DISCUSSION AND CONCLUSION

"...These policies, which took hold in the early 1980s and is spearheaded by the International Monetary Fund (IMF) and the World Bank, may have created conditions favoring the spread of HIV infection. These policies led to the declining sustainability of rural subsistence economies.... people in rural areas are often forced to leave their families in search of work.... Ultimately, these migration patterns may be linked to the spread of HIV."
[DeNoon J, 1995]

The structural adjustment policies refer to a set of macroeconomic measures designed to address the underlying structural problems that led to the economic collapse of several developing countries in the 1980s and 1990s. These policies usually start by a stabilization package financed basically by the International Monetary Fund (IMF) to cut the budget deficit and control the inflation rate. This initial stabilization is then followed with structural reforms to reduce the state involvement in the productive, financial and social fields and to encourage the private and non-governmental sectors to replace the state in these fields. Governments are required to bring in new legislative and legal frames required to put the adjustment activities into action. These activities include privatization of the state-owned enterprises, elimination of control over prices, liberalization of the trade and financial regimes and cutting back governmental expenditure. The ultimate goal of the structural adjustment is to achieve positive economic growth rates.

The structural adjustment policies were introduced in the early 1980s, when developing countries were hit with three major shocks and the curtailment of external funding that came with the debt crisis in 1982. The three shocks were the global recession of 1979-82, the increase in real interest rates to positive levels for countries that had become accustomed to cheap financing, and the decline in the terms of trade for producers of oil and primary commodities. These shocks led to
large and growing internal and external imbalances just when external financing declined sharply because of the debt crisis. Since 1981, structural adjustment has moved from a vehemently contested set of proposals to a widely if grudgingly accepted reality for most states in the third world. This development has been endorsed by the failure of the socialist economic model and the predominance of the neoliberal model in the globalization era.

The impact on health of the structural adjustment policies has emerged as a controversial debate in international health. Some economists and public health researchers and some government and non-government commentators allege that the structural adjustment programs have had a detrimental health impact. Some have even alleged that the health outcomes of the structural adjustment programs have been so adverse as to reverse many of the gains made in the earlier post world war II decades. The World Bank has been criticized as negligent about the health impact of the structural adjustment programs it sponsors. Further, in its response to this criticism, some contend that the World Bank has in general conducted face saving activities instead of remedial action grounded in a solid scientific basis. This impact was even criticized by several international agencies like UNICEF, WHO and NORAD.

Furthermore, the role of the World Bank in health sector financing and reform in developing countries has significantly increased throughout the last two decades. World Bank's lending to health sector has been tied to the structural adjustment reforms and has stipulated a policy package for health policy reform. As a result, the World Bank has become the world largest international health agency and the major player in the international health scene, eclipsing, in certain domains, the position of WHO and UNICEF. Several analysts have raised concerns over this role and warned that concentrating in a single institution impressive financial resources and heavy political weight might be detrimental. The argument has been advanced that the blanket policy prescriptions of the World Bank are not grounded in the specific history, history, experiences and problems of a particular country. Furthermore, since lending loans are tied to structural adjustment policies, most countries are unable to negotiate the attendant conditionalities as equal partners with the Bank. The conditionalities of structural adjustment have been blamed meanwhile to have diverted government revenues away from education and health care and toward debt repayment and the promotion of exports. This was described to have given the World Bank and IMF a degree of control that even the most despotic of colonial regimes rarely achieved.

Furthermore, the structural adjustment policies are being heavily criticized by the public, press and non-governmental organization. The public response is so strong that peaceful as well as violent demonstrations against these policies have accompanied all meetings of the World Bank and IMF in the last few years. International alliances and fronts against these policies are actively voicing
opposition and calling to stop the World Bank's "crimes against humanity" in developing countries.

The opponents of the structural adjustment including the World Bank argue that these claims are not based on an empirical bases and therefore lack the scientific evidence. They stress that it is impossible to attribute with confidence any of these claims to the structural adjustment policies. They indicate that the adoption of these policies came in the wake of economic difficulties, their implementation has taken place at a time when developing countries face an increase in the incidence of absolute poverty, environmental degradation, deterioration of housing conditions and nutritional standards, emergence and resurgence of infectious diseases. These are the circumstances that made the adjustment necessary and attributing them to adjustment is a misconception of what the cause and the effect are.

Recognizing the importance of the current debate, a review of all the available literature on this subject revealed that there is a severe shortage of solid research in this area. Furthermore, the extant set of studies suffer from several shortcomings. First, they are too general in their analysis, with the result that their conclusions and/or proposed solutions too often blur what is desirable with what is feasible in health outcomes, and are more in the nature of wish lists. Second, they were mainly designed in a way that is more suitable for polemics in a polarized debate between defenders and opponents of structural adjustment programs - more suitable for providing confirmation of an ideology rather than making objective tests between reasonable alternative explanations of the observed health outcomes. Third, they lack a systematic comprehensive framework for separating the effects of background conditions and other external shocks from those of the structural adjustment program itself. Fourth, they fail to analyze the distinct components of a structural adjustment package, with the consequence that they lack estimates the relative importance of the (often countervailing) effects that each distinct component of the package has on health outcomes. Fifth, they fail to trace the intermediate links between external shocks and policies on the one hand, and the health outcomes on the other hand. Sixth, they are too imprecise in their methods of quantifying the magnitudes and time lags of the variables in each stage of the causal chain. Seventh, they fail to identify early warning health indicators of respectively the short, medium and long run health (and hence economic productivity) outcomes that are attendant on a structural adjustment program.

The conclusion from this review is that no solid conclusions can be drawn on whether the structural adjustment programs have been highly damaging, somewhat deleterious or overall roughly neutral, in their health outcomes. Furthermore, given the economic necessity of restructuring, information about its undesirable health side effects is of limited use to policy makers unless accompanied by information on how to intervene to alleviate them. The issue is how to intervene so as to reduce or
eliminate the negative impact on health costs while yet reaping benefits from economic reforms.

This study was undertaken to ascertain and identify means of improving the impact on public health in developing countries of their structural adjustment programs. The study has basic three features. First, analysis took place within a consistent causal model: rich enough to be comprehensive in causal factors— including background conditions and other external shocks as well as the structural adjustment program, be able to identify the separate contribution of each key component of a country's structural adjustment program, and be attentive to the time path of health effects, distinguishing between the short, medium and long run. Such a comprehensive disaggregate consistent framework is required to sort out which causes contribute to each health outcome, and where there are multiple causes, the differential magnitudes of their respective contributions.

Second, emphasis on the intermediate causal links between structural adjustment programs and health outcomes. These are where a scope for intervening is anticipated to alleviate or even reversing adverse health impacts. Third, emphasis on early warning indicators that can be used in assessing the detrimental effects of the structural adjustment program on health, distinguishing between short, medium and long run effects, and the effectiveness of interventions in alleviating those detrimental effects. Selecting health indicators that precede health outcomes is essential if we are to act in the foreseeable future, rather than leave the task of assessing the health outcomes from structural adjustment programs as a task for future economic and health historians. Likewise, it is of limited value to design preventive or remedial interventions whose effectiveness we can only assess in the distant future.

