The Relationship between Healthcare Services and the Political Economy with Reference to the Jamaican Experience

SR Maharaj

ABSTRACT

The availability of, and equitable access to, health services have challenged healthcare providers with a greater degree of urgency since the end of World War II. Prior to that time, concepts such as equity and social justice were just that, concepts but no real attempts were ever made to operationalize them. Goods and services were still produced and distributed based on market forces, that is, one's ability and willingness to pay for something. Health in that context was a service, some say a commodity, to be bought and sold, hence its availability was not necessarily commensurate with its accessibility.

Keywords: Economic policy, political ideology, social welfare policy

La Relación entre los Servicios de Atención a la Salud y la Economía Política con Referencia a la Experiencia Jamaicana

SR Maharaj

RESUMEN

La disponibilidad de los servicios de salud y la posibilidad de su acceso equitativo, han desafiado a los proveedores de atención a la salud con un mayor grado de urgencia a partir del final de la Segunda Guerra Mundial. Con anterioridad a ese momento, conceptos tales como equidad y justicia social no eran más que conceptos sin que se realizaran intentos reales por hacerlos operacionales.
Los artículos y servicios todavía se producían y distribuían sobre la base de las fuerzas de mercado, es decir, la capacidad y disposición de cada cual a pagar por algo. En tal contexto, la salud era un servicio. Para algunos se trataba de una mercancía que podía ser comprada y vendida, de ahí que su disponibilidad no estuviese necesariamente acorde con su accesibilidad.

Palabras claves: Política económica, ideología política, política de bienestar social

West Indian Med J 2010; 59 (6): 706

As for equity, that was never a consideration in that context. Ideology, therefore, was a driving force in determining policy in terms of allowing the free interplay of market forces. The economy and politics were inextricably linked and in the case of healthcare, these two – both as independent and co-variables – had significant influence on the availability and equitable distribution of health services.

The counter ideology to Capitalism – which was characterized by a hands-off or *laissez-faire* approach to the production and distribution of goods and services – was Socialism which in effect meant State control. There were several shades of Socialism and hence varying degrees of State Control, the bottom line was, however, a sharp contrast to the "hands-off" *laissez-faire* Capitalism.

Socialism was concerned with equity and social justice; these were inherent in the principles of basic human rights which in the case of health was seen as a social good. Health thus became a basic human right which must not be treated as a commodity to be bought on the basis of ability and willingness to pay for same.

Political economy deals with ways in which politics determines or influences economic activities, or how economic circumstances and institutions determine or influence political institutions and processes. The political economy of

From: Department of Community Health and Psychiatry, The University of the West Indies, Kingston 7, Jamaica, West Indies.

Correspondence: Dr SR Maharaj, Department of Community Health and Psychiatry, The University of the West Indies, Kingston 7, Jamaica, West Indies. E-mail: satnarine.maharaj@uwimona.edu.jm.

healthcare, therefore, influenced quality, quantity, availability and accessibility of healthcare.

The concept of health and the development of healthcare delivery systems are therefore consistent with views held by the dominant prevailing value system in a given setting. Within these systems and by their organization, health can be seen to be either a human right, a political demand, an expenditure or an investment in development. When health is seen as a human right, policy and planning actions are directed to ensuring equitable access to all the available range of services. Where political demand is the major determinant, equal access is less a feature of the system's organizational design, and more responsive to those with access to the power base and decision-makers. If health is seen as an expenditure, the pattern of health financing reflects this by having in-built cost recovery mechanisms with the potential for denying access to those unable to pay.

Healthcare based on demand or cost recovery are less likely to achieve equitable access when compared with health as a human right or health as an investment in development. The link between ideology-economy and policy-planning as they impact on healthcare delivery systems can also be recognized by the epidemiological paradigm (1) which underpins the organization-services component of the system. The clinical epidemiological paradigm, for example, models the human being as a machine and regards ill-health as a natural breakdown of the machinery. The cause of the breakdown is sought in the particular individual and treatment is confined to the individual's signs and symptoms.

This is the paradigm underlying the scientific medical approach which emphasizes the doctor-patient relationship and a therapeutic regime to the exclusion of a social context. It is a pathologic orientation focussing on disease and ignoring the social nature of health.

The social epidemiological paradigm recognizes the social basis of diseases and approaches treatment by trying to eradicate/minimize exposure to the aetiological agents at two levels, the individual – to cure the episode – and the environment through public health interventions.

The third paradigm, the critical-socialist epidemiological paradigm takes into account the effect and impact of the socio-economic and political context on health and illness in a society. This relates to the need for social changes affecting the structure of society – in much the same way as the early advocates for public health reform based health improvement on living and working conditions. This paradigm emphasizes the socio-economic causes of ill-health and thus the need for interventions to address the underlying causes of health inequality and empowerment of the individual and the community, in order that they may take action in their own self-interest.

