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Structural Adjustment Programs and the Delivery of Health Care in the Third World

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Introduction

“We did not think that the human costs of these programs could be so great, and the economic gains so slow in coming”

World Bank Chief Economist for Africa, quoted in *Dark Victory: The United States, structural adjustment, and global poverty* (Bello, 1994).

The history of structural adjustment can best be understood by beginning in 1944 with the creation of the World Bank and International Monetary Fund. These institutions would become involved in the 1982 Third World debt crisis in order to solve global economic difficulties. While the World Bank and IMF were originally were not created for the purpose of Third World debt relief, this is exactly what they became involved in. Third World governments would be “structurally adjusted” according to neoliberal economic theory. While the purpose was to increase their efficiency in the global market, the implementation of structural adjustment programs by the World Bank and IMF also demand curtailed government spending. Thus, these policies have manifested into increased poverty and the subsequent decline of health care delivery in the Third World. These effects on health as they relate to structural adjustment programs will be discussed and solutions to the debt regime will be suggested.

History of Structural Adjustment

In 1944, leading economists from Europe and the United States gathered in Bretton Woods, New Hampshire, to propose a new international economic order, given Europe’s need for reconstruction and economic rehabilitation in the aftermath of World War II (Hoy, 1998). The Bretton Woods conference would provide the blueprint for the postwar capitalist economy (Rapley, 1996). These meetings produced the World Bank, the International Monetary Fund, and the General Agreement on Tariffs and Trade (Hoy, 1998). The General Agreement on Tariffs and Trade was a treaty organization that aimed to reduce tariffs, or taxes on imports,

thereby lowering the barriers to trade among nations. The World Bank was created to invest money in the reconstruction of war ravaged Europe. Beginning in the 1950s and 1960s, it turned its attention to development (Rapley, 1996). The IMF, on the other hand, was set up to provide short term loans to any government facing balance of payment difficulties, the problem a government encounters when more money leaves its economy than enters it (Rapley, 1996). Despite similarities between the IMF and World Bank in philosophy and activities, the primary goals of these two institutions differ. The World Bank was established in order to provide loans to encourage development projects, whereas the IMF was created in order to oversee monetary and exchange rate policies. All nations have the right to financial assistance from the IMF, unlike the World Bank, which lends only to governments of developing nations (Hoy, 1998).

The World Bank and IMF would become involved in the Third World after a series of economic shifts that began in the early 1970s. First of all, the United States was suffering from what economics call, a gold overhang, meaning that more dollars were in circulation than there was gold in Fort Knox (Rapley, 1996). The government had been printing money to cover deficits and to fund the war in Vietnam. However, as overseas dollar holdings grew, dwarfing American gold reserves, they became a liability to the government if cashed in for gold. In 1971, President Richard Nixon ended the gold-dollar standard by which all currencies were fixed to a gold value through the American dollar. From now on, currencies would float in relative value, with the ubiquitous American dollar as the dominant currency. This shift from fixed to floating currency exchanges ushered in an era of uncontrolled and heightened capital mobility (McMichael, 2000).

Soon thereafter, the world economy was shaken by the first of the oil shocks. In 1973, the thirteen members of the Organization of Petroleum Exporting Countries (OPEC)¹ formed a sellers cartel and agreed on a common price for oil (McMichael, 2000). They placed an embargo on oil supplies to the United States, Europe, and Japan to protest the United States' support for Israel in the Yom Kippur War. This sudden cut led to a fourfold increase in the world price of oil (Rapley, 1996).

OPEC states deposited their profits in offshore transnational banks (McMichael, 2000). These transnational banks (TNBs) formed in the 1970s. They were helped by the burgeoning offshore capital market that evaded the regulatory power of states. The TNBs were banks that were beyond the jurisdiction of any government (McMichael, 2000). These banks, which had to pay depositors interest, had to find someone to whom they could lend at a higher rate of interest in order to avoid losing money (Rapley, 1996). With the First World in recession because of skyrocketing oil prices, these banks turned to the Third World governments, eager to borrow and considered unlikely to default. TNBs began to lend money to Third World governments so they could fund development projects. The presence of these banks was a golden opportunity for Third World states to exercise some autonomy from the official financial community. Until now, they had been beholden to powerful First World states for foreign aid and to multilateral agencies for funding of their development programs (McMichael, 2000).