In this study, the “Deductive pragmatism” design was innovated, its principles were laid, and tools were developed. Deductive pragmatism is a research method aiming at helping researchers communicate qualitative assumptions about cause-effect relationships, elucidate the ramifications of such assumptions and drive causal inferences from a combination of assumptions, experiments, observations and case studies. This unique methodology couples the affirmative nature of causal effects tracing measures (such as correlational studies) with the interpretive nature of process tracing schemes usually found in case studies and other qualitative methods. Furthermore, it bridges the gap between the academic interests of research and the prescriptive demands of policy-making.

Deductive pragmatism responds basically to the fact that conventional epidemiological models for causation have serious limitations as a source of causal inference. This is particularly true for complex situations such as the impact of structural adjustment on health. Such an issue involves several reciprocally interacting variables that cannot be accurately accounted for by conventional
correlational approaches. Furthermore, a big part of the literature on the impact of structural adjustment encompasses subjective and qualitative assumptions, which lack a sound empirical base in most of the cases.

Deductive pragmatism consists of three basic steps; 1) hypotheization of causal relation, 2) verification of causal effects, and 3) tracing of causal processes. The following sections explains each component in details.

The assumptions about the causal pathways between structural adjustment policies and health can be extracted from the narrative and illustrated using causal diagrams. The causal diagrams explicate a scenario's causal structure with categories of variables (distal, intermediate and proximate) and causal relations (social, economic, behavioral, psychological and biological). The basic function these causal diagrams serve is that the causal structure of the events and processes that are implicated in the impact of structural adjustment can be more formally described and analyzed.

The causal diagrams add visibility to significant features of the alleged causal relations such as causal hierarchies, conflicting causal assumptions, the reciprocal and mutual effects of variables, unintended consequences, and the dual constitutive and reflective roles of structural adjustment. Regarding causal structure, a causal diagram represents a scenario as a branching network of events and causal relations. This structure conveniently allows the causal role or meaning of each event to be defined in terms of the causal relations it has to other events in the diagram.

The second step in the deductive pragmatism approach was to statistically examine individual causal assumptions among variables illustrated in the causal diagrams. The pragmatic methods proposed in this section permit the investigator to translate complex considerations of causal links between structural adjustment and health into a formal language, thus facilitating the following tasks: 1) explicate the assumptions underlying the causal model, 2) decide whether the assumptions are sufficient for obtaining consistent estimates of the target quantity: change in certain health indicators, 3) if the answer to item 2 is affirmative, the model provides a closed-form expression for the target quantity, in terms of distribution of observed quantities, and 4) If the answer to item 2 is negative, the method suggests a set of observations, which if performed, would render a consistent estimate feasible.

Verification of the causal relationship included the comparisons of carefully selected set of indicators for the causal domains of the causal diagram between adjusting and non-adjusting countries. A set of 90 developing countries was included in the analysis. The selection of these countries was guided by the following criteria: 1)
Only low and middle income countries were included in the study. The OCED as well as non-OCED high income countries were excluded, 2) only countries whose population in 1997 is larger than 1 million was included. Smaller countries usually have much smaller economies and can undervalue the comparative value of the analysis, 3) Communist economies such as China, Cuba and North Korea were excluded from the analysis, 4) Iraq was excluded from the analysis because of the devastating effects of three successive wars and the international embargo. These have influenced the health and the social welfare of the society more than any other factors, 5) Countries were classified into adjusting countries if they received at least one structural adjustment loan from the World Bank or the International Monetary Fund by 1997.

The regional distribution of the countries included in the analysis indicated that 39 countries were from sub-Saharan Africa, 14 countries from the Middle East and North Africa, 21 countries from the Latin and Middle America and 16 countries from the Asia and Pacific region. With respect to national income, 49 were low income countries, 25 were lower middle income countries and 16 were upper middle income countries.

With respect to structural adjustment, 63 countries were classified as adjusting countries and 27 as non-adjusting countries. Classification was made according to structural adjustment lending by end of 1995. The regional distribution showed that sub-Saharan Africa had 29 adjusting and 10 non-adjusting countries, the Middle East and North Africa had 6 adjusting and 8 non-adjusting countries, the Latin and Middle America had 17 adjusting and 4 non-adjusting countries, and the Asia and Pacific had 11 adjusting and 5 non-adjusting countries. The distribution of these countries by national income showed that the low income category had 38 adjusting and 11 non-adjusting countries, the lower middle income category had 18 adjusting and 7 non-adjusting countries, and the upper middle income category had 7 adjusting and 9 non-adjusting countries.

According to the deductive pragmatism model, 4 causal pathways were drawn for the potential impact of structural adjustment on health. These pathways were:

1) A direct pathway on survival and health. Three sets of indicators were used to assess changes in the health status in adjusting and non-adjusting countries. These are survival indicators, mortality indicators and summary (composite) health indicators.

   a. Survival Indicators. Life expectancy at birth was the basic survival indicator in the study. It expresses the number of years a newborn infant would live if patterns of mortality prevailing at its birth were to stay the same throughout its life. Male and female life expectancy are compared at two time points among adjusting and non-
adjusting countries; 1978 and 1998. And to account for the longitudinal effects and the time lag of the effects of the structural adjustment, the gain of life expectancy made between these two time points were compared among adjusting and non-adjusting countries.


c. Summary Health Indicators. Eight summary health measures are used to compare health status among adjusting and non-adjusting countries. They are 1) Male Healthy Life Expectancy at birth, 2) female Healthy Life Expectancy at birth, 3) male Healthy Life Expectancy at age 60, 4) female Healthy Life Expectancy at age 60, 5) Expectation of disability at birth for males, 6) Expectation of disability at birth for females, 7) average male Life Span Lived with Disability, and 8) average female Life Span Lived with Disability.

2) A direct causal pathway on health system performance. Health system performance is assessed using 7 indicators: 1) the WHO’s country score for health attainment level of the health system, 2) the WHO’s country score for health attainment distribution of the health system, 3) the WHO’s country score for responsiveness level of the health system, 4) WHO’s country score for responsiveness distribution of health system, 5) WHO’s country score for financial fairness of the health system, 6) WHO’s country score for overall attainment of the health system, and 7) WHO’s country score for overall performance of the health system.

