime, one must also understand the role of political and economic interests in society.

The Role of Interests: Appeals for government intervention in health and for political commitment to equity often approach these as disinterested concepts and normative values, to be accomplished for humanitarian goals. Only rarely do the appeals recognize that politics is not simply a residual variable in public health but a primary determinant of who gets what, and thereby has a major impact on health status. W. Henry Mosley acknowledged the distributitional consequences of political and economic interests when he commented, "The real question is not 'What is the cost?' but, rather, 'Who pays and who benefits?'" (1985:244). Improving the health of the majority in a poor country probably involves an income transfer of one sort or another, which affects the distribution of resources in society. The organization of interests in that particular society will influence the adoption and implementation of policies, as well as the ultimate health outcomes.

Compared to the field of health policy, the study of agricultural policy in poor countries has achieved a greater understanding of the role of interests in shaping government intervention. Robert H. Bates argued persuasively that the stated social objectives of governments do not adequately explain the particular forms that agricultural policy takes in the Third World (Bates 1988a). The dominant pattern of agricultural policy, in Africa as in other poor countries, does not favor the majority of producers. Government objectives to increase food supplies, to strengthen incentives for food production, to increase output, and to meet shortages are systematically translated into policies that fail and that tend to impose costs on most agricultural producers. Bates concluded (1988a:345):

The policy instruments chosen to secure social objectives are... often inconsistent with the attainment of these objectives. And yet the choices of governments are clearly stable; despite undermining their own goals, governments continue to employ these policy instruments. Some kind of explanation is required, but one based on factors other than the social objectives of government.

In short, the notion of governments as "agents of the public interest" cannot explain choices of policy. Bates offered two alternative political explanations.

The first alternative views governments as agents of private interests. Here, public policy results from the pressures of organized interest groups, reflecting an established approach in political analysis. For agricultural policy, governments in poor countries tend to make pricing decisions that benefit urban consumers rather than rural producers, because urban residents often constitute an important political constituency and tend to be better organized and more powerful. Higher food prices can squeeze wages and profits, compelling both workers and employers to pressure governments for price reductions. And small-scale farmers, more often than not, bear the costs of lowered food prices for urban consumers (Bates 1988a:345-351). Small-scale farmers can assert their interests and oppose the urban bias of agricultural policy by influencing national leaders through two methods: organization of pressure groups and participation in competitive elections.
The second alternative proposed by Bates views governments as agencies that seek to retain power. Governments design policies and programs to secure control over the majority of the population and thereby to remain in power. Bates argues that this approach helps explain how African governments can “get away” with policies that adversely affect the interests of most farmers (1988a:351-356). Governments use agricultural policies to organize a rural constituency and to disorganize the rural opposition, through the allocation of investments, jobs, and projects as forms of political patronage. In short, “public officials are frequently less concerned with using public resources in a way that is economically efficient than they are with using them in a way that is politically expedient” (Bates 1988a:352). In both organizing a rural constituency and discouraging a rural opposition, governments use regulated markets for political purposes in order to maintain social control and retain governmental power.

The political analysis of agricultural policy in poor countries has direct relevance for health policy. More analysis is needed of the political determinants of health policy in poor countries, especially the influence of private interests on government intervention in health and the government’s use of public health resources to protect its access to power.

The analysis of governments as agents of private interests appeared in several chapters of the Rockefeller volume. For example, the historical strength of competitive political processes in Sri Lanka (Gunatilleke 1985:122) and Costa Rica (Rosero-Bixby 1985:126-127) contributed to a redistribution of political power to the rural poor, giving them greater voice in the allocation of health resources. But the volume gave little indication of how these four societies dealt with the most powerful organized interest group in health: physicians. Many analyses of health policy discuss conflicts between the interests of physicians and urban consumers who want high-technology medical care and the interests of rural residents and government officials who favor primary health care (Scagl1 1983). It would be instructive to know how the four cases of the Rockefeller volume resolved this fundamental conflict in the distribution of medical resources.