While Third World nations began their development projects, several external economic shocks would lead to a debt crisis. First, interest rates increased fourteen times between 1974-78 and 1981-82, meaning the dollar reserves countries used for repayment had lost their value (McMichael, 2000). In 1979 there was a second oil shock which increased stagnation and

¹ Algeria, Egypt, Indonesia, Iraq, Iran, Kuwait, Libya, Nigeria, Qatar, Saudi Arabia, Syria, United Arab Emirates, and Venezuela.

inflation in the First World. First World governments began fighting inflation through tight monetary policies, raising interest rates. This in turn increased the value of the US dollar, and because loans had been disbursed in US dollars, the value of debt in developing countries was effectively raised (Rapley, 1996). This second oil shock also caused a recession in the First World; because of this, the First World decreased consumption of Third World products. Export commodity prices fell seventeen percent during this period and the Third World lost \$28 billion in export revenue. The Third World's share of trade fell from twenty-eight to nineteen percent between 1980 and 1986 (McMichael, 2000).

The result of these wavelike events caused Third World countries to be in a debt trap: debt was choking their economies (McMichael, 2000). When in 1982 Mexico, Brazil, and Argentina all announced they could not meet their current debt obligations, the debt crisis erupted. The World Bank relegated development to a secondary status, and devoted energy to trying to recover old debts (Rapley, 1996). The IMF would also intercede and provide loans to Third World governments for the purpose of debt repayment. These two institutions were thus granted the authority to restructure the economies of indebted nations.

Debt management took several forms, beginning with stabilization measures. Stabilization focused on financial management—such as resolving the imbalance of exports and imports. By the mid 1980s, loan conditions demanded a restructuring of economic policy, the idea that debtors should follow a multilateral prescription for political and economic reform to ensure economic growth and debt service (McMichael, 2000). Governments would have to be “structurally adjusted” in order to receive new loans and debt relief.

Policies and Ideologies of Structural Adjustment

Structural adjustment packages (SAPs) have usually included elements such as fiscal austerity and disinflationary policies, the privatization of state-owned enterprises, trade liberalization, currency devaluation, and the general deregulation of the economy, including financial and labor market deregulation. SAPs also try to attract foreign investment in industry (Rapley, 1996). By reducing spending, governments enable interest-rate cuts in order to control inflation and reduce the demand for capital inflows from abroad (Hoy, 1998). By capping pay raises and slashing budgets, they reduce inflation. Private investment thus becomes cheaper, and the environment for business more attractive (Rapley, 1996).

Such SAPs are based on a certain class of economic theories, known as neoliberalism. This ideology was heralded by the newly elected Reagan and Thatcher administrations. The assumption follows that the most productive economy will be one in which individuals are allowed the greatest freedom to engage in activities or enter into contracts as they choose, and to reap the full benefits of their labors (Rapley, 1996). Deregulation, privatization, and withdrawal of the state from many areas of social provisions are common elements (Harvey, 2005). Privatization and deregulation combined with competition eliminate bureaucratic red tape, increase efficiency and productivity, improve quality, and reduce costs, both directly to the consumer through cheaper commodities, and services and indirectly through reduction of the tax burden (Harvey, 2005). Continuous increases in productivity should deliver higher living standards to everyone. Under the assumption that “a rising tide lifts all boats,” or of “trickle down,” neoliberal theory holds that the elimination of poverty can best be secured through free markets and free trade (Harvey, 2005). For example, short term rises in unemployment are offset by expansion of labor markets which will translate into more jobs available. While such

macroeconomic reforms can cause economic hardships temporarily, they are thought to develop the economy. Eventually, then, the country comes out ahead (Peabody, 1996).

