Consequences of Structural Adjustment Programme for health policy and health outcomes in less developed countries

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Introduction

During the early 1980's, the two largest financial institutions in the world, the World Bank and International Monetary Fund (IMF), released a joint mission statement declaring that poverty in the developing world was "the greatest challenge facing the international community" and that together they would play an important role in its eradication (Easterly, 2003, p.361). This was a response to a series of crises during the 1970's that ranged from natural disasters in the form of droughts to man-made failures like erroneous currency overvaluations (Peabody, 1996); these caused economies throughout the developing world to go into stagnation. The chief strategy proposed by the World Bank and The IMF for rebuilding these economies came in the form of Structural Adjustment Programme (SAPs). These were conditional loans that focused upon the shifting of power from the state to the market, which mirrored the neoliberal ideologies dominant in the West in the same era under the Thatcher and Reagan administrations. SAPs were offered to developing countries without exception and were deployed in remarkably similar ways, which is why in many respects the effects of SAPs can be generalised across the developing World (Gloyd, 2004). These economic policies have been described as "short-term austerities that lead to long-term growth" (Peabody, 1996, p.823) and there is a wealth of literature charting the successes and failures of them in all spheres of society. This essay will focus on both the direct and indirect consequences of SAPs on health policy, which unlike some other aspects of economic planning, cannot be delayed. For an individual short term 'health austerities' cannot necessarily be corrected by improved healthcare in later life.

Structural Adjustment Loans

The structural adjustment loans offered by the World Bank and IMF to developing nations could only be arranged if certain conditions were met. These focused on embracing globalisation by liberalising transnational trade through increasing imports and decreasing exports as well as taking power away from centralised governments by withdrawing subsidies and reducing the number of civil servants (Wakhweya, 1995). Has this Western free market ideology been successful? Many think not, and the facts tend to agree with them: debt throughout the developing World almost doubled in the first six years of SAP's implementation, from $562 billion in 1982 to
$1020 billion in 1988 (Kanji, 1991). SAPs have also been criticised for having a more selfish motive than was first publicised. In reality, they have served to maintain the international 'status quo' created under imperialism and colonialism in which the South was financially exploited by the North. SAP's have continued this exploitative relationship by re-orienting the economies of debtor nations towards "cut- price" exports which the developed World can exploit, as well as forcing governments to switch economic priorities away from a focus on the interests of their own people (Pettifor, 2001). The failure of the SAPs is acknowledged by research from the World Bank itself, who found that while in 1979 there was a net flow of capital of $40 billion from the developed to developing countries (through aid payments), by 1991 this trend had reversed, with a flow of $60 billion from the poorest to the richest countries in the World, primarily through debt repayments of SAP loans (Kanji,
1991).

SAP's and malnutrition

One of SAPs' greatest effects on health comes indirectly through their impact on agriculture. SAPs encourage a shift from subsistence farming to the production of cash crops like tobacco and coffee for export, in an attempt to increase the income of the rural populations whilst promoting trade with the developed world. A study in Ghana and Zambia exemplified this by showing that between 1983 and 1986, when SAPs in these countries had just been introduced, per capita output of each major food staple, such as rice and cassava, decreased by 30% (Loxley, 1990). However, the market competition cr-ated by dozens of countries moving into cash crop exports served to drive the prices down, limiting exporters' income to a bare minimum, while allowing the importers (e.g. the global North) to enjoy huge savings (George, 1990). For these two reasons the poorest people were unable to either grow their own food or raise enough money to buy imported food, so malnutrition rates increased in countries that were already hampered by famine and drought. This is particularly dangerous for children as demonstrated by a recent study involving 53 developing countries, which found that 56% of child deaths throughout the developing world are attributable to malnutrition's debilitating effects (Pelletier, 1995). Women, and in particular mothers are also a group at risk from malnutrition which result from SAPs because the programs assume that the whole workforce is "equal before the market." Due to women's arbitrary culturally assigned social responsibility for sustaining

the family, they cannot participate in the, albeit small, benefits of cash crop farming. So men reap the benefits of the agricultural adjustment and women are often left caring for children with little source of income, so are prone to malnutrition (Stromquist, 1999). Anaemia rates are important indicators for malnutrition and it has been shown that 65% of pregnant women in developing countries are anaemic, which is a risk factor for low birth weights and increased perinatal mortality (Kanji, 1991).

A study into the effects of SAPs in Jamaica explored another way in which Structural Adjustment can cause malnutrition and hence the adverse health effects discussed earlier. The SAP loan here, and in many other countries, was conditional upon economic steps that induced a steep devaluation in currency. The aim was to make their goods cheaper for foreigners to buy but also made it more expensive to import goods. The latter consequence had a particularly damaging effect on the price of food, as two staple foods, rice and flour, inflated exponentially due to increased import prices. The study found that the short-term indicator of malnutrition, wasting, increased in children after SAP implementation and so the researchers concluded that the SAP was the causal link for increased malnutrition (Handa et al., 2003).

Decentralisation of the state:

Many other sectors of society, also indirectly related to health outcomes, were damaged by the Structural Adjustment through the decentralisation of the state and consequent reduced government spending. Investment in education, sanitation and infrastructure, all major determinants of the health status of the poor, suffered as the cost of social services that had previously been provided free or at minimal prices increased (Gloyd, 2004). Literacy rates, an indicator for better child health outcomes, went down as recur-rent expenditures on education aids were slashed and efficiency measures to increase class sizes were implemented (Gloyd, 2004). Sanitation and Infrastructure projects were also halted all over the developing World, with increasing rates of diarrhoeal diseases and reduced access to health services, particularly in rural areas (Peabody, 1996).