3) A direct causal pathway on health system financing. This causal pathway included two causal domains of health system financing.

a. Flow of Resources. Indicators for the flow of resources include 1) total health expenditure as a percent of Gross National Product (GDP), 2) public expenditure as percent of total health expenditure, 3) private expend as % of total health expend, 4) out of pocket as % of total health expend, 5) tax-funded expend as % of public health expend, 6) social security exp as % of public health
expenditure, 7) public health expend as % of total public spending, 8) per capita total expenditure at official exchange rate, 9) per capita out-of-pocket at official exchange rate, 10) per capita total health expend in IDS, 11) per capita public expenditure on health in IDS, and 12) per capita out-of-pocket health expend in IDS.

b. Patterns of Spending. Indicators for the health financing patterns include 1) public expenditure on health in 1990s, 2) public expenditure on health in 1960s, 3) public expenditure in 1998 as % of 1960, 4) public expenditure on education (as % of GNP) in 1985, 5) public expenditure on education (as % of GNP) in 1995, 6) public expenditure on education as percent of total government expenditure in 1993-95, 7) defense expenditure as percent of GDP in 1985, 8) Defense expenditure as % of GDP in 1996, 9) defense expenditure per capita in 1985, 10) defense expenditure per capita in 1996, 11) military expenditure as percent of combined education and health expenditure in 1960, and 12) health expenditure as percent of GDP in 1998.

4) Indirect causal pathway to utilization of health system through cost recovery and user fees. This pathway traces the allegation that the introduction of cost recovery and user fees schemes has led to severe under-utilization of health care services, especially by the poor.

5) Indirect causal pathway to organization and quality of health services through privatization. This pathway traces the assumption that the privatization of health system has led to deterioration in the quality of health services by fostering the uncontrolled practice of the private sector. It also examine the allegation that the privatization of health care has not led to increased efficiency of health care delivery as promised by the adjustment proponents.

6) Indirect pathway to health through poverty and income inequalities. This pathway included four basic domains.

a. **Size of Economy.** The indicators used for the size of the economy were 1) the per capita gross national product and 2) the annual growth rate of the per capita gross national product.

b. **Levels of Poverty.** The indicators used for the poverty level domain were 1) human poverty index, 2) population below income poverty 1$ a day and 3) population below income poverty defined by the national poverty line.
c. **Income inequalities.** Indicators used for income inequalities were 1) the Gini coefficient for income distribution, 2) the share of the poorest 20% in the real GDP per capita, 3) the share of the richest 20% in the real GDP per capita, 4) female share in earned income and 5) male share in earned income.

d. **Entitlement to basic services.** Four indicators were used for this domain: 1) the proportion of population without access to health care, 2) proportion of population without access to basic sanitation, 3) proportion of population without access to safe water and 4) proportion of children not reaching grade 5.

7) **Indirect Pathway to health through literacy and education.** Eight indicators were used to determine the impact of structural adjustment on health through the education and literacy causal limb. These indicators are 1) adult literacy rate, 2) Combined first-, secondary- and third-level gross enrolment ratio for female, 3) combined first-, secondary- and third-level gross enrolment ratio for male, 4) total primary gross enrolment ratio, 5) female total primary gross enrolment ratio as percent of male, 6) total secondary gross enrolment ratio, 7) female gross secondary enrolment ratio as percent of male, and 8) children not reaching grade five.

Furthermore, the causal mechanisms explicitly stated in these causal pathways were traced and examined using the "process tracing" component of the deductive pragmatism methodology.

The causal process tracing may take different forms. The simplest form of process-tracing, "linear colligation," depicts "a straightforward chain of events" which is often a simplification of a complex phenomenon. Convergent colligation depicts the outcome to be explained as flowing from the convergence of several conditions, independent variables, or causal chains. Causal process tracing in this study used a hybrid approach between linear and convergent colligation. The overall model for the causal relation was designed using the linear colligation form. Using that form, the causal chain including all the seven causal domains of the model was linked with each other. These causal domains are a direct detrimental effects on health, health system performance, health system financing, poverty and income inequalities, nutrition and food security, education and literacy, and urbanization and environment. Within each domain, a complicated causal limb was proposed using the convergent colligation form of process tracing. [For more details, refer to chapter 2]

The basic findings of this research can be summarized in the following points:
Survival Indicators. The empirical analysis showed that there was a statistically significant difference in the aggregate mean of life expectancy at birth between adjusting and non-adjusting countries. Non-adjusting countries were shown to survive adjusting countries by 6 years. Likewise, the gains in life expectancy throughout the last two decades were shown to significantly differ between adjusting and non-adjusting countries. However, the differences were shown to be more methodological artefact rather than real differences in survival and life longevity.

When the national income was taken into consideration the gap decreased in low income countries to only 3 years. Furthermore, adjusting countries in the lower middle income category were shown to have a higher life expectancy of the same magnitude than non-adjusting countries. Upper middle income countries did not show significant difference.

In low income countries, the difference in life expectancy is believed to be due to the fact that many of the adjusting countries in sub-Saharan Africa are stricken by the HIV/AIDS epidemic. The AIDS has cut the average life expectancy in Zimbabwe by a quarter-century, besides significantly reducing life spans in other African nations. The average Zimbabwean can now expect to live 39 years, down from 65 prior to the AIDS epidemic sweeping the country.

AIDS results in higher mortality rates in childhood, as well as among young adults where mortality otherwise is low. As a result, AIDS deaths will have a larger impact on life expectancies than on some other demographic indicators in these nations.

A recent report [US Census Bureau] estimated that Zimbabwe has 1.6 million fewer people directly and indirectly due to AIDS, while Uganda has 1.3 million fewer; Nigeria has nearly 1 million fewer and South Africa has 900,000 fewer. By the year 2010, sub-Saharan Africa will have 71 million fewer people than it would have without the effect of AIDS. The projected population declines are: Nigeria, 11.7 million fewer people; Kenya, 6.7 million fewer; South Africa, 5.6 million; Zimbabwe, 4.4 million; and Uganda, 4.2 million.

Some of the countries most affected by AIDS epidemics are projected to have zero or near-zero population growth, because of the higher mortality rates combined with low projected fertility rates. By the year 2010 growth rates are projected to be reduced 75 percent or more in South Africa and in Zimbabwe. In Kenya, growth rates will be reduced 66 percent, while Nigeria's growth rate is expected to drop more than 40 percent.

Seven developing countries in Asia and Latin America also are significantly affected by AIDS, including Guyana, Myanmar, Haiti, Cambodia, Honduras, Brazil and Thailand.
Childhood Mortality. The claim that structural adjustment policies have led to setbacks to improvements in childhood mortality does find a support in our study and is therefore refuted. The overall under-five mortality rate declined by almost 51.6% and 52.9% between 1969 and 1999 in both adjusting and non-adjusting countries respectively. Through the levels and trends differed among different regions and by country income category, adjusting and non-adjusting countries showed similar levels and trends of U5 mortality in each region and in each income category. Furthermore, the countries which showed reversal or significant slowdown in the reduction of U5 mortality rates were all non-adjusting countries. The overall trend of reduction in U5 mortality has relatively slowed down throughout the 1990s. However, this was witnesses in both adjusting and non-adjusting countries alike. This is believed to be due to the already low child mortality levels in many countries in Latin America, the Western Pacific Region and the Middle East. Furthermore, the lack of substantial progress in the African Region and the South-East Asia Region played a significant role in slowing down the pace of reduction in U5 mortality.