In the Third World, SAPs are based on neoliberal economics. Structural adjustment seeks to make both the state and the market more efficient in order to accelerate growth and eliminate waste. Structural adjustment gives priority to the free market, assigns the state a secondary role, and puts its faith in the potential of “unfettered individual initiative” (Rapley, 1996). Because freedom in the marketplace is guaranteed, each individual is accountable for their own actions. This principle extends into the realm of welfare, education, health care, and even pensions. Individual success is interpreted in terms of entrepreneurial virtues or personal failings rather than being attributed to larger economic structures, such as class exclusions usually attributed to capitalism (Harvey, 2005).

Since the 1970s, there has been a turn towards neoliberalism in political economic practices and thinking. According to David Harvey (2005, 3), “neoliberalism has, in short, become hegemonic as a mode of discourse. It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in, and understand the world.” Indeed, economic ideologies are rarely questioned today, as they are taken as normal and expected. Yet when examined, these notions of economy, market, and production have historical contingencies (Escobar, 1995). “This history can be traced, and the mechanisms of truth and power revealed. In short, the Western economy can be anthropologized and shown to be made up of a particular set of discourses and practices” (Escobar, 1995, 59). According to Arturo Escobar (1995), institutions such as the World Bank are extremely efficient in deploying and renewing the discourse surrounding structural adjustment.

Effects of Structural Adjustment

When SAPs are implemented, these macroeconomic changes have immediate consequences for the people living in structurally adjusted states. For example, the most common effect of neoliberal economics is a dramatic increase in the income gap between the rich and the poor. For example, between 1970 and 1990 General Pinochet of Chile pursued a radical free market reform, masterminded by economists trained at the University of Chicago. Over two decades Chilean GDP grew from 35 percent in 1970 to 57.4 percent in 1990 (McMichael, 2000). However, income gaps between the richest and poorest also increased: the share of national income of the richest ten percent grew from thirty-five percent to forty-seven percent, while the poorest half of the population declined from 20.4 percent to 16.8 percent. Social spending fell, wages were frozen, and the peso devalued. Unemployment levels rose to thirty percent and forty percent of the Chilean people were defined as poor in a country that previously had a substantial middle class (McMichael, 2000). In Brazil, a major player in the debt crisis and adjustment, the top fifth earn twenty-six times more than the bottom fifth. The costs of adjustment fell disproportionately on the middle and low income groups, while the top five per cent of the populations retained or, in some cases, even increased its standard of living (Bello, 1994).

Even in developed nations, neoliberal economics increases inequality. Consider that by the end of the Republican era, the United States was becoming the most unequal of nations. Some twenty million Americans were experiencing hunger; twenty five million were receiving food stamps. The child poverty rate, twenty-two percent in 1991, was the highest among industrialized countries, and among minority groups, the rates reached as high as fifty percent (Bello, 1994). In addition, the infant mortality rate for African Americans now stands at 17.7

infant deaths per 1000 births. This compares unfavorably to industrial countries and developing countries alike—Jamaica has 17.2 per 1000, Trinidad 16.3 per 1000, and Cuba 16 per 1000 (Bello, 1994).

According to physician anthropologist Paul Farmer (2003), these gross inequalities translate into “structural violence,” the perpetuation of poverty through institutions and governmental structures, such as neoliberal theory. “The poor are not only more likely to suffer, they are also less likely to have their suffering noticed. As Chilean theologian Pablo Richard notes, ‘We are aware that another gigantic wall is being constructed in the Third World, to hide the reality of poor majorities. A wall between the rich and poor is being built, so that poverty does not annoy the powerful and the poor are obliged to die in the silence of history’” (Nelson-Pallmeyer, 1992, cited in Farmer, 2003, 50).

This type of social inequality can often ignite unrest and political instability. For example, in 1994, a small band of peasant rebels, the Zapatista National Liberation Army, began an uprising in Mexico. Here, in the midst of one of the supposed “success stories” of structural adjustment, was widespread dissent. Poverty and the general suffering of Mexico’s peasantry had become unbearable (Rapley, 1996). In Zambia, similar distress led to a democratic model government being forced out of power. During Frederick Chiluba’s two year presidency, SAPs led to state hospitals charging fees, implementation of tariffs for water and electricity, and elimination of subsidies for fuel and “mealie meal” (the staple diet of Zambians). With trade liberalization measures, Zambia’s industries were losing in competition with imports; three quarters of textile factories closed in one year, and a third of commercial farmers stopped production, unable to sell due to subsidized flour imported from South Africa (Hoy, 1998).

