

GLOBAL TRANSFORMATION AND THE QUALITY OF LIFE*

NIMAL SANDERATNE

1. Introduction

“Global Transformation” has been defined as *“The integration of the national economies to a global system of production, consumption and trade.”* The background paper of the AASSREC Conference on “Local Impact of Global Transformation with Special Reference to Social Development Issues”, goes on to say that *“this would signify trade and investment liberalization in the immediate period, and domestic structural adjustment as part of a long term adjustment”*. (AASSREC 1994:1)

Global transformation may therefore be interpreted as being the movement towards liberalized trade, the dismantling of foreign exchange restrictions, the free flow of foreign investments and services, the reliance on private enterprise and private foreign investment. It implies an economic system with a greater reliance on market forces and a departure from central planning and the state control of the commanding heights of the economy.

The concept of global transformation is easily comprehensible to Sri Lankans as these processes have influenced the country's economic and social policies since the economic reforms of 1977. Therefore Sri Lanka has nearly two decades of experience to draw on to assess the impact of these policies on social development and the quality of life.

The concept of the quality of life necessarily conjures a very wide spectrum of issues. In fact it may be said that there is hardly any aspect of economic, social, political, cultural and other aspects of human life which could be excluded in considering the quality of life. Yet, following on the school of thinking of Morris D. Morris, James P. Grant, Florizelle B. Liser, which generated the Physical Quality of Life Index, and the later thinking of Mahbub ul Haq and the Human Development Index, AASSREC has defined the quality of life mainly in terms of attainments in literacy, education, health indicators and life expectancy. To quote the AASSREC background paper:

Education and health status basically determine the quality of life of a population. Education interacts with the quality of life in numerous ways. It enables the population to process information in a better and more efficient manner, to participate in higher

* A revised text of the presentation at the NARESA theme seminar on “Global Transformations and the Quality of Life” in March 1995. The author has benefited from comments by Dr Godfrey Gunatilleke on an earlier draft of the paper.

forms of cultural activities, trains people to move to better and higher paid jobs, and strengthens their ability to make important decisions concerning the welfare of the family and the society. Similarly, life expectancy and infant mortality are closely related to the access to and efficiency of, the health care system. (AASSREC 1994: 1)

While not disagreeing with this line of thinking, it may be pointed out that these indicators, however important, do not capture fully other components of living which enhance or could enhance the quality of living. The quality of life defined in terms of these indicators relates only to basic needs and basic living conditions. They do not measure the access to numerous other facets of living. This paper would go somewhat beyond this definition to discuss and raise the issues with respect to the impact of the global transformation on other aspects of living too, albeit to a limited extent.

By the time Sri Lanka became integrated with the global transformation, she had attained fairly high levels in health indicators, literacy and basic education. (See Tables 1-3). These improvements in social indicators establish two factors. First, that the achievements in health indicators were in fact based on the country's earlier social policy which gave a high priority for improving health and education. Second, while it may be incorrect to conclude that the global transformation *per se* affected some of these indicators adversely, given the already high attainments, it appears that further progress was tardy due to a change in emphasis on social policy largely owing to the new economic policies of globalisation. It is also arguable that economic difficulties had reached a stage when, without the structural adjustment policies of the late 1970s, the country's social development would have been adversely affected by worsening economic conditions. In fact there is some evidence to this effect in the slow social progress and curtailment of social development expenditure. (*Alailima & Sanderatne 1997*).

2. Health Indicators

By 1971, six years before adopting the Structural Adjustment Programme, liberalising trade and adopting market oriented policies, life expectancy at birth had reached 66 years. It increased to 70 in 1980 and is estimated to be 71 years in 1990. By 1975 the infant mortality rate (IMR) had fallen to 45 per thousand live births and continued to decline to reach 19 in 1990. The Maternal Mortality Rate (MMR) had reached 100 per one hundred thousand in 1975 and is currently only 40. (See Table 1).

Table 1: Key Health Indicators.

Year	1960	1965	1970	1975	1980	1985	1990
Life Expectancy (Year)	-	64 (1963)	66 (1971)	-	70 (1981)	-	71
IMR per 1000	57	53	48	45	34	24	19
MMR per 100,000	300	240	150	100	60	50	40

Source: Dept of Census & Statistics.

These developments indicate that the country had impressive attainments in health prior to the global transformation and that these indicators improved further since then. In as far as these indicators are concerned, it is difficult to draw out any definite conclusions regarding the impact of the global transformation.