But few studies exist on how interest groups, such as physician associations, have influenced specific health policies in the Third World, as has been done, for example, in Britain (Eckstein 1960) and in Japan (Steslicke 1973). One observer of the Indian Medical Association concluded, however, that the group “has not been notably successful in attempting to protect its narrow interests or otherwise to influence policy” (Jeffrey 1988:167). Understanding whether this pattern fits other Third World countries, and the conditions under which physicians exert substantial influence on policy, represents an important area of inquiry. Julio Frenk and Avedis Donabedian have suggested a useful model for thinking about the influence of physician associations on health policy (1987:28-29); their ideas could be developed and applied in several settings to examine the mobilization of interest groups that shape health policy in the Third World countries.

Several studies exist of interventions in health designed to retain power for government organizations. China’s emphasis on the mass mobilization of a rural constituency through public health campaigns provided a mechanism that both organized support and disorganized opposition for the government. Similarly, Kerala’s emphasis on the rights of the rural poor resulted from a strategic emphasis of government, social movements, and leftist political parties to organize those interests as their key constituents (Nag 1985:58, 70-71; Nag 1989). Additional research is needed to address the political benefits to Third World governments from interventions in health.

Analysis of the political economy of “targeting” health and nutrition programs could improve our understanding of when these efforts succeed at helping relatively powerless groups in society. Advocates of targeting tend to focus on the technocratic aspects of policy design and understate the political difficulties of policy implementation. One recent review concluded, “Targeting social spending to the poor is a bright idea that seems so attractive and sensible that it should take the world by storm. Why would a government not want to target its income subsidies to people who need them most?” (Heffernan and Griffin 1989:23). The authors answered their own question earlier, by recognizing the political roots of income and consumption subsidies, which “are often distributed so as to secure patronage, votes, or clients rather than assist the poor, who rarely have political clout” (1989:3). They decided, nonetheless, to give only “passing reference” to the political forces that shape the design and implementation of subsidies. More explicit analysis of these forces is needed to explain who benefits and who pays for subsidies.

The use of highly regulated health markets by governments to reward private interests and to retain or gain political power represents another critical area for research. Governments have liberalized pharmaceutical
policy, for example, to meet the demands of both domestic and international private companies, as occurred in Sri Lanka following the change in political parties in power in 1977 (Lall and Bibile 1978). And some governments, such as Bangladesh, have been accused of introducing restrictive pharmaceutical policies based on the concept of essential drugs, in order to serve the economic interests of individuals rather than the health needs of the public (Jayasuriya 1985). Overall, much more could be done to analyze the role of interests in shaping and changing government policy on health in poor countries and in producing better (and worse) health outcomes.

Market Forces

Advocates of market forces to improve health conditions in poor countries encounter many of the same problems shown by the proponents of government intervention. Those who call for the market as the solution rarely provide cogent political analysis. They often reduce their recommendations to the familiar neo-classical refrain of using a competitive market to solve the problems of public services. Indeed, they view government intervention and political processes as the sources of social costs that subvert and distort development in Third World countries (Lal 1983). Overall, this school underestimates the problems of the market and overestimates the problems of government, while neglecting the role of politics on both scores. Political analysis of market forces to improve health conditions in poor countries needs to begin with a concept of the role of the state in economic and social development, and then proceed to examine the selection of cases, the trade-offs of markets, and the role of interests.

The Concept of the State: A tendency exists among some market advocates to view the state as equivalent to the government or the public sector, or at least not to distinguish these as separate concepts. General problems of public administration in the Third World are then extrapolated to the state, leading to the conclusion that market forces must be unleashed. These concepts, however, are not one and the same. The term "government" usually refers to the official agencies directly concerned with the tasks of governance at the central and decentralized levels, while the "public sector" includes these plus a broader range of institutions, particularly autonomous state-owned enterprises (Mamalakis 1989,1045).

The concept of the state among contemporary social scientists is strongly influenced by the work of Max Weber, who viewed the state as the institutions that assert control over specific territories and the people within them. Following a Weberian perspective, Alfred Stepan (1978:xii) provided this description:

The state must be considered as more than the "government." It is the continuous administrative, legal, bureaucratic and coercive systems that attempt not only to structure relationships between civil society and public authority in a polity but also to structure many crucial relationships within civil society as well.