Child mortality has continued to decline despite the economic difficulties of the 1970s and 1980s and despite the adoption of tough economic measures under adjustment.

The 1990s have seen a remarkable fall in infant and child mortality in most of the less-developed countries. In some countries, particularly in sub-Saharan Africa, these declines in mortality among children have slowed and are now rising again. The availability of high quality data about levels, trends and determinants of child mortality has provided insight into some of the factors that may explain these trend in mortality. A large scale study of the world health organization has identified five groups of variables that might explain the mortality trends. These groups were fertility behavior, nutritional status and infant feeding, use of health services by mothers and children, environmental health conditions, and socio-economic status. The study indicated that all the groups of explanatory variables had a role in the mortality trends. It revealed, however, that the relative roles of these variables differed with time.

For example, the WHO suggested that during the 1990s, fertility behavior, breastfeeding, and infant feeding have changed less than other factors and so would seem to have played a smaller role in mortality trends. Furthermore, by comparing mortality rates with variables and comparing trends in mortality with trends in the variables the study showed that some of the variables associated with mortality do not explain much of the decline. And Other factors have effects that are the opposite of those expected. This is especially true for the variables for fertility behavior and breastfeeding. This was contributed to the fact that these variables have not changed all that much over the decade. It was suggested that the trends in mortality that have occurred are related to more than just a handful of variables.
It was shown that countries with the largest decreases in mortality have had substantial improvements in most of the factors that might be used to explain these changes. In some countries mortality has risen due to several reasons. An example is the deterioration in the seeking of medical care for children with fever, which was associated with rises in mortality and thus has offset some of the potential decline that may be explained by improvements in other factors. Other suggested factors were increasing resistance of malaria to drug treatment and the increased prevalence of parental HIV/AIDS.

The conclusion to be drawn from this chapter is that there is no reason to believe that the claim being advanced by the opponent of the structural adjustment policies that the latter has led to deterioration of child mortality. Using the best available set of data on the levels and trends of child mortality, the study refuted these claims on the following bases: 1) There is no statistical significant difference in the levels or trends of child mortality between adjusting and non-adjusting countries since 1965 till 1999, 2) the pace of reduction in U5 mortality did not significantly differ between adjusting and non-adjusting countries over the last four decades, 3) there was no statically significant difference in the levels or pace of reduction in U5 mortality before and after the implementation of structural adjustment in adjusting countries, 4) a does-response relationship was not established between the duration of implementation of structural adjustment policies and levels and trends of child mortality. In other terms, neither the level of child mortality was significantly higher nor the pace of reduction in child mortality was significantly lower early implementers than late implementers of structural adjustment policies, and 5) the existing body of literature suggests that variables rather than structural adjustment have been responsible for the reduction in child mortality. These variables were suggested to have been independent even from the economic stresses, the political system and the structure adjustment policies.

**Maternal Mortality.** The claim that structural adjustment has had detrimental impact on maternal survival was ascertained. The analysis started by comparing the maternal mortality ration between adjusting and non-adjusting countries. The statistical analysis was stratified by region and by country income category. Then, indicators for three proxy domain for maternal mortality were compared among adjusting and non-adjusting countries. These domains were 1) access to maternal health care, 2) female poverty and income inequalities, and 3) female education and fertility. The indicators for these domains were 1) the proportion of deliveries attended by a trained health care worker, 2) overall access to health care, 3) the supply of doctors per 100,000 population, 4) the supply of nurses per 100,000 population, 5) the human poverty index, 6) women’s share of earned income, 7) the female combined primary- and secondary-enrolment ratio, and 8) the total fertility rate.

The statistical analysis refuted the claim because of the following reason:
DISCUSSION AND CONCLUSION

1) the levels of the maternal mortality expressed by the maternal mortality ratio did not differ between adjusting and non-adjusting countries in a statistically significant manner, even after statistically adjusting for the region and the country income category,

2) The levels of maternal mortality did not appear to differ with the duration of implementation of structural adjustment policies in a statistically significant manner,

3) The 7 indicators of the three proximate determinants of maternal mortality did not generally differ between adjusting and non-adjusting country in a statistically significant manner.

4) Whenever, a statistically significant difference was revealed, it was in favor of the adjusting countries.

The maternal mortality ratio and the indicators for its proximate determinants differed significantly by region and by country income groups. However, within the individual region or the income group, there was no statistically significant difference between adjusting countries.

Disability Adjusted Life Expectancy. Four summary health indicators were compared between adjusting and non-adjusting countries. These indicators combine data about mortality and non-fatal health outcomes, including morbidity, disability and invalidity from disease. The indicators are considered internationally to be the best known indicators of population health so far. These four indicators were used to determine whether or not the health status in adjusting countries differed from non-adjusting countries and whether early implementers of adjustment policies perform differently from early or non-implementers. The analysis included stratifying the analysis by sex, region and income category of the country.

The analysis revealed constantly that adjusting countries tended to have better averages of these health indicators than non-adjusting countries. However, the differences were not statistically significant.

There was wide disparities between different income categories, with low income countries showing worse health indices than the lower middle and upper middle income countries. However, within each income category, adjusting and non-adjusting countries were shown to perform similarly on the four health indicators and for both sexes. Although the differences were statistically insignificant, it was usually in favor of the adjusting countries.

Likewise, regional comparisons indicated that sub-Saharan Africa lag behind the three other regions. The inter-regional differences in the male and female averages of the four health indicators were statistically significant. Again, differences between
adjusting and non-adjusting countries with each region appeared in the statistical analysis to be insignificant. In each region, adjusting and non-adjusting showed very close averages.

The duration of structural adjustment implementation did not appear to have any influence on countries’ performance on these health indicators. Non-implementers, early implementers and late implementers showed in the statistical analysis high degrees of intra-group variability and inter-group homogeneity. The linear regression model revealed that the association between the duration of adjustment implementation and the levels of the four indicators was in all cases statistically insignificant. Regional analyses yielded the same pattern.

**Health System Performance.** The conclusion to be drawn from the statistical analysis for the relationship between the structural adjustment programs and the health system analysis is that there is no empirical evidence justifying the claims that structural adjustment has had a detrimental impact on the health system. Comparing five aspects of health system performance between adjusting and non-adjusting countries and stratifying these comparisons by national income category and region supported this conclusion.

These aspects were the overall health performance, the overall health system attainment, the health system performance on health, the health system performance on responsiveness and the fair financial contribution to the health system. In all these five aspects, there was no statistically significant difference between adjusting and non-adjusting countries. When the performance index was compared within each income category between adjusting and non-adjusting countries, the analysis revealed that some statistically significant differences. However, the differences in all cases were in favor of the adjusting countries whose mean score in these cases were better than non-adjusting countries.

Furthermore, there was no association between the duration of structural adjustment implementation in years and the scores of the five aspects of the health system performance. If structural adjustment to have a detrimental impact on health system performance, early adjusting countries should have had worse performance indicators than late adjusting and non-adjusting countries. This pattern of dose-response relationship was refuted by the statistical analysis.