It is therefore very pertinent to this discussion to compare these health indicators with regional indicators. Sri Lanka's health indicators compare very favourably with those of other South Asian countries (Table 2). But it is noteworthy that several South East Asian and East Asian countries which had lower attainments in health have caught up with Sri Lanka and in some instances surpassed Sri Lanka's achievements in the last three decades (Table 3). The achievements of these countries are generally attributed directly to their high rates of economic growth, which enabled higher public and private investment in health. Their economic growth is in turn attributed to their more effective "globalisation" of their economic policies.

Table 2: Sri Lanka's Health Indicators - (Compared to other South Asian Countries.)

Country	Sri Lanka	India	Pakistan	Bangladesh	Nepal
Life Expectancy	72	61	62	56	54
Infant Mortality Rate	17	81	89	106	98
Under 5 Mortality Rate	19	119	137	117	118
Maternal Mortality Rate	140	570	340	850	1500

Sources: UNDP, Human Development Report 1996.

Note: For comparability, data on Sri Lanka are based on the same international source.

Significant differences in health policy occurred after the global transformation in the post 1977 years. There was a difference in emphasis in public health expenditure. Although the core of health policy interventions continued after 1977, and the total expenditure on health as a percentage of GDP, as well as total government expenditure, did not vary much, capital expenditure on health became more significant than current expenditure.

Table 3: Comparison of Health and Literacy Indicators 1960-1993.

Indicator	Life Expectancy		Infant Mortality Rate per 1000 Live Births		Adult Literacy Rate	
	1960	1993	1960	1993	1970	1993
Sri Lanka	62.0	72.0	71	17	77	90
Malaysia	53.9	70.9	73	13	60	82
Singapore	64.5	74.9	36	6		90
South Korea	53.9	71.3	85	11	88	98
Thailand	52.3	69.2	103	36	79	94

Source : *Human Development Report 1996.*

Capital expenditure on health grew from 9 percent of the health budget in 1977 to an average of 19 percent during 1978-82. In 1983 it grew sharply to 36 percent. The construction of new hospitals and sophisticated equipment absorbed significant sums of money. The increase in capital expenditure can be attributed to a substantial inflow of foreign aid, the need to rehabilitate infrastructure and a greater willingness by the government to spend on capital projects. (*Alailima 1985:24*)

After the adoption of structural adjustment policies funds were readily available for new projects and the improvement of existing infrastructure. In 1978 and 1979 the Ministry of Health initiated several new large-scale infrastructure projects and obtained large amounts of equipment for ongoing programmes. Equipment purchases quadrupled between 1979-82. The tendency was to purchase high technology items. Building activities also shifted from provincial and base hospitals in the mid seventies to teaching hospitals at the end of the decade. (*Alailima 1985:25*)

After the global transformation foreign aid had an important influence in shaping medical expenditure. Foreign aid favoured large capital projects like new hospitals, and high cost sophisticated technology. This resulted in a decrease in budgetary finances for the maintenance of existing hospitals, the

purchase of drugs and improvement of facilities in the periphery, as domestic finances had to be channelled to meet the local component of the foreign funded projects. The encouragement of private enterprise in medical services also resulted in several new private hospitals catering to the affluent and middle classes. Consequently vocal and influential sections of the population may be less concerned with public hospital facilities. The positive aspects of the expansion of private health care are that sophisticated medical technology is financed by private expenditure and there is an easing on some of the demands on public health expenditure.

The impact of foreign aid on health facilities has been considerable. Two new hospitals costing about Rs 1,300 million and a large amount of equipment and vehicles were obtained as grants. The dependence of the community health services on foreign aid increased from 7% of its total budget in 1976 to 53% in 1979. In 1982, foreign aid came to about one-fifth of total health expenditure and foreign voluntary service organisations' involvement and foreign support for local service organisations also increased. (*Alailima* 1985:25)

The increase in capital expenditure and the tendency towards purchasing higher cost sophisticated health technology, combined with the reduction of recurrent expenditure contributed to difficulties in maintaining buildings and equipment, supervision and falling service standards. A World Bank Aid Memoire of 1983 observed that "only about 0.6% of the replacement cost of equipment was budgeted for maintenance and repairs, in contrast to a requirement of at least 4%", and went to say that "Taking past capital expenditure into account, the under funding of the health services may now be in the region of 20% of existing budget approvals." (Quoted in *Alailima* 1985:32)