A narrow concept of the state, as somehow equivalent to government or the public sector, deprives this approach of its analytic power. Political economy in the 1970s and 1980s emphasized "bringing the state back in," a major shift away from social science in the previous two decades that stressed pluralist perspectives and structural-functionalism (Evans et al. 1985). Social theorists of the state have sought to explain the state's efforts to pursue goals independent of specific social groups and the state's capacity to achieve those goals despite actual or potential opposition (Skocpol 1985:9). They have employed cross-national and historical analysis to examine why some states are more successful than others in achieving their objectives and why specific states are more capable of intervening in one socioeconomic area compared to another.

The central question for Third World states, in the view of Joel S. Migdal (1988), is explaining their striking duality: "their unmistakable strengths in penetrating societies and their surprising weaknesses in effecting goal-oriented social changes" (1988:9). According to Migdal, conflicts inevitably arise between the state and other social organizations over who has the right and ability to make and enforce binding rules. Simply put, Migdal concluded that weak states and their failures in policy implementation result from strong societies with strong systems of control based in other social organizations that keep the state out. Only after massive social dislocations, often accompanied by war and revolution, have strong states emerged that can challenge previous systems of social control and thereby effectively implement social policies (1988:269). In most Third World countries, however, strong societies compel state leaders to employ the "politics of survival" to assure that state agencies do not become too aligned with social organizations and thereby undermine the leaders' power (1988:209). To
protect their power, political leaders undermine the effectiveness of the agencies intended to carry out social policies.

Migdal’s analysis suggests that strategies designed to strengthen the market and weaken the state are likely to have counterproductive results. In producing good health, the capacity to intervene effectively in society may be more important than the maintenance of competitive markets. A similar argument has been made about the role of the strong “developmental” state in producing a healthy economy, especially for Japan and the newly industrializing countries of East Asia (Johnson 1981; Johnson 1987). In this view, strong political institutions of the state are necessary to control distributive politics (the efforts by groups to advance their own interests instead of collective welfare) and bureaucratic politics (the organizational rivalry and fragmentation that can obstruct decision making and implementation) (Haggard and Moon 1990). Strong states, however, also have political and economic costs, as noted earlier in the discussion of the trade-offs of government intervention. In considering health improvements associated with the market forces approach, one must also ask whether this strategy is expected to work in all countries, regardless of the state of the state.

Selection of Cases: While the advocates of government intervention have used specific cases to argue their approach to good health, the advocates of “market oriented” policies have not provided a selection of countries in which their proposals would yield better health outcomes. The latter argument implies that market forces should be applied and should succeed in all states, regardless of the particular institutions, values, histories, or power structures. One could ask, however, whether market oriented approaches would have been more effective or appropriate in those countries where government intervention is considered to have played a major role in mortality declines and health improvements. Specifically, for the four governments in the Rockefeller volume: Why were these governments more effective than others in producing good health? Should their methods of government intervention be applied in other countries or subnational entities? Would market oriented approaches have been as effective in producing good health?

Birdsall, in her article on “good health and good government,” unfortunately did not directly address these questions and sometimes offered a confusing message. On the one hand, she approvingly cited the Rockefeller volume as demonstrating that government delivery of personal health services “has clearly contributed to the high levels of life expectancy” in the volume’s four case studies (1989:95-96). On the other hand, she seemed to question the conclusions of the Rockefeller volume (and her own prior statement) by referring to the “apparent success of governments in the developing world in bringing about major declines in mortality” (my emphasis) (1989:96).

The explanation of “apparent success,” however, remained ambiguous. In which states was the success of government more apparent than real? Birdsall argued that government intervention worked “in the past” when new health technologies could be introduced without requiring changes in individual behavior. (Importantly, the Rockefeller volume did not reach this technology-based conclusion.) But she did not specify which states are likely to achieve the “future potential” of state involvement. Nor did she indicate which states are likely to deal better with the problems that undermine the effectiveness of government efforts to produce good health: the diminishing returns of health technology, the difficulties of altering individual behavior, the fiscal pressures of growing deficits, and the changing demographic and epidemiologic patterns.