Thus, despite the introduction of a democratic state, Chiluba's embrace of neoliberal economic reform would lead to his downfall.

SAPs and the Delivery of Health Care

The history of structural adjustment and how SAPs are implemented has been previously discussed; now the direct and indirect effects of SAPs on health care will be examined. Direct effects affect the health care system, such as a cut in government revenues that leads to a cut in health care services. In terms of indirect effects, decreased employment, raised prices of commodities, and reduced government services and spending on infrastructure have the potential to increase morbidity and mortality and thus affect health status indirectly (Peabody, 1996).

Budget Cuts and Privatization: The Direct Impact on Health

Direct effects on health care include fewer subsidized health services and health centers, so that individuals must purchase health care from the private sector. Public facilities are likely to have fewer staff, less equipment, inadequate supplies, or lower quality services (Peabody, 1996). In Nigeria, for example, the quality of health services overall has deteriorated as foreign exchange to purchase drugs and other imported medical supplies has become increasingly scarce. The consequences of the decline of foreign exchange for health are severe—shortages of imported drugs, migration of skilled health workers, and development of private medical practice are now being exacerbated throughout Africa (“Structural Adjustment,” 1990). In Nigeria budgetary allocations to health had been below ten percent in most states since 1982 and there are glaring examples of suspended health projects and abandoned construction sites for health centers and hospitals (Emeagwali, 1995). In Brazil, anthropologist Nash Turner found that the Brazilian government had cancelled all forms of aid to indigenous communities, including medical care. The Kayapo Indians demanded that they be allowed to mine and log to pay for the

medical and other services the Federal government had ceased to provide. As a result, the Kayapo Indians were arguing that the right to their own land should mean that they had the right to cut down their rainforest and sell it for profit if they so chose (Turner, 1995).

In developing countries, the shadow of structural adjustment and the pressure to reduce government expenditure on health, and to reorganize the health sector to bring in private provision and payments for service, has been seen by many as a major threat to equity. It is now thought that variations in health between high income countries are in fact related to inequities in income distribution, rather than overall national wealth. Almost thirty years ago, Julian Tudor-Hart proposed the inverse care law, stating that “the availability of good medical care tends to vary inversely with the need for it in the population served” (Leon & Walt, 2001). For instance, when Mozambique reintroduced private practice in the early 1990s, it created a two-tier system. Patients who could pay more could see private practitioners, get better service, and attend special clinics in hospitals. In the upper tier of this system, income determined access to services. In the lowest tier, patients were dependent on a national health service, where charges put the service out of their reach (Turshen, 1999).

These types of charges have been found to reduce utilization of health services despite some exemption mechanisms for the poor. Proponents of privatization claim that charging for health care can have substantive positive impact on the efficacy, equity, and sustainability of health care financing (Turshen, 1999). Such supporters maintain that the public sector has a poor record of addressing rural poverty and ill health, and that governments squander precious resources by over-investing in secondary and tertiary care facilities and by overstaffing facilities with non-technical workers (Turshen, 1999). However, cost recovery programs, such as user fees and copayments, are the way that government clinics offset the loss of revenue in SAPs.

Patients, faced with a cost barrier, may respond by using fewer services (Peabody, 1996). In some countries, such as Cote d'Ivoire, hospitals settle expenses by requiring patients to bring their own drugs, cotton, alcohol, surgical gloves, and bandage. In Tanzania, poorly paid health personnel steal government medical supplies and sell them illegally to patients, who are told that these same items are out of stock in public facilities (Turshen, 1999).