**User fees and utilization.** Health care demand studies all strongly suggest that quality of health care is an important factor in choosing a health care provider and that patients are willing to pay for improvements in quality. Most of the studies indicated that the strongest preference was for the availability of drugs, both in amounts and types of essential drugs. Preferences for building infrastructure and type of health providers were weaker, but apparent.
Investigations of demand patterns—in this case, patient choice of type of provider—should include patient and not provider perceptions of quality. However, most studies measured quality using only structural attributes (the most easily collectable quality data) without careful investigation as to whether these were appropriate or complete measures of what patients were looking for. Perceptions of process or outcome measures of quality are almost totally lacking in health care demand studies. Further investigation of patient perceptions of quality is merited.

Little has been done to investigate the distributional aspects of quality improvements. The most recent study of Kenya tested gender-specific effects of quality attributes [Mwabu et al., 1993]. The results implied higher demand for antimalarials by men. The Lavy and Quigley [1993] study looked at welfare-neutral willingness to pay for three different income groups. The results indicated that willingness to pay (as measured by percentage of income) increased with income. The income effect was more important for the quality variables (infrastructure, drug availability, services, and personnel) than for distance or price. The authors concluded that the richest are more concerned with quality of health services than its costs (price or distance).

These findings lend mixed support to an increasingly posited hypothesis that user fees could be a source of welfare transfers if fees are based on ability to pay and are channeled into improvements in service quality and accessibility [Creese, 1991]. Anecdotal evidence suggests that quality improvements, especially improved drug supplies, might be more important to the poor. What remains to be done is to understand how preferences and willingness to pay for various types of quality improvements differ over income groups, gender groups, and other vulnerable groups (i.e., children under five).

The more recent health care demand studies paid particular attention to measurement problems associated with quality variables, especially in the analysis of nonexperimental static cross-sectional studies. The coefficients on the quality variables could be biased for a variety of problems related to endogeneity. First, quality improvements might actually affect health outcomes, reducing population morbidity. If so, demand for health care services would drop in future periods. Second, observed quality reflected both supply and demand conditions. An estimated negative relationship between probability of use of a provider and the quality attribute of the provider might simply reflect excess demand rather than the counterintuitive behavior that individuals do not prefer better quality. Third, data on quality should be exogenous indicators of quality. Data collected solely from patients who actually use the facility are hampered by selection bias.

Other data problems encountered in these cross-sectional studies were the small sample sizes of facilities and multicollinearity of various indicators of quality. Typically, the solution has been to use aggregate measures of quality or omit more
detailed measures of quality. This greatly limits one’s ability to look at willingness to pay for specific dimensions of quality, the information most pertinent to health care managers.

Some health care demand studies have attempted to measure elasticities of demand with respect to quality improvements, where demand is measured in terms of probabilities of choosing a given provider. These elasticity measures should be interpreted with caution since it is difficult to quantify incremental changes in quality, especially in a manner that can be compared across quality attributes. Is a 10 percent improvement in drug availability comparable to a 10 percent improvement in building conditions or provider knowledge?

Finally, one of the most recent health care demand studies attempted to go beyond traditional estimates of price elasticities of demand to estimate willingness to pay (at constant utility). The interest here was to generate actual price levels for various quality improvements. However, one should use these estimated price levels with caution. They were based on simulations using the discrete choice empirical results where quality was typically measured in an aggregate form and coefficients were potentially biased due to endogeneity problems. As we will see in a later section, compensating variation can also be measured through contingent valuation surveys. Such surveys can elicit information on more specific aspects of quality, but only in a hypothetical scenario.

The studies of WTP for quality improvements in developing countries suggested that patients intend to pay for quality improvements, especially for pharmaceuticals and that these amounts are quite substantial. Strikingly, rural populations exhibit strong intentions to pay for improved services. Although higher income groups tend to be willing to pay more for quality improvements, the results suggest that WTP can be quite high in lower income groups. Strong preferences for improvements in drug availability at facilities over other types of quality improvements, such as provider attitudes and building conditions, suggest willingness to pay for quality improvements may be closely tied to financial considerations, a hypothesis that should continue to be tested. Also, some quality improvements (e.g., improved accounting systems) are less visible to patients. Another interpretation might be that rural populations have fewer alternatives.

It is difficult to determine the extent to which these results may be artefacts of methodology. For example, rural populations may be less able to deal with the hypothetical nature of contingent valuation studies. Over-pledging might occur if they believe their preferences will affect provision of quality improvements, but that they will not have to pay the full costs (i.e., donor aid programs). As previous literature has shown, lower education levels, less experience with private health markets, and difficulties in dealing with hypothetical situations may all contribute to
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the estimated differences in median WTP between different groups, such as rural-urban and/or lower-higher populations.

The summary of the review of the quality of care in public and private providers revealed a surprising finding. There is a severe shortage of systematic comparative research of the quality care in both settings that can cover the technocratic requirements and the lay perception of quality. However, the existing body of literature points out to facts. The first is that in several developing countries the private sector provides a considerable proportion of health care. The private sector provision is concentrated at the primary care level, especially outpatient services.

Secondly, there is no evidence that the quality of health services in the private sector is better than the public sector. Aspects of quality related to the outcome of treatment are similar in both sector. For example, the patterns of drug prescription, the quality of diagnostic workups, the quality of counseling and follow-up are similar. However, aspects related to patient satisfaction and convenience are better considered in the private sector.

**Poverty and Income Inequalities.** The aim from this chapter was to ascertain whether or not structural adjustment has had negative impact on aspects of poverty and income inequalities which can have detrimental health impact. The chapter started with a review of the relation between poverty and health presenting for the four main theories that explain how poverty results in bad health and mortality. Chapter moves then to present the empirical evidence from the literature for the relation between poverty and health and the indicators usually used to monitor this relation. The literature is organized in three levels: population level studies, community level studies and individual level studies.

The second part of the chapter reviews the global and regional trends of poverty and income inequalities. Longitudinal data for regions are presented and analyzed since the 1980s and trends are related to the political and macroeconomic changes characterized basically by globalization, liberalization and structural adjustment.

The third part is a comprehensive empirical analysis of the impact of structural adjustment on a wise set of poverty indicators that are sensitive to the health status of the population. These indicators are organized in four basic domains, including the size of the economy, the levels of poverty, the distributional inequalities and entitlement to the basic services.

Before drawing a conclusion for this chapter, it is important to mention her that ascertaining whether structural adjustment programs have augmented poverty and inequality is difficult to answer. Defining poverty as well as structural adjustment, for example, appeared to be very problematic and an area for criticism. [Fields, 1993, Foster et al., 1984; and Kanbur, 1987]. However, a considerable body of
research has been defining macro-economic components of the structural adjustment that can cause poverty and inequality. A distinction has been made between stabilization and structural components.