Birdsall divided states into those with “good” governments and those with “bad” governments, and then suggested that the fundamental problem is “the advent of ‘bad’ government” (1989:106-107). She described bad government as involving “bloated public sectors with substantial internal and external debt,” plus problems of increasingly ineffective, inefficient, and inequitable performance. The article, however, provided no persuasive evidence that Third World governments today are substantially worse than those of the 1950s to the 1970s. The murky standard for measuring “good” and “bad” government makes evaluation difficult. In addition, trade-offs exist among the goals of government; for example, in the health sector, pockets of effective performance may result in an inequitable distribution of services. Finally, most of Birdsall’s reported problems of “bad” government did not refer to specific countries and seem simply to be politics as usual. What is economically irrational often is perceived as politically essential.

Migdal’s categories of strong and weak states, on the other hand, provide some help in discriminating among countries and explaining the problems of implementation. Migdal concluded that strong states, capable of effective implementation, emerge only rarely in the world, when the right confluence of highly disruptive domestic and international political circumstances occurs. He also concluded that weak states...
rarely can improve policy performance, except under special conditions. Those conditions involve countervailing forces at the regional level to assure that the implementors of policy act responsibly or face sanctions. Migdal held out little hope for the current vogue of solutions: "New policies, management techniques, administrative tinkernings, more committed bureaucrats are all inadequate to change the structural relations between weak states and strong societies" (1988:277). One doubts he would consider a call for good government as likely to be effective in producing good health.

Trade-offs of Markets: In contrast to the advocates of government intervention, who usually ignore the trade-offs of administrative action, the proponents of market forces see mainly the trade-offs of government efforts. Birdsall characterized these two worldviews as the public-interest and the private-interest perspectives of government. Additional consideration of this Manichaeian split is worthwhile.

The public-interest view sees government intervention as essentially positive, contributing to the improvement of the entire community, and necessary to foster development. In the health sector, government intervention is necessary to assure that the health transitions in poor countries move in positive directions not only for the aggregate but also for specific groups. Government action could have positive outcomes, in terms of access to services or improvements in health, even if specific policies are implemented due to pressure from self-interested groups. According to the public-interest view, government intervention is required because markets fail to produce public goods (preventive health services) or merit goods (freedom from avoidable death or illness) and fail to control bad goods (pollution or traffic hazards).

The public-interest view has both proponents and critics. Proponents consider the concept of public interest as normatively essential. James W. Fesler, reflecting his specialization in public administration, embraced the concept as an ideal (1988:897):

It is for administrators what objectivity is for scholars—something to be strived for, even if imperfectly achieved, something not to be spurned because performance falls short of the goal. If there is not a public interest then we must denounce the idea of ideals...

Bates, on the other hand, rejected the public-interest perspective as empirically unhelpful: As noted above, he concluded that the public-interest objectives of governments do not explain the specific forms of policy adopted (1988a:343-345). The views of Fesler and Bates may seem mutually exclusive, but are not necessarily so; one could consider the public-interest viewpoint as normatively desirable but empirically unachievable.

The private-interest school of thought on government takes the critique one step further, rejecting the public-interest viewpoint on normative grounds. In the private-interest view, the actions of government are intentionally designed to meet the personal interests of politicians and bureaucrats, not to meet the needs of the population. Government intervention inevitably results in an inefficient allocation of resources due to diversions to meet private interests. In health, for example, the private-interest school would recommend against government provision of health services for the poor at no cost, since "most resources are likely to go to support bureaucratic interests and to reach the poor at higher cost to society than private, voluntary efforts would" (Birdsall 1989:97).

The interpretation of the private-interest view as emphasizing the "personal goals" of bureaucrats is rejected by both Bates and Fesler. Bates supported a broader political interpretation of the private-interest approach, with his interest-group model and power-maintenance models to explain government policy, as described earlier in this chapter. And Fesler argued from personal experience, "No-one who has served in the government, as I was privileged to do, could suppose that the behavior of career civil servants can be summed up as simply self-regarding" (1988:897).

While Birdsall did not advocate a pure private-interest worldview of government, she proposed partial adoption of market forces to correct for the imperfections of government action. Her main recommendations were selective user charges ("particularly charges to the nonpoor for private curative services"), decentralization of government services, and greater government use of the private sector (1989:111). She argued that these "market oriented" policies would lead to more efficient and more effective achievement of health goals than what might be called "government-oriented" policies.