The Jamaican Experience

* *Post Emancipation Years, 1838–1938*

The Moyne Commission Report (2) documented evidence of high levels of chronic illness brought on by venereal disease, yaws and hookworm infestation among adults, and malnutrition among infants and young children. Environmental health was unsatisfactory (poor sewage and garbage disposal) as well as overcrowded housing conditions. Health expenditure was predominantly for curative services with much less spent to improve social conditions. Jamaica inherited from its colonial past, a health service system for which money was derived from general tax revenue and spent largely on hospitals and traditional public health measures. Availability and ability to pay for medical services were constraints for local inhabitants. Several variations of "fee-for-service" arrangements did not solve the problem of those unable to pay and thus gain access to acceptable standards of healthcare.

Developments in the colonial era served to create a broad consensus about goals for the future and provided the institutional framework for the healthcare delivery in modern Jamaica.

Some of the features of personal health and healthcare services of Jamaicans were true of many developing countries prompting the World Health Organization to re-define Health in 1946 as, "not merely the absence of disease or infirmity but the social, mental and physical well-being of the individual as well" (3) – that is, a bio-psychosocial package of wellness.

Implicit in this is a recognition that measures to alleviate poverty and poverty-related illnesses as a means to improve the quality of life tend to run into social, political and administrative obstacles which must not be underestimated.

The re-definition of health gave governments the opportunity to reform their health sector and formulate policies to link national development with economic development through a new paradigm, that of health development, wherein health will be seen as an investment in development, a basic human right with policies and programmes designed to achieve total coverage of the population with adequate, available, accessible, appropriate, adaptable and culturally acceptable services. Equity will be the cornerstone of this system design and the challenge will be to balance the triad of efficient use of resources with effective programme design through equitable distribution of the available resources.

This approach will allow a more practical blend of politics with economic targets with the ultimate goal of national development instead of the earlier model of "economic development" which seemed to neglect social issues.

Post World War II and the New Millennium

Jamaica has been able to achieve, if even for periods at a time, the goal of "better access" to government healthcare despite upheavals in geopolitical and global economic systems – both of which have impacted the political economy of Jamaica's healthcare system.

Successive governments have wrestled with the challenge of access and equity and have succeeded to varying degrees ranging from "free" healthcare to cost recovery to free access to some service and back to free access to all services.

How was the transformation achieved? Let us examine the political economy context of healthcare reform during this period.

One possible system-wide approach to understanding healthcare is through an examination of its degree of conformity to some aspects of social policy and the aspect most likely to be used in practice is equity: this was an important theme in the preparation of a healthcare plan for the newly independent country of Zimbabwe (5).

Increased attention to social issues leads to a renewed social policy mandate and less concentration on policy and political efforts on economic reform *per se*. Economic and social policies are now more likely to be complementary and mutually supportive rather than conflicting. The aim was to achieve a more integrated approach to development through appropriate policies while recognizing access to social services as a fundamental right.

The fact that successive governments have had to vary the arrangement concerning how one gains access to health services, *eg* fee-for-services (cost recovery), free at point of delivery *etc* is a reflection that healthcare reform is a dynamic process, a long term process, which takes place in an ever-changing environment, thus requiring political commitment, strong research and health-policy-making underpinnings (4). Reform must also be able to accommodate balances between public and private health sectors, primary and secondary health services and social and economic policies.

Successive governments have been guided by contrasting ideologies and differing patterns of economic growth nationally and internationally. There is a reasonable good correlation with health indicators and the prevailing political economy of the day, interestingly however, within the twenty or so years where sharp differences in ideology is not as much a factor as before, and global economic recession is affecting all political stripes; policies and political effort are becoming similar in many respects, not the least of which are efforts to improve quality of life through access to social services, which impact on bio-phychosocial well-being, *eg* better health.

Overall, the factors responsible for health development include basic public health measures, improved medical technology and increasing incomes, literacy and public awareness of health matters, the balance between them varying over time.

The Jamaican case is an example of the success of the health development approach in the context of limited resources (6).

REFERENCE

1. Kuhn J. The Structure of Scientific Revolutions,1962 University of Chicago Press,+ Chicago.
2. Moyne Report (1938–1039) Royal West Indian Commission – under Lord Moyne – His Majesty's Stationery Office (HMSO) London.
3. WHO/UNICEF, 1978, Primary Health Care: Report of the International Conference of Primary Health Care, Alma-Ata, USSR, 6–12 September, 1978, WHO, Geneva.
4. de Kadt E. Ideology, social policy, health and health series: a field of complex interactions. Social Sciences and Medicine 1982 vol. **16:** 741–52.
5. Segall M. Planning and politics of resource allocation for primary health care: promotion of meaningful national policy. Social Sciences and Medicine 1983; **17:** 1947–60.
6. Cumper GE. Jamaica: A case study in health development. Social Science and Medicine **17:** 1982–93.