The declining purchasing power of doctors' salaries, the relaxation of the 5-year compulsory service requirement for newly graduated doctors and the availability of foreign exchange for travel after the globalisation, contributed to an exodus of doctors from the country in the late 1970s and early 1980s. To counteract this brain drain doctors were permitted to engage in private practice from 1977 onwards. The privilege of private practice was widely abused throughout the health service and led to a deterioration of morale, discipline, and the quality of service provided by all categories of supporting staff. One positive effect of private practice has been to lure doctors to peripheral units and district hospitals in remote areas. (*Alailima* 1985:32)

Therefore, globalisation did have a qualitative impact on the health services. Though the basic indicators continued to improve, the access of the poor to quality health services appears to have been adversely affected. On the other hand, the more affluent probably had better health care facilities; drugs and medical accessories as these were freely available to those who could afford them.

3. Literacy and Education

A similar pattern prevails with respect to the attainments in education and literacy. Sri Lanka achieved a relatively high adult literacy rate of 65% as early as 1953. By 1971 the adult literacy rate reached 78%. The trend continued and by 1981 adult literacy had reached 87% with male literacy being 91% and female literacy 83%. (Table 4). However, since 1981, although there is a lack of national data, indications are that adult literacy has hovered around 90%. The initial achievements in literacy gave expectations for literacy to reach a near 100% by the 1990s. This has not been achieved. This is partly due to the increased expectancy of life and the older illiterates surviving.

In comparison, South East Asian and East Asian countries which opened up their economies and experienced rapid economic growth, have made significant strides in literacy. (Table 3)

There are also indications of inadequate improvements in the primary enrolment rates and primary completion rates. School drop outs have remained high. One of the reasons for this is child employment and child prostitution which has increased with tourism, a facet of globalisation.

Besides this, regional disparities in educational facilities: with a very large number of ill equipped schools in the rural and estate areas, have been some of the unsatisfactory features of education. The persistence of wide disparities in education has been discussed in the *Sri Lanka National Report for The World Summit on Social Development* as follows :

The quality of schooling and health care provided by government services is quite uneven and is associated with the size of facility. The public school system caters to about four million students; but the size of the school is associated with better facilities and performance since "good" schools expand in response to pressure from parents to obtain admission for their children, attract the more affluent, and are able to maintain their facilities through parental support. In spite of various regulations on school admissions and a common curricula, the schools have undergone a stratification in which the lowest stratum consists of poor, ill-equipped schools located in urban slums, remote villages and areas with a large plantation sector. These schools have relatively high drop-out rates and the performance levels of their pupils in literacy and numeracy are low.

(Ministry of Health, Highways and Social Services 1995:25)

Table 4: Literacy in Sri Lanka.

Year	1953	1963	1971	1981
Adult Literacy Rate- %	65.4	71.6	78.5	87.2
Male	75.3	79.6	85.6	91.1
Female	53.6	63.2	70.9	83.2

Source: Dept of Census and Statistics.

4. Impact of Global Transformation

The implications of the above trends in health and education are that several aspects of the global transformation have affected social development, if not adversely, at least in terms of retarding progress in social development. These include the increase in prices of basic commodities subsequent to a market oriented approach, the removal of food subsidies and the depreciation of the currency. A shift in policy emphasis also resulted in the curtailment of expenditure on health and education. For instance, Sri Lanka invested about 4% of GDP on education in the 1960s. This proportion declined to around 2% of GDP in the post 1977 period when the globalisation policies were adopted. There also appears to be a lesser emphasis on rural and disadvantaged regions since the 1977 economic reforms and consequently a greater disparity between urban and non-urban facilities in education in particular. The emphasis on economic growth conferring benefits which would enable the population at large to participate in health facilities and educational opportunities was part of the new emphasis in the economic policies since 1977, compared with the earlier policies of more direct intervention to provide health and educational facilities for all. However, it must be recognised that though there was a shift in emphasis, the basic elements of the earlier policies on free education and free health continued, though some of the changes in economic policies did affect the quality of facilities in health and education.