Private practice also affects the nation's health status because practitioners do not undertake the preventative and community health measures needed. For example, a survey in Zimbabwe found that private practitioners and specialists provide curative services only (Turshen, 1999). This also occurs in Mexico, where a large uninsured population receives little preventative health care and faces substantial barriers when seeking curative care. In Mexico, 52.9 percent of total health spending is out of pocket expense, compared to 16.6 in the United States and 3.1 in the United Kingdom (Barraza-Llorens et al., 2002). Consider the effect of privatization of health care in America. In America, there is little commitment to providing basic health care for all, and more than forty million people are without any kind of medical coverage or insurance in the US. The majority of this uninsured population lacks the ability to have medical insurance because of economic circumstances (Sen, 1999).

Poverty: The Indirect Impact on Health

While SAPs affect the delivery of health care directly through budget cuts and privatization, SAPs also make an impact indirectly by contributing to poverty. Poverty is multi-dimensional, and thus has the potential to decrease health care delivery in many ways. For instance, decreased incomes, limited employment opportunities, elimination of food subsidies, and the lack of infrastructure not only makes it difficult to locate and afford treatment, but also puts individuals at a higher risk for contracting disease.

Income and employment levels.

First of all, macroeconomic changes from SAPs tend to lower incomes and decrease employment levels. Consider the case of Peru when Victor Paz Estenssoro took office. Because the economy was in shambles, Estenssoro closed the nationalized mines and imposed a tax on rural producers. According to anthropologist June Nash (1994) the cessation of the mining economy disastrously impacted rural peasants. When employment opportunities were eliminated, families had to struggle to make ends meet. At a household level, if this happens, family savings will decline and soon disappear. The poor will soon require an increase in the number of family workers, particularly women and children (Peabody, 1996).

As poor households try to cope with falling or nonexistent incomes, children share the burden. Declining school enrollment of children from poor households is associated both with falling incomes (no money for school fees) and with rising child labor, as children are sent to look for work to supplement income (Mesmesskoub, 1992). This impacts health because education is associated with better child outcomes (Peabody, 1996). In addition, if parents are working harder at earning income, there is less time for managing resources effectively at home: less time for childcare, food preparation, and nursing the sick (Mesmesskoub, 1992).

Commodity prices.

While families struggle to cover costs with a limited income, the prices for imported consumer goods skyrocket. This is due to rising interest rates, trade policies of developed countries, and exchange rate fluctuations (Mesmesskoub, 1992). For example, in 1989, anthropologist James Ferguson (1995, 271) traveled across Zambia and documented how its economy was reeling from the effects of a newly imposed IMF structural adjustment regime.

Prices of essential goods were skyrocketing, employment declining, and real incomes rapidly shrinking. Many wondered how they would manage to make ends meet. Many,

indeed, were failing to make ends meet: with high food prices, many went hungry; with free medical care abolished, many sick could not receive treatment. For my part, I was trying to some blankets for a trip to the countryside, but everywhere I went, blankets were either unavailable or selling for preposterously high prices.

Risk factors for contracting AIDS.

As families struggle to provide for their families, many are driven into urban areas to find work. Here, poverty has driven women in particular into engaging into high risk sexual behavior in hopes of bettering financial situation. In Tanzania, it was found that seventy percent of commercial sex workers engage in prostitution for economic survival (Lee, 2003). Haitian native Anita Joseph has experienced this situation firsthand. Consider the following interview with her conducted by physician anthropologist Paul Farmer in rural Haiti:

When I did that [take Vincent as a lover], it was only because I had no mother. And when she died, it was bad. My father was just sitting there. And when I saw how poor I was, and how hungry, and saw that it would never get any better, I had to go to the city. Back then I was so skinny—I was saving my life, I thought, by getting out of there (Farmer, 1992, 84).

To Farmer, “Anita Joseph was a victim: She had lost her mother, run away at fourteen, and been forced into a sexual union by poverty which led to her contracting the AIDS virus. She was a child without choices and she had to make a living” (Farmer, 1992, 94). Due to abject poverty and decreased employment opportunities, many young women will migrate into urban areas in the hopes of finding a partner to financially support them. Rather than finding a brighter future, contracting HIV/AIDS is usually the outcome. Indeed, it is within conditions of poverty that women are more likely to engage in risk behaviors that heighten their exposure to HIV infection, and it is within impoverished communities that HIV infection has gained the biggest foothold (Lee, 2003). In Africa especially, the AIDS crisis is decimating the most productive stratum of the population, those aged between twenty and forty-five years old. Surveys have found that in

Zimbabwe fifty percent of the armed forces carry AIDS, and more than twenty-five percent of women seen in maternity clinics are HIV positive (Bello, 1994).