The concept of selective medical user charges (MUC) has direct parallels to the concept of selective primary health care (Walsh and Warren 1979). The latter stressed the point that government could not provide all health services and therefore needed to focus on the high priority, cost-effective items. Selective MUC suggests that government
should not charge everyone for all health services, but that those who can pay should pay. Selective PHC argues that equity must be balanced with efficiency in health care, while selective MUC argues that efficiency must be balanced with equity.

The introduction of medical user charges inevitably arouses opposition and imposes political costs. The beneficiaries of free services resist the idea of making even nominal payments. When the beneficiaries have strong political allies, user charges become difficult, if not impossible, to implement. In these cases, the political costs are perceived to exceed the financial benefits, in rich as well as poor countries. In the United States, for example, political opposition in Congress and the Pentagon has blocked efforts by the Office of Management and Budget to introduce user charges for medical services provided to military dependents and retirees. In 1986, when first proposed, reaction to the idea was so strong that Congress passed a law banning such fees for two years (New York Times 1988). No one likes to lose existing benefits, and more powerful groups are better positioned to prevent the erosion of their interests.

The debate over medical user charges in poor countries has focused on the impacts on the poor. The market forces school has argued that MUCs are good, because they raise money for the medical care system and improve allocative efficiency (making prices approach marginal costs) (de Ferranti 1985; Jimenez 1986). The government intervention school has responded that free access represents a basic right in many countries and that the poor would suffer most from higher prices and reduced medical utilization (Correa et al. 1987). Economic modelers have predicted that higher user fees in government clinics would reduce utilization, especially among the poor, and that in urban areas, poor people would probably substitute private care for the previous public care, unless private practitioners raised their prices (Alderman and Gerlter 1989). Unfortunately, the modelers did not estimate the probability that such prices would rise in the private sector.

A fundamental problem with advocating greater reliance on market forces to improve health conditions in poor countries is that not enough attention has been given to the political consequences. One review of the "principle and practice" of medical user charges argued that efforts at cost recovery in the rural health sector are regressive and that hospital-based fee systems could redress some inequities in society (Griffin 1988:36). But the author did not analyze the political obstacles to full cost recovery — mentioning political feasibility only once in passing, in parentheses (1988:11) and discussing political costs in one paragraph in the next-to-last Appendix (1988:76). He concluded that "loans or outside assistance" would be needed to compensate for the political costs and to assure "careful timing." In short, political feasibility does not automatically follow economic rationality. These "market oriented" approaches invariably confront significant political barriers; and market oriented economists, ironically, end up recommending administrative intervention (by international agencies) to change the political cost-benefit calculation.

Markets and Interests: Proponents of market forces in the health sector of poor countries tend to assume a separation between markets and interests. These advocates see an idealized vision of the world, in which The Market appears (or is assumed to be) immune to the influence of politics. But in many poor countries, the prevailing reality approaches the opposite: through various mechanisms, the market becomes part of politics.

Bates identified several ways that political actors take over market forces in agricultural policy (1988a:355-356). Price controls below market levels for commodities create opportunities for huge profits and for allocating those benefits as political favors. The power to grant access to regulated markets provides a major method for government leaders to accumulate political influence and secure political allies. Another way that markets become part of politics involves the implementation of rules. Government bureaucrats achieve political influence through their discretion to enforce the rules, for example, of regulated prices for agricultural commodities (1988a:355):

By allowing exceptions to the rules, the bureaucracy grants favors; by preparing to enforce the rules, it threatens sanctions. Market regulations thus become a source of political control, and this, in a sense, is most true when they are in the process of being breached.

Rationing provides another method for the distribution of benefits to political allies and for depriving one's opponents. Finally, the appointment of allies to positions of power in the regulated market creates ties of political loyalty and a basis for political organization. In their work of coalition building, political actors find the market's invisible glove quite handy in dispensing rewards and punishments.
Similar processes operate for health policy in poor countries. The notion of an "unruffled private market" (Birdsall 1989:97) may represent a theoretical standard against which some economists seek to measure the efficiency of public health programs, but at least some analysts regard this standard as pie-in-the-sky reasoning for rich as well as poor countries (Culyer 1982; Reich 1988a). Price controls on pharmaceuticals provide opportunities to allocate the benefits of profits to political allies, through the distribution of scarce supplies and through the allowance of black market activity. Access to regulated markets for private services, in providing health care and in selling medical products, represents another way of dispensing political favors. Similarly, rationing of scarce resources and appointments to public programs operate as political processes in the health field.