An important manner in which the post 1977 policies affected health is through the impact of these policies on income distribution. Until 1973 there was a trend of improvement in income distribution as disclosed in the Consumer Finances and Socio Economic Surveys of the Central Bank. Since 1978/79 there has been a deterioration in income distribution. In the last survey of 1986/87 income distribution had deteriorated to the extent of the top decile enjoying as much as 39% of incomes. The lowest 40% of income receivers, on the other hand, enjoyed an income of less than 15% of total incomes. (*The Central Bank of Sri Lanka* 1994). This pattern of income distribution appears consistent with the emerging pattern of morbidity. The morbidity pattern in Sri Lanka has a bi-polar distribution with a high incidence of diseases associated with low incomes, poor

housing and sanitary conditions, as well as a high incidence of illnesses associated with stressful conditions of modern living, unhealthy foods and excessive food consumption.

It may not be unreasonable to conclude that this morbidity pattern is closely associated with the global transformation, which brought about this income distribution pattern as well as modern styles of living. Although the Kuznet's curve of income distribution, which indicates a deterioration in income distribution at early stages of rapid economic growth and an improvement in income distribution after a higher level of economic growth is achieved, is now not widely accepted, the Sri Lankan experience appears to confirm this earlier wisdom. Whether there would be an improvement in income distribution in subsequent years with the continuation of the globalisation is an interesting question to pose.

The other related impact of globalisation or structural adjustment policies was on nutrition levels. Prior to the change in economic policies basic food prices were kept low through administered pricing and food subsidies. These policies were changed. Economic growth and improvements in income were expected to ensure adequate nutritional levels. The removal of the food subsidy, discontinuance of administered pricing and the devaluation of the currency resulted in a sharp rise in prices of basic commodities. Between 1978 and 1985 food prices tripled. (Sanderatne 1985) Those who were entitled to food stamps were inadequately compensated. (Alailima & Sanderatne 1982) Between 1978-79 and 1981-82, the lowest quintile consumed less of staple foods like rice, wheat flour, bread, coconut and sugar. (Alailima & Sanderatne 1982) By 1981-82 the consumption of the lowest decile fell to 1181 calories and 49 percent of children in the lowest income quintile was chronically malnourished. With the nutrition intervention programmes for school children by 1993 there was an improvement. (Alailima & Sanderatne 1997).

These developments indicate that the initial impacts of globalisation on nutrition and poverty could be adverse and that unless direct interventions to protect the poor are in place, their quality of life, in a very basic sense, tends to deteriorate. Paradoxically, at the very time when such support is needed, the theoretical underpinnings of the system actually militate against such intervention in the name of competition, the free market, investment and growth.

5. Broader Indicators of the Quality of Life

The above discussion has been in terms of a few social indicators related to health and education. The impact of globalisation on the quality of life has been much more than could be captured by these basic indicators. The inclusion of other indicators could reflect the quality of life in a more comprehensive manner.

In the area of health it could include not merely the mortality rates but also access to health facilities, doctors and nurses per population and the incidence of illnesses and morbidity patterns. In determining the status of health of a country one could also consider social tension indicators such as suicide rates, as well as the qualitative aspects of health care rather than confine it to the quantitative aspects.

The impacts have been on a whole range of economic, social and cultural aspects of living that have affected the lives of a very large proportion of the population and most notably the poorer sections. These impacts relate to higher female participation in the work force, the mobility of labour, the access to television, information technology, international travel and tourism, availability of a wide range of goods, especially imported commodities, consumer durables, changes in the modes of transport and a greater international awareness.

There are indications that some of these broader indicators have deteriorated after globalisation. For instance, suicide rates have increased to 47 per 100,000 - the highest in the world. Mental illnesses are more rampant. An estimated 70,000 persons suffer from Schizophrenia, depressive and anxiety disorders account for up to one-third of all primary health care visits and around 5-20% of those over 65 years suffer from dementia. (*National Council for Medical Health* 1996) Alcoholism has increased and Sri Lanka's per capita alcoholic consumption rates are among the highest in the world.

Are the deteriorations in these aspects owing to the processes of global transformation? Even though no definite answer could be given to this, there is little doubt that the processes of modernization effected through globalisation has led to social alienation, stress and unhealthy conditions of living, weakening of traditional family cohesiveness and an insatiable consumerism. These developments are no doubt part of the explanation for these adverse developments in society.

More positive aspects are also evident after globalisation. The access to newspapers, magazines, radio and television has increased dramatically since the new economic policies were implemented. There is also no doubt that a number of material indicators such as the quality of clothing, the access to luxuries and semi luxuries, the possession of vehicles etc. have increased. For instance, Sri Lankans did not have television prior to globalisation. Today there is a television set for every 29 persons. Radios, cameras, motor cycles and similar goods are quite common. Whether the access to these material possessions has improved the quality of life is a question which is difficult to answer. This is especially so as several improvements in material wellbeing bring with them some negative aspects as well.