Food insecurity.

Food insecurity, the lack of food or sustainable income to purchase food, and subsequent malnutrition are additional consequences of SAPs that have a profound effect on health outcomes. It is repeatedly argued that food security depends on buying food from international markets, rather than relying on food grown locally for local consumption. However, this is often not the case. In India, for instance, according to the ideology of free trade, earnings from exports of farmed shrimp and flowers should finance imports of food. However, India could only buy one-fourth of the food it could have grown with its export earnings (Shiva, 2000). Thus, India is faced with food shortages and increased rates of malnutrition.

Lack of proper nutrition reduces resistance to disease and mediates poor health. For example, malnutrition is the most common complication of measles, an important cause of death in children (Turshen, 1999). Tuberculosis and cholera are additional diseases which are complicated through the lack of food (Bello, 1994). Malnutrition ravages many areas of the world. For example, according to the National Nutrition Institute, about forty percent of the Mexican population is malnourished—their diets have little rice, eggs, fruit, vegetables, milk, or meat. As part of the IMF loan rescheduling conditions in 1986, food subsidies for basic foods such as tortillas bread, beans, and milk were eliminated (McMichael, 2000). This is also the case in Zambia, where a UNICEF study found that due to the pressures of structural adjustment, families reduced food consumption from two meals per day to one (Bello, 1994). In such situations women are especially vulnerable, a deficiency that can lead to low birth weight babies and a higher risk of infant mortality (Bello, 1994).

In some areas of the world, the high rates of infant mortality due to malnutrition have become commonplace occurrences. Unlike the Western world, which views death from starvation as an anomaly, in the Third World it is practically anticipated. Anthropologist Nancy Scheper-Hughes illustrates what high mortality truly means for women's lives in Brazil.

Within the first month of my arrival, a young mother came to me with a very sick and wasted baby. Seeing that the child's condition was precarious, I rushed with him to the local hospital, where he died soon after. I had come from a society in which babies didn't die, or if they did, where it was a great human tragedy for all concerned. I wept bitter and angry tears all along the way. To my great wonder and perplexity, however, the young woman took the news and the bundle from my arms placidly, almost casually and indifferently. Noting my red eyes and tear-stained face, the woman turned to comment to a neighbor woman standing by, "Tsk! Tsk! Poor thing! Funny, isn't she?" What was funny seemed to be my inappropriate display of grief and my concern over a matter of so little consequence.

"Why do the church bells ring so often?" I asked Nailza de Arruda. "It's nothing," replied Nailza, "just another little angel gone to heaven." Nailza had sent more than her share of little angels to heaven...Nailza could barely remember the names of the other infants and babies who came and went in close succession. One had died unnamed and had been hastily baptized in their coffins. Few lived more than a month or two. It wasn't the deaths that surprised me. There were reasons enough for the deaths in the miserable conditions of shanty-town life. Rather, what puzzled me was the seeming "indifference" of Alto women to the deaths of their babies and their willingness to attribute to their own offspring an "aversion" to life that made their deaths seem wholly natural, indeed all but expected (Scheper-Hughes, 1992, 268-271).

What Scheper-Hughes illustrates poignantly is that in Third World countries, the "naturalness" of infant and child mortality has yet to be questioned. Such deaths are viewed as an unalterable fact of existence; however, they are anything but natural when they are preventable.

Infrastructure.

Finally, the lack of infrastructure can also impact health outcomes. As mentioned, countries managing debt must comply with SAPs that demand decreased government spending. Often, Third World governments are afraid to make badly needed reforms, such as land distribution, sanitation projects, health care, and educational funding, for the same reason—such reforms might hurt their ability to service their debts and attract foreign capital (Kiefer, 1992).