The stabilization component refer to the fiscal and monetary policies coupled with wage policies and devaluation and thus form part of macro economic policy. Fiscal and monetary policies deflating the economy as part of a stabilization program reduce the absorption in the economy, which lowers growth rates or even results in decline in the national income [Khan, 1990]. A pathway for effect was suggested by an assumption which goes this line: If income distribution does not change, then a deflationary action, per definition, increases poverty. How much poverty increases depends not only on the amount of deflation but also on the parameters which determine the slope of the income inequality function around the cut-off point for poverty. A first approximation is therefore that stabilization policies increase poverty. However, it is difficult to maintain the assumption that income distribution remains unchanged during a process of stabilization, since the very policy instruments applied in the stabilization process change the parameters of the various sets of income distribution, such as income before tax (wages, profit, rents), income after tax and net incomes which include the imputed benefits of public services (respectively, primary, secondary and tertiary income distribution [Ndulu, 1992].

This effect was suggested to depend not only on the nature of the policies but also on the forces which drive income inequality. These forces were described by Taylor [1988] as the social matrix and by Khan [1993] as the interface between institutional organization and policy regime of the country applying stabilization policies. Based upon an overview as part of a UN/WIDER set of studies of the stabilization experiences in the mid-1980s of 17 countries, Taylor concludes:

The moral is that getting into and out of economic stabilizations are not processes independent of major groups in the country, their political role, and insertion in the economic system. On the whole, professional economists deal uneasily with these issues, and often carry through their analyses of economic classes and their political roles ineptly. But such factors have been vital to the successes and failures of many stabilizations "with a human face". This can only be realized on the basis of a serious analysis of the social matrix [Taylor, 1988].

Early analysis of the effects of stabilization policies pointed to an adverse effect on the poor which was at least equal to the deflationary push and often larger [Cornia, Jolly and Stewart, 1987; van der Hoeven, 1987; PREALC, 1985]. The contraction in the economy has also frequently led to a decline in the wage share in national income, as Manuel Pastor has demonstrated [Pastor, 1987]. Some authors (e.g. Sahn, 1992] argue that poor people do not take part in the formal economy and especially do not make much use of government services, and hence, are less (either negatively or positively) affected by stabilization policies than non-poor groups
which used to profit much more from public services. Hence, stabilization policies and especially the fiscal contraction results in a more equal tertiary income distribution. These views are however questioned by many observers. In general it is accepted that the deflationary component of stabilization policies results in increased poverty, although the intensity depends both on the relative weight and intensity of the policies adopted as well as on the initial conditions.

The adjustment components suggested to cause poverty include devaluation of the national currency which changes the price ratio between tradeable and non-tradeable goods. Exchange rate policies are applied to stabilize the economy as well as to change production patterns and belong thus partly to stabilization measures and partly to adjustment measures. Here the key question is to what extent the poor are producers of tradeables and non-tradeables and consumers of tradeables and non-tradeables. The theory is rather agnostic. The application of the Salter-Swan type of analysis is now widespread [Sachs and Larrien, 1993; Demery and Addison, 1993]. The difficulty lies with the interpretation of the theory in practice. Firstly, the definition of tradeables is not as clear as it may sound. Secondly, the production patterns and consumption patterns of the poor cannot easily be mapped on the category of tradeables and non-tradeables, as some want to lead us to believe. The complication is well explained in Jamal and Weeks [1993] and in Stewart [1995]. Stewart argues that initial conditions determine whether switching policies lead to more employment and poverty, reduction or not. In the absence of growth, employment and income distribution (and thus poverty) are likely to worsen following devaluation in economies: specializing in mineral exports or agricultural products whose production is unequally distributed; where urban poverty is high in relation to rural poverty; where there is a large oligopolistic modern sector, specialized in import substituting production - this will affect urban incomes in particular.

Employment, income distribution and the poverty situation are most likely to improve where: (iv) tradeables are labour-intensive relative to non-tradeables (i.e. in economies specializing, especially at the margin, in labour-intensive manufactures or labour-intensive agriculture); rural poverty is high in relation to urban poverty, and rural incomes (and tradeable production are fairly evenly distributed.

The effect of other adjustment policies on poverty is more difficult to judge. For example, the effect of privatization on poverty or of a shrinking in the public sector employment depend very much on whether, for example, dismissed civil servants belong to poor groups or not, whether they can find other jobs, and whether the privatization process will result in a decline in the tax burden for the poor. Also, the effect of deregulation cannot be predicted in advance. If deregulation reduces rent-seeking by wealthy and influential groups and this results in lower prices of products consumed by the poor, then adjustment policies can contribute to a decline in poverty. However, if deregulation results in the creation of natural monopolies, then
the effect of deregulation on the poor can be negative. The effects of adjustment policies on poverty depend therefore much more on the initial social economic setting in the country undergoing adjustment and on the type of adjustment policies applied. The next chapter will therefore review some aspects of adjustment policies and poverty especially in relation to some labor market issues.

Our empirical analysis which included a wide set of indicators for poverty and inequalities does not support the assertion that structural adjustment has had negative impact in the poverty and income inequality domain sufficient to cause detrimental health impact. Generally, adjusting countries did not differ with respect to 12 basic poverty and inequality indicators from non-adjusting countries. This was held true even when the analysis was stratified by national income category and by region. In the few cases, where there was a statistically significant difference between the two groups, the difference was always in favor of structural adjustment.

**Education and Literacy.** Adjustment programs have incited strong debate since their inception. The effects of adjustment on education depend on the external environment as well as on conditions within the country and within the sector before the adjustment period. Sahn [1989] suggests that the variability in performance and outcomes observed in adjusting countries largely reflects: 1) external and domestic circumstances that precipitated the need for such change (inefficient domestic policies, external shocks, the debt crisis) and under which reform programs are applied; 2) the character of the policy package (macro versus sector-specific measures); 3) the degree and pace of implementation; and 4) the choice of the year as the starting point for "adjustment."

Most critics argue that adjustment negatively affects incomes and living conditions of the poor. Evidence to support these arguments is not conclusive. Although critics say little about education directly, their arguments do apply indirectly to education: deteriorating incomes and living conditions may reduce demand for education, while improved education may help improve incomes and living conditions. One argument is that adjustment programs stem from a strictly economic outlook that considers recurrent expenditures on education to be the same as any other recurrent spending. Thus education is simply one more source of public spending that aggravates budgetary disequilibrium.

However, human capital theory views recurrent education spending as a productivity-raising investment in human resources. Therefore, changes in recurrent spending that alter the output and quality of education affect the productivity of human resources, and in turn affect national income and growth over the long term. Adjustment policies that reduce education spending may reduce investment in human capital if spending does not become more efficient, and may have long-term costs that outweigh short-term cost savings. In fact, many Bank-funded adjustment
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program explicitly protect real education expenditures, particularly at the primary level, and focus on ways to increase the efficiency of resource use in the sector.