For instance, while the access to television *per se* may be considered a potential improvement in the quality of life, if the quality of the television programmes is such as to damage social ethics or do not elevate the viewers' thinking, critical awareness and the enjoyment of what may be deemed the higher levels of cultural life, then the quality of life is not necessarily improved. In fact, some of the programmes may damage the moral and social fabric of society, and could be deemed as damaging the quality of life. On the other hand, television holds out the prospect of access to latest technology and other cultures. It has both an entertainment - cultural value as well as a means of enhancing awareness of the world and access to the latest knowledge. It can be especially valuable in increasing the knowledge and awareness of the young, language learning and broadening of the mind.

Another important impact of globalisation is the large scale migration of workers to Middle Eastern countries. This outflow of labour has significant economic and social ramifications for the country. The foreign exchange remittances have become an important component of the country's savings and investment. For the quality of life it has had both positive and negative impacts. On the positive side, a significant number of persons have improved their standard of living and acquired material assets such as houses, or improved their dwellings, found start up capital for small enterprises and been able to afford consumer durables like vehicles, television, radios, cameras etc. No doubt these acquisitions have improved their quality of life. On the other hand, the migration of workers has resulted in single parent households, break up of marriages, alcoholism and other social evils. Besides this, some of those who have gone on work assignments have faced unnatural death and humiliation. Therefore this aspect of globalisation has had both positive and negative impacts on the quality of life especially for the poorer segments of society.

While a proper assessment of the quality of life requires the consideration of these broader indicators, the evaluation and determination of whether the global transformation, which made possible increased material possessions, has in fact improved the quality of life is difficult to determine in an objective manner. Nevertheless, it is important to point out that a narrow definition in terms of basic health and education indicators has serious limitations in assessing the impact of global transformation on the quality of life.

6. Conclusions

In terms of the definition of the quality of life AASSREC has adopted, which are also the ones which most development studies utilise, Sri Lanka has had impressive improvements prior to the global transformation arising out of the economic reforms of 1977. Since the integration of the Sri Lankan economy with the global economy in the late 1970s there has been a tardy progress of some of

these indicators. This slow progress is no doubt partly owing to the strains in economic growth since the 1960s and not necessarily attributable to the globalisation and economic reforms alone. The shift in economic policies, including the change in emphasis on welfare and direct interventions, as well as the impacts of the new economic policies have had their effect on these indicators. Apart from the slower growth of these indicators, there also appears to have been qualitative deteriorations in health and education. On the other hand, there have been increased access to a number of other material goods and services. Whether the access to these material possessions and services have contributed to an improvement or deterioration in the quality of life remains a difficult issue to resolve. Yet, a discussion on the impact of global transformation on the quality of life, if restricted and confined to the basic indicators, is inadequate. Social scientists must look at the impact of the global transformation on the quality of life in terms of much broader indicators. The sooner they grapple with the more difficult issues of determining the impacts on all aspects of social development the more relevant would be their contribution to this discussion.

References

AASSREC (Association of Asian Social Science Research Councils) (1994). "Local Impact of Global Transformation with Special Reference to Social Development Issues".

Alailima P.J. (1985). "Impact of Social Programmes and Service Delivery". pp. 24-40. In: UNICEF. *Social impact of economic policies in the last decade*.

Alailima P.J. & Sanderatne N. (1982). *Trends and Future Prospects for Food Supply and Consumption. Implications for Food Policy in Sri Lanka*. Mimeo, Colombo.

Alailima P.J. & Sanderatne N. (1997). "Sri Lanka's Social Development : A Retrospective Analysis". In: Mehotra Santosh and Richard Jolly (Eds) *Development with A Human Face*. Oxford University Press, New York.

Central Bank of Sri Lanka (1994). *Consumer Finances and Socio-Economic Survey 1986/87*.

Ministry of Health, Highways and Social Services (1995). *Sri Lanka National Report - The World Summit on Social Development*.

National Council for Medical Health (1996). *Improving Mental Health in Sri Lanka*. Colombo.

Sanderatne, Nimal (1985). "The Effects of Policies on Real Income and Employment", pp. 11-24. In: UNICEF. *Social impact of economic policies in the last decade*.

UNICEF (1985). *The Social Impact of Economic Policies in the Last Decade*. Colombo.