In short, political elites have powerful incentives to use regulated health markets to retain power by rewarding constituents and excluding opponents. Birdsall's notion that a market oriented approach "could encourage a reorientation of government's role toward 'public' goods, especially more public spending on basic care for the poor" (1989:111) ignores these basic political realities. The implementation of selective medical user charges could provide another area for "selectively" dispensing benefits to political allies. Studies on the political economy of introducing medical user charges would improve our understanding of who gains and who loses and how governments adjust the implementation of such policies to fit local interests.

Advocates of market forces have recently begun to promote decentralization of government services, which is supposed to make the public sector more responsive and accountable to local needs. But decentralization can increase rather than decrease the political use of markets, as Birdsall recognized, by creating opportunities for politically tied appointments or by strengthening secessionist tendencies (1989:114). The decentralization of financing for social programs, in order to improve central budgets, can undermine the effectiveness of programs and exacerbate regional inequities (Pfeffermann and Griffin 1989:25). Even calling decentralization a market oriented approach stretches the definition of that concept.

India's long history of decentralized planning illustrates important limits of this proposed remedy. Since its First Five Year Plan, India has sought to decentralize the planning and implementation of development, to achieve more efficient use of resources and more equitable distribution of benefits. The results, according to one review, have been "dismal," despite the establishment of institutional structures, the panchayat inray, at the local level (Rao 1989). "Under the prevailing social structure and property relations, the rural elite has often come to dominate these institutions and appropriated a major share of benefits from development so that the improvement in the living conditions of the poor and the underprivileged has been negligible" (1989:412). Without changes in the socioeconomic structure of rural society, through policies oriented toward the poor and through effective social mobilization, decentralization is more likely to perpetuate rather than ameliorate the inefficiencies and inequities of the political use of markets in development. In short, Migdal's notion of a strong state may be more efficient and equitable in promoting development and social welfare for the poor.

The likelihood of implementing decentralized planning increases when political leaders perceive political needs or opportunities to expand their constituencies. In the mid-1970s, decentralization stalled in Kenya, despite the declarations of official policy, the incentives of foreign aid, and the dispatch of technical advisors. Only after a new president took office in 1978 did implementation begin, because the leaders viewed decentralization as a convenient means to expand their political base (Grindle and Thomas 1991:90-91,140). Here, the political cost-benefit analysis produced incentives that made decentralization both feasible and desirable for the political leaders. Whether the circumstances of the rural poor consequently improved is uncertain.

Another popular solution, proposed by international agencies, is to expand the government's use of private sector strategies. One consulting company identified 17 "discrete privatization options" in the health sector, ranging from the transfer of all curative services to the private sector, to the promotion of health maintenance organizations, to the expansion of autonomy for public hospitals and other health facilities (Jeffers 1989). But even this explicitly pro-privatization review concluded with a veiled warning that governments need "careful consideration" whether the supplier industry will remain competitive over the long term, implicitly recognizing, in the article's last sentence, the dangers of becoming a "captive of the private sector" (1989:12). In the absence of perfect competition, privatization can produce a broad arena for political activities, in the assignment of contracts, decisions about fees, and payment for services.
One could argue that the efforts by international agencies to increase the use of markets in Third World countries, in the recent fashion of “conditional” loans, represents a form of administrative intervention in markets. These aid programs seek to reduce the state control of the economy by making loans “conditional” on critical changes in government services and policies, and thereby are supposed to increase overall efficiency and economic growth. The “conditions,” however, often impose costs on important political constituencies of the groups in power. In effect, the promise of economic growth and the lure of continued aid represent a "bribe" to powerholders "to embolden them to incur the political cost of taking away rents from those who receive them" and "to buy out some of the restrictive practices by which they currently hold the state together" (P. Mosley 1988:53).