Spending on social goods, such as water and sanitation projects, roads, and communication are reduced despite the fact that water and sanitation services are associated with decreasing diarrheal diseases, and infrastructure development with improving access to health services (Peabody, 1996).

The issues discussed, including cuts in health care budgets, the privatization of health care, decreased employment, raised commodities prices, and reduced spending on infrastructure have been shown to decrease access to health care and increase mortality. Individuals living in structurally adjusted states are thus deprived of opportunities and rights that those in wealthy nations enjoy. Consider the experience of anthropologist Catherine Maternowska in rural Haiti. Haiti, one of the poorest countries in the world, has long been involved in the debt regime. Through her research on health care, Maternowska finds that while individuals are ignorant of specific diseases that may affect them, they are excruciatingly aware of the structural imbalances which oppress them.

Can you tell me three sicknesses that are likely to affect adults in this community? I asked. Marie Dedette, twenty-two years old and mother of two children, responded: “There aren’t three illnesses, there are only two: *maladi grangou* (hunger sickness) and *maladi seksyel* (sexually transmitted infections). When I asked another the same question about three main sicknesses in the community, she distilled her answer even further: *maladi peyi a* (the country’s sickness). Elaborating, she talked about the simple absence of opportunity. “Just look around you,” she said, gesturing to her children naked and covered with flies (Maternowska, 2006, 109).

According to Maternowska (2006, 109), “her [Marie’s] response reflected the nature of structural imbalances and the unhealthy impact these imbalances impose on people’s lives and bodies in this community.”

Solutions

There are multifaceted approaches to solve the problems presented by structural adjustment. The first step is to dispel myths surrounding Third World debt, such as the problem

diagnosed by the World Bank and IMF and the level of corruption in Third World governments. Secondly, the discourse of health care must be reframed as a human right. More challenging solutions include organizing grassroots health organizations, increasing aid to the Third World, and socializing health care.

Dispelling Myths

First of all, the World Bank and IMF may have misdiagnosed the problem (Bello, 1994). SAPs were based on a simplistic view of the challenge of poverty. The rich countries told the poor countries: “Poverty is your own fault. Be like us (or what we imagine ourselves to be— free market oriented, entrepreneurial, fiscally responsible) and you too, can enjoy the riches of private sector led economic development” (Sachs, 2005, 81). As mentioned previously, the IMF-World Bank programs of structural adjustment were designed to address the four maladies assumed to underlie all economic ills: poor governance, excessive government intervention in the markets, excessive government spending, and too much state ownership (Sachs, 2005). However, the barrier to growth was not principally the distorted economic structures of the Third World economies, but the two macroeconomic shocks of the mid-1970s and early 1980s. The problem, according the Massachusetts Institute of Technology economist Lance Taylor, arose from the OPEC oil price rise and the debt crisis (Hoy, 1998).

By assuming that Third World countries fail to recover from debt because they are “corrupt nations,” prejudices and misperceptions leave millions of impoverished people stranded in unnecessary suffering. These notions survive as conventional wisdom because of existing widespread racism (Sachs, 2005). According to Sachs (2005, 188), “The outside world has pat answers concerning Africa’s prolonged crisis. Everything comes back to corruption and misrule. Western officials, included the countless missions of the IMF and World Bank to African

countries, argue that Africa simply needs to behave better, to allow market forces to operate without interference by corrupt rulers.” The truth is, many governments are trying to do the right thing, but they face enormous obstacles of poverty, disease, ecological crisis, and geopolitical neglect (Sachs, 2005). Jeffery Sachs (2005) visited nearly a dozen African countries to find that all have better governance than expected, especially considering burdens of extreme poverty, illiteracy, lack of financial resources, massive debt overhang, AIDS, malaria, and repeated droughts.