Another important argument is that in practice policy changes under adjustment are guided by political rather than efficiency considerations. This argument addresses the implementation rather than the design of adjustment programs. Nevertheless, changes in program design may alleviate some implementation obstacles. Serageldin [1989] asserts that a common tendency is to cut back on social spending at basic levels (primary education) in favor of areas where political constituencies are more powerful (universities). Experton [1988] concurs that governments find it easier to avoid increasing access to primary education than to impose structural reforms to reduce demand for higher education. The result is that resources increasingly favor higher levels of education, particularly at the expense of rural and marginalized populations, the ones least likely to react negatively to these austerity measures. Furthermore, Gallagher [1990] states that for political reasons, direct hardships to employees and immediate costs to society or policymakers are avoided. Amadeo and Camargo [1989] also argue that tight budgets result in spending cuts to those items easiest to cut (supplies, infrastructure) rather than those making the most sense from an efficiency viewpoint (salaries, jobs). Contractionary budgets therefore tend to be accompanied by allocative efficiency although the goal is to improve efficiency.

Although adjustment policies do have certain direct and indirect implications for education, current trends often have their roots in pre-adjustment mismanagement or economic recession. Most critics of adjustment programs do not distinguish the effects of international recession, fiscal constraints, or structural problems from the effects of programs or policies designed to offset them. Some recognize that recession and the debt crisis produced severe fiscal imbalances that require adjustment of some form [Knight, 1989], but others imply that countries would make no policy changes to improve the situation in the absence of Bank lending, although policies are often unsustainable [Michalopoulos, 1987]. Adjustment is an essential and continuous process for every country that vis-à-vis its economy to grow. Countries must continuously adapt to changing international economic conditions, particularly external shocks such as increases in the price of oil, world recession, and changing terms of trade. Many countries that do not adjust quickly enough face serious difficulties, including unsustainable fiscal and trade deficits, large debts, unrealistic exchange rates, inappropriate tax and price structures, and inefficient public sector management. Non-adjustment results in distortions and inefficiency at the macroeconomic and sector levels that are exacerbated while resources decline and economic growth stagnates, and is likely to have serious detrimental effects on education.

Structural adjustment programs are claimed to affect education through changes at the macro and micro levels of the economy. Adjustment at the macro level often
implies a combination of budget containment measures for the public education system, limited access to post-primary public education, and higher user fees for education services at the secondary and tertiary levels. At the micro level, changes in household incomes and prices (user fees, reduced student subsidies) directly influence the demand for education by altering the opportunity cost of attending school [UNDP, 1989].

Household incomes also affect health and nutrition status, and thus indirectly influence attendance and learning ability. Finally, adjustment affects education through changes in markets and infrastructure (resulting from currency devaluation, fiscal and monetary restraint, and price liberalization) that affect the supply of education services and the opportunity cost of attending school [World Bank, 1990b]. More specifically, adjustment policy effects on education supply and demand are described below.

Education Supply: The most obvious impacts of adjustment policies on education are short-term changes in public expenditures. Education supply need not decline if private resources replace public resources. But in most countries, education is primarily funded by the public sector. Because structural adjustment loans focus on correcting imbalances in the economy and laying the foundations for growth rather than on equity, the particular forms taken by cuts in subsidies, real wages, and real education expenditures have high social costs, at least until the economy begins to grow [Cornia, et al., 1987]. Griffin and Knight [1989] argue that in many Third World countries human development programs are "savagely" cut, and long-term prospects for development diminish while inequality and poverty increase. The most sophisticated analysis available [Kakwani, Makonnen and van der Gaag, 1990] associates adjustment lending with declining trends in public education financing and gross primary enrollment rates. Lower public education expenditures may result in lower quality and quantity of education services, fewer amenities (school lunches), or higher user fees. Furthermore, any change in civil service wages or employment has particularly strong effects on the labor-intensive education sector. Lower wages may reduce the short-term efforts of teachers, if not cause an exodus of experienced teachers [UNDP, 1989]. Even if adjustment policies do not cause deteriorations in social conditions directly, they are criticized for not reversing declining trends.

On the other hand, Kakwani, et al. [1990] suggest that the need to cut expenditures provides an opportunity to increase efficiency and equity i.e. the use of resources. Serageldin [1989] notes that the Bank increasingly supports specific measures to protect vulnerable groups, for example by shielding public expenditures on key education and basic welfare services, by reviewing the composition of education expenditures and reorienting government spending in the sector, and through compensatory actions and transitional arrangements. Berg [1989] emphasizes that measures to reduce secondary and higher education's budget share; over time release resources that can be reallocated to primary education. Costs can be reduced
by improving the efficiency and cost-effectiveness of all public expenditures. The Bank hopes that by giving the social impacts of adjustment programs earlier and more serious attention, the adverse impacts of adjustment can be reduced [Ribe, et.al., 1990]. For example, education expenditures can target those most in need, while the burden is placed on the relatively wealthy who have access to private education facilities and are able to pay higher fees [Demery and Addison, 1987]. The need to restructure the public budget under adjustment is an opportunity for governments to evaluate social programs. If these measures are effective, the quantity and quality of education services could improve during the adjustment period, even when sector resources decline. Guaranteeing access to education services protects the human capital of the poor, but will often require additional public resources. The Bank [1989e] explicitly recommends that governments in Africa commit additional resources to the social sectors, with an overall objective of 8-10 percent of GDP to be spent on human resource development.

The major demand effect is likely to be short-term reductions in income that lower demand for schooling. Declining household incomes, higher unemployment levels, and changes in relative prices raise the opportunity cost of time spent in school, relative to time spent in economic or household activities. Demand for education also decline if poor health and nutrition reduce attendance and the capacity to gain from education. Finally, demand responds to changes in supply such as lower quality and higher user fees.

Demand effects of adjustment policies are also positive. Children have less attractive labor market options, the opportunity cost of attending school declines. Demand also increases in response to more attractive labor market options: adjustment in the long term increases the expected private rate of return to education in response to expected improvements in the long-term prospects of the economy if the adjustment program is successful [UNDP, 1989]. Overall impacts on demand vary by level of education because of differences in social and private rates of return to education investment. The social rate of return from primary education, and the private rate of return from tertiary education, are relatively high. Therefore, reductions in public education expenditures win affect subs-sectors differently, depending on how the cuts are implemented. Cuts at the primary level tend to reduce demand, whereas cuts at the tertiary level are more likely to induce private expenditures, and demand is less likely to decline. For this reason, many adjustment programs include reallocations from tertiary to primary education.

World Bank analysts continue to argue that some short-term social costs are inevitable when an economy has to adjust to adverse external shocks or to the effects of previous policy mismanagement. Even a well-designed adjustment program harms some groups, while the majority benefit, since adjustment usually involves changing relative prices and reducing government expenditures. But Nicholas [1988] proposes that the transitional costs of orderly adjustment are
smaller, particularly under recent adjustment programs that include conditions for maintaining social sector expenditures, and the long-term benefits larger, than with ad hoc adjustment.