This process of international influence, in Paul Mosley’s metaphor, is like “persuading a leopard to change his spots” and requires careful consideration of political feasibility. In Mosley's sample, the two countries that most faithfully implemented World Bank conditional policy-reform packages were Jamaica and Turkey, which had undergone changes in government prior to signing the loan agreements. "The important point is that neither government was significantly obligated to the groups who could be expected to lose from a liberalization of domestic and foreign trade, or could be accused of inconsistency of betrayal of those groups if it went ahead with an economic stabilization program" (1988:78). Indeed, the new governments of these two countries had already committed themselves to liberalization programs prior to completing the World Bank agreements.

Interventions in national markets by international agencies thus are constrained by the structure of political interests. The economic incentives of international persuasion work best when governments have already decided to change their political spots. When pushed to economic brinks, the survival politics of most Third World governments depend more on local constituencies than on world bankers. Government leaders are not easily persuaded by international agencies to implement policies perceived as posing significant political costs to important constituencies, as illustrated by the case of agrarian land reform in the Philippines (Grindle and Thomas 1991:145).

The above analysis suggests that the market has a limited and complicated role to play in health transitions. One should not doubt the ability of user fees, if properly managed, to improve the financial situation of health services in poor countries. But the market (even a market oriented approach) does not provide a panacea for the multiple ills of the health sector or for the problems of development more broadly. Nor does the market necessarily lead to better health for all. Any effort that seeks to impose market solutions, without taking into account the impact of political and economic interests, may end up creating more problems than it solves.

Conclusion

Analysis of political economy constitutes an essential element in understanding health transitions in poor countries — something that Marxist analysts have been saying for a long time. Simple calls for government intervention or for market forces, as the method to improve health conditions in poor countries, are more likely to mystify and confuse than to explain and clarify. Yet most studies of health transitions in the Third World, especially when carried out by economists or health professionals, have underplayed and underanalyzed the pervasive influence of politics.

From a political perspective, the two approaches of government interventions and market forces are imperfect alternatives. Neither strategy is a magic wand to produce health for all in Third World countries. Political processes affect the design and implementation of both government policies and market mechanisms so that actual results often differ dramatically from the stated or intended ones. Indeed, it seems likely that no single path to good health exists. Each country may need to design its own combination of governments and markets to avoid the pitfalls and potholes that plague the implementation of policy and to arrange the political costs and benefits so that stability and positive outcomes result.

The costs of seeking to impose a single solution, in hopes of improving health, need to be explicitly assessed. A strong state may be able to implement public health measures effectively (even ruthlessly). But that implementation may occur at great costs in terms of political liberty and human lives — as in the case of China during the Cultural Revolution. And strong states do not necessarily produce health improvements, as illustrated by the mixed achievements of the command-and-control states of the Soviet Union and Eastern Europe (Eberstadt 1988:207-230). Similarly, a single-minded reliance on market forces may unleash a plethora of health hazards associated with industrialization and
urbanization along with positive health consequences for some social groups. The opening of Eastern Europe, for example, could contribute to continued deterioration in health conditions if reliance on the market results in even worse environmental pollution or wider availability of tobacco products.

In order to understand how the politics of governments and markets affect health conditions, both positively and negatively, we need more political inquiries into the patterns of health transitions in different kinds of states. Analysis is also needed of the values that underlie the evaluation of health achievements and the accompanying costs in different states, especially beliefs about how the state should relate to individuals in society and how to assess conflicts between state power and individual freedom.

Attention should also be directed to a third major analytic approach to health transitions in the Third World: that involving competitive political markets. This approach stresses the empowerment of relatively powerless groups in society, the development of mechanisms for state and market accountability, and the emergence of nongovernmental groups that form coalitions and mobilize latent interests. The experiences of Costa Rica, India, and the Philippines suggest that these political processes played a major role in shaping both government interventions and market forces in directions that had positive health consequences — and with lower human costs than the strong state approach to good health adopted in China.