Structural adjustment assumes a teleology to the extent that it proposed that the “natives” should be reformed. However, it also reproduces endlessly the separation between reformers and those to be reformed by renewing the premise of the Third World as different and inferior (Escobar, 1995). In mainstream literature, the Third World is endowed with features such as powerlessness, passivity, poverty, and ignorance, “usually dark and lacking in historical agency, as if waiting for the white Western hand to help subjects along, and not infrequently hungry, illiterate, needy, and oppressed by its own stubbornness, corruption, and lack of initiative” (Escobar, 1995, 8). Many in the West have a great difficult thinking about the Third World in terms other than those provided by this discourse. These terms—overpopulation, the permanent threat of famine, poverty, illiteracy—are the most common signifiers stereotyped (Escobar, 1995).

The dangers of these representations of the Third World are clear. The responsibilities for poverty reduction are assumed to lie entirely with the poor countries themselves, thus increased foreign financial assistance is deemed not to be needed. First World donors believe they have done everything they could, with any problems caused by issues beyond their responsibility (Sachs, 2005).

Health as a Human Right

The next step in countering the lack of adequate health care is to reframe and integrate health as a human right. The adjustment policies promoted by the IMF and World Bank for developing countries in financial crisis have not addressed the issues of health and living standards of the population (Borrini, 1985). Those who consider economic development necessary to improve the life and health of a population usually make the assumption that improved health is prerequisite for economic development. Because ill-health traps people in poverty, sustained investment in the health of the poor could provide a policy lever for alleviating a persistent poverty (WHO, 1999). This perspective emphasizes ill health as an obstacle to economic progress. Thus, if a nation invests in the health of its citizens, it improves productivity and wealth creating potential (Leon & Walt, 2001). It is true that development, such as increased food production, is good for health; in turn, better nutrition provides for healthier workers, able to produce more and sustain development. However, the people most in need of support are likely the elderly, children without families, landless peasant families, and the disabled. Their concern is for survival and self-sufficiency, not likely to increase a country's GNP. It is important that health advocates promote and pursue health not because it furthers economic development, but because health is a value in itself (Borrini, 1985).

In poor debtor nations of the world, recognition of a human right to health could shape policies of the IMF and World Bank in several ways. It could bolster efforts to protect infrastructure and the provision of health care services in a country by recognizing the importance of the right to health in the imposed economic development policies associated with the international loans and economic assistance (Kinney, 2001). Also, this right could end the disruptive practice of requiring user fees for the use of publicly funded clinics and other health

care services—a practice that, as mentioned above, has had a detrimental impact on health poor debtor nations.

One major source of international human rights law that is relevant to the right to health is the international treaties of the United Nations. A 1948 UN Universal Declaration of Human Rights affirmatively states a human right to health: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including...medical care...and the right to security in the event of...sickness, disability...” (Kinney, 2001, 1459). Additionally, the UN Committee on International Economic, Social, and Cultural Rights has published a General Comment 14 that outlines the content to the international right to health. General Comment 14 then observes that the right to health extends “not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health” (Kinney, 2001, 1457).

However, the United Nations has no legal authority to impose these treaties upon nations. The Universal Declaration of Human Rights and General Comment 14 are both calls to action, much like the Declaration of Independence. In addition, even countries that deem health care as a human right fail to implement programs that ensure compliance. For example, although protection against ill health has been deemed a constitutional right since 1983, more than half of all Mexicans remain uncovered by any explicit form of health insurance (Barraza-Llorens et al., 2002).

Paul Farmer advocates liberation theology, which emphasis an option-for-the-poor approach to health. “The task at hand is to identify the factors conspiring to promote suffering.

If we do this, we stand a chance of discerning the causes of extreme suffering and also the forces that put some at risk for human rights abuses, while others are shielded” (Farmer, 2003, 50). Farmer explains that instituting health as a human right would mean treating the poor according to the highest standard of care, rather than what happens to be deemed cost effective. “Introducing antiretroviral medications, and the health systems necessary to use them, is viewed as pie-in-the-sky by international health specialists but as only fitting by liberation theology” (Farmer, 2003, 158). As of 2001, the world shunned the idea of using anti-AIDS drugs in low income countries to save the lives of people with late-stage AIDS. The donor world viewed anti-AIDS drugs as hugely expensive and impractically—not cost-effective. The most common claim was that anti-AIDS treatment