The long-term effects depend very much on whether the adjustment policy is successful (economic growth resumes, employment increases, and wages rise). If it is, then as compared with the situation that would have prevailed without the adjustment program the private returns to education and the supply of resources for education will probably be greater. However, the opportunity cost of time spent in education rather than in productive activities is also likely to be greater. Generally the former effect is expected to dominate, though it is far from obvious that it will in all cases [UNDP, 1989]. According to Turok [1989], "education is a slow process requiring sustained effort which cannot be made up for by crash-courses when funds once more become available." Likewise, Simai [1986] warns that unavoidable cuts in social expenditures should be made with extreme caution and with a long-term policy view, since losses in these areas cannot be easily recouped and long-term damages, even of shorter-term measures, may be excessively high. Not investing in human capital threatens the country's future development potential.

Our empirical analysis of the literacy level, accessibility and attainment of education indicators show that claims that structural adjustment have had negative influence on education and literacy that might have detrimental impact on health status are baseless. Adjusting countries were shown to have levels of adult literacy, school enrolment, female education and duration of female schooling comparable to non-adjusting countries. The statistical insignificant difference was obtained even when the influence of national income category and region were held constant.

CONCLUSION

Since the inception of the structural adjustment programs, these policy packages have had a bad reputation. They are blamed for having resulted in worsening in the health status indicators, reversals in the achievements made in the post-world war era, deterioration of the quality of health services, severe cuts in public health spending, and impoverishing the population. These policies are perceived to have been introduced by international financial institutions, dominated by representatives of developed countries, and involve a loss of autonomy for national governments and political elites. Most important of all, many programmes have failed, so well informed theorists can claim that the approach is ill conceived and damaging.

This study provided an evidence, based on sound methodology and concrete empirical data, that these allegations are baseless and politically motivated. The study compared a huge set of health and welfare indicators among adjusting and non-adjusting countries, followed the trends of their development before and after adjustment, ascertained the levels of these indicators in relation to the structural
adjustment duration and traced the causal mechanisms suggested by the adjustment opponents. The study revealed that adjusting countries are performing similarly or even better than their counterparts in the region or in the national income category. The levels and trends of survival, mortality, composite health indicators, health financing, health system performance, poverty and literacy were not shown to be different between adjusting and non-adjusting countries in a statistically significant manner. There have been few exceptions for this statistical insignificance. However, in these few cases, the difference was always in favor of adjusting countries, which showed better levels of the indicators than their non-adjusting counterpart.

The equal performance of adjusting and non-adjusting countries refuted the claims by the opponents of the structural adjustment that these policies have results in worsening health and welfare conditions. Many critics underestimate the difficulties involved in the adjustment process, misunderstand the causes of failure, misrepresent the nature of the programmes, and can rarely offer alternatives which take account of the financial, political and administrative constraints under which they operate. Many of the costs of adjustment are unavoidable, and less damaging solutions would usually require more international intervention and resourcing, rather than less.

A reasoned critique of the adjustment process requires a clear understanding of the causes of the problems it is designed to address, and of the nature of the relationship between the policies advocated by the international financial institutions and the actual performance of the governments concerned. We can concede that health status or health system performance may well have deteriorated after these programs were begun, that some programmes imposed heavy costs upon particular groups, and that many countries have made limited progress after many years. However, before we can rubbish the whole exercise, we have to answer at least four questions:

1) has the improvement in health status indicators sluggish because of structural adjustment policies or despite them?

2) Were the costs imposed on the worst affected groups by cuts and closures necessary to shelter other, perhaps more deserving, groups from even greater suffering?

3) Is the lack of progress in many countries attributable to their implementation of SAPs, or to attempts to block them by local governments and elites?

4) What alternatives are on offer which are backed by the necessary financial and institutional resources?
Structural adjustment reforms were only introduced when governments confronted balance of payments and fiscal crises which they could not finance without external support. In most of the cases they occurred after a period of borrowing which allowed them to sustain levels of consumption and services well in excess of those they could finance on their own. When the crisis came, credit dries up and existing debt has to be repaid, thus compounding the funding and foreign exchange crisis. Here imports, domestic consumption and public services must fall, even without a structural adjustment. The World Bank and the IMF oblige governments to reduce spending and imports, but their demands are an effect, not the cause, of the crisis. In fact, consumption without a structural adjustment would fall even more, since they bring additional external funding with them.

It is true that these crises are not only the outcome of economic mismanagement but also of external economic shocks. Unfortunately, one of the costs of national sovereignty is the obligation to earn a living in the world as it is, and not as we would prefer it to be. The resources at the disposal of the international financial institutions and donor community can be used to shelter poor countries from some of these effects, but they depend on the goodwill of the donor countries, are very limited, and will never be given unconditionally to governments which cannot manage their own economic problems. Governments go to the international financial institutions for support when their people are being forced to pay a heavy price for the failure of their economic policies. It is they who have created the underlying problem, not the international financial institutions.

In these circumstances new policies which are bound to have negative consequences for many people are inevitable. The key issue, then, is whether the new policies have unnecessarily regressive results.

A second important question concerning the allegations being advanced about the impact on health and poverty of structural adjustment is related to the question: Who loses and who gains from structural adjustment policies? Experience indicates that they are consumers of imports with access to overvalued foreign exchange, and of subsidised food or other essential products; civil servants and parastatal employees who lose their jobs; and users of services which are cut or subject to user charges. These groups are usually highly visible and vocal, but they are rarely the poorest of the poor. Their benefits have had to be paid for, often by less fortunate and less politically visible groups than they.

For example, high quality health services in developing countries are known to be consumed by the elite of the middle class. These services are dependent on imported medical equipment, supplies and medications. Therefore, any devaluation of the national currency as a part of a stabilization package will definitely result in increase in the prices of these services. Such services are not being consumed, however, by the poorest of the poor. The poor seek care from traditional healers or
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from low resources health posts. The impact is expected, therefore, to be greater on
the middle class elite than on the poorest of the poor. The middle class elite are the
more vocal groups and the one with access to media, academic circles and policy
making bodies. Therefore, the anti-adjustment allegations have been strongly voiced
in the adjustment loans recipient countries.

Most bureaucracies and parastatals in developing countries do not offer the poor
producers who finance them an adequate return. They are run by a rent-seeking
elite and are overmanned, underpaid and do not deliver cost-effective services or
output. This is not to say that state services must always operate like this, only to
recognise the inappropriateness of the centralised bureaucratic systems created by
colonialism in Africa.

Privatisation, liberalisation, civil service reform, and 'good governance'--key
elements in most structural adjustment reforms --are all policies designed to
strengthen the position of consumers vis-a-vis service providers. These reforms are
highly problematic, given the low levels of 'social capital' in most developing
countries, and implementation is slow and difficult, given the resistance to them by
all the well placed elites with a vested interest in maintaining the old system.
However, it is difficult to claim that the attempt to reform these structures
represents a regressive rather than a progressive trend.

A related point here is that adjustment lending is usually bound to conditionalities
related to financial and economic transparencies. Obviously such conditions go
against the interest of the corrupted local elites, which make benefits out of the
existing system of power relation in the society.