This third approach would depend on the role of nongovernmental organizations (NGOs) as agents of political change in promoting good health and development and in addressing the problems raised by government-oriented and market-oriented approaches. A growing literature recognizes the potential contributions of NGOs in development (Drabek 1987). NGOs have a number of comparative advantages over states, especially in the quality of relationships with intended beneficiaries and in the autonomy of choice in organizational design and objectives (Fowler 1990a). A political analysis of the role of NGOs in southern Africa pointed out their potential in advancing democratization but also the efforts by national governments and international agencies to contain NGOs (Fowler 1990b). Additional research is needed on the political conditions in which NGOs can promote positive health transitions and how NGOs can manage the obstacles created by both national and international institutions.

NGOs have also demonstrated an ability to affect the health consequences of national and international markets. In the past decade, international networks of NGOs have emerged to exert increasing influence on markets of specific products and on the agendas of international organizations (Reich 1991). The formation of international networks has resulted from two patterns of organizational development: the strengthening of domestic NGOs in poor countries and the internationalization of existing groups in rich countries. On health and environment issues, examples include Pesticide Action Network (PAN), Health Action International (HAI), and the International Network of Victims of Corporate and Government Abuse. The international linkages created and maintained by these networks hold the potential for political action to reduce the negative health consequences of market oriented approaches in both domestic and international markets. To understand when and how these networks succeed, additional research is needed on case studies and political strategies.

A final conclusion of this chapter is the importance of assessing the political feasibility of policies to improve health conditions in poor countries. Policy analysis needs to take into account the vast areas of uncertainty that surround important social issues and the inevitable influence exerted by the values of administrators and experts. Analysis that considers the political implications of policy proposals can help decision makers and the general public "avoid both reckless underestimation and harsh overstatement of the limitations of the possible in public policy" (Majone 1988:165). To do this, analysis must explicitly recognize how governments act as the agents of private interests, how governments act to retain power, and how markets become instruments of political organization. Lastly, greater attention needs to be directed to the international political economy and its impact on national health policy and health conditions.

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The Political Economy of Health Transitions in the Third World

achieve greater voice and thereby affect national policy, as illustrated by the tendency for politicians to launch major rural development programs just before elections (Bates, 1985:350). In Africa, as in other parts of the developing

world, the weakness of electoral politics means a weakness of rural influence on agricultural policies.

References


Caldwell, J.C. 1990. "Introductory thoughts on health transition." In J.C. Caldwell, S. Findley, P. Caldwell, G. Santow, W. Cofield, J. Braid, and D. Broers-Freeman, eds. What We Know About the Health Transition: The Cultural, Social

Notes

1 The field of political economy covers a broad range of schools and traditions that involve political and economic analysis in various combinations. Martin Staniland (1985) provides a good map and guidebook to the array of approaches. These include: the new political economy, which applies assumptions of economic rationality to explain political choices in society; "political" theories, which argue that power and political institutions take precedence in explaining economic patterns in society; international political economy, which examines political and economic forces in the international arena and includes schools of liberalism, realism, interdependence, and dependency; and Marxist political economy, which includes several traditions with different emphases on internal class structures and external capital influences.

2 Regarding the broad theoretical territory covered by political economy, Staniland (1985:198) wrote, "The term political economy, used generically, refers to a continuing intellectual enterprise, a particular agenda, a specific object of theoretical ambition. Because 'political economy' is an agenda rather than a method, there will always be a variety of theories of political economy. And because a variety of assumptions and values underlies such variety of theory, it may be possible (indeed, it is very desirable) to criticize each theory; but it will never be possible to decide between them, to end the debate, and to remove variety by purely logical means."


4 These two broad approaches, government interventions and market forces, represent a heuristic dichotomy to characterize studies of the political economy of health transitions. Some studies, however, may not fit easily in these two next categories. For example, I have not included many studies of international political economy of either the dependency or the interdependence type (although the first would probably fit in the government intervention approach, while the second would be compatible with the market forces school). Similarly, Marxist analyses would fit best in the government intervention approach, although such studies also have problems in their political analysis. Finally, the analysis of new non governmental and non market actors does not fit well in either normative school; I discuss some implications of these new actors in the chapter’s concluding section.

5 In rare circumstances, when farmers are well organized and connected to national elites, sufficient political pressure can be exerted to shape government policy and resist efforts to push down agricultural prices. In countries where competitive elections occur on a regular and fair basis, agrarian interests can