Curiously, the World Bank and the IMF did not focus their demands on reducing military expenditures, which in many developing countries take up a large proportion of public sector spending (Gloyd, 2004). Many governments, particularly in Sub-Saharan Africa, have argued that this spending was necessary in robustly tackling the violent protests that started in the 1980's and became almost ubiquitous amongst adjusting nations in response to SAPs. However, the paradox is that if more social sector spending in SAPs had been on the poorest parts of societies as opposed to the military, then the populations would have been less prone to stratifying into

the "have" and "have not" groups which tend to brew conflict and civil unrest (Wakhweya, 1995).

Health system privatisation

The primary effect of SAPs on health is through the changes they bring about to national healthcare sys-tems. In the context of SAP privatisation, healthcare is seen as a commodity for purchase as opposed to a basic human need (Kanji, 1991). The introduction of user fees in many developing countries is testament to this, and the implications for health are considerable, with many inhabitants seeking other means of cheaper healthcare. In Zimbabwe, shortly after the country embarked on an SAP in the early 1990's, user fees were introduced into primary healthcare settings and healthcare attendance immediately declined. Research indicated that during the first two years of adjustment attendance at healthcare facilities declined by 25-30% (Bassett, 1997). The majority of those affected were in the lowest income households. They compensated for not being able to afford modern medical treatments by relying on traditional health practices and home- based medicine. The same research study in Zimbabwe found that home treatments increased shortly after implementation of SAPs (Robson, 2000). Despite strong beliefs in the value of traditional med-ical practices within the cultures of many developing countries, there is very little scientific evidence base for their effectiveness. It is a clear example of social inequality. If affordability makes people resort to these practices rather than the biomedical healthcare, which is scientifically proven to be effective.

The cost of treatment

Another major problem for healthcare is the lack of financial resources to buy medicine, which has been brought about by SAPs. Around 80% of medicines in Africa are imported from huge multinational pharmaceutical countries in the West, which, even before the birth of Trade Related Intellectual Property Rights in 1994, was an unsustainable practice (Sanders, 1991). With SAP conditions including currency devaluation and decreased healthcare budgets, drug spending was inevitably curtailed in many developing countries. Zambia and Uganda are primary victims of this as the 1986 allocation for drug imports was only 25% of its value in 1983, with SAPs both being implemented in this three year period (Sanders, 1991). Even more worryingly, in Mozambique, immunisation outreach programmes stop in August or September every year, as the allocated money runs out before the end of their fiscal year (Gloyd, 2004). As a result of this drop in availability of medicines and vaccines, market prices within the country invariably increase, only adding to the effect of user fees in preventing the poorest people from accessing healthcare.

Effect on healthcare workers

The human resources, doctors and nurses, are also caught up in Structural Adjustments. SAPs often required huge layoffs in public sector employees, with the ministry of health usually the hardest hit due to its large volume of workers (Gloyd, 2004). This triggered many healthcare professionals to either transfer to the private sector, contributing to the social phenomenon of brain drain, or if no jobs became available, to face unemployment. Even the healthcare personnel lucky enough to keep their jobs faced salary cuts, as high-lighted in Mozambique, where nurses who had been earning $150 per month in 1980 were earning $30 by 1995, a 500% decrease (Gloyd, 2004). As health care workers faced a reduction in earnings and decreased job security, it is understandable that economic survival, not patient care, became a dominant daily concern (Bassett, 1997). It is no surprise then that nurses across Sub-Saharan Africa began to strike (Bassett, 1997) and many others started to charge patients under -the- table fees to raise their incomes (Gloyd, 2004). This is highlighted by a 2013 study by 'The Afrobarometer' that found that nearly a third of Africans have paid a bribe in the last year, with medical treatment being the second most likely reason for this *(Washington Post*, 2013).

Conclusions

SAPs were set up by the IMF and World Bank ostensibly to demonstrate their strong commitment to ending poverty. However, from the outset, the policy's cardinal flaw was to focus solely on economic growth, and overlooked the fact that it takes more than just fiscal policy adjustments to improve health (Breman et al., 2007). It is difficult to blame reduced health out-comes throughout the developed world unequivocally on SAPs because there were no areas or countries that were left unadjusted to use as 'controls' to give us a comparison. But what is true is that there has been little improvement in health and healthcare through-out Africa and other adjusting countries during the 1980's and 1990's, despite it being a period of unparalleled economic expansion throughout the world (Gloyd, 2004). UNICEF argues that development must be implemented with a "human face" and that social effects of development should take precedence over economic growth (Cornia et al., 1987). The Jubilee movement, a coalition of 40 countries established in 2000, echoed UNICEF's sentiments and called for the cancellation of SAP debts, to allow developing countries to rebalance their books, in order to prioritize their spending on the critical areas of health, education and clean water. Gloyd neatly summarises the situation in the book *'Sickness and Wealth: The Corporate Assault on Global Health':* "The economists of the IMF and World Bank have pushed many countries down paths that have undermined the capacity of governments to respond to the needs of their population and to provide basic services" (Gloyd, 2004, p.54). And as has been argued earlier, all of these services play a critical role in maintaining the most basic of human rights: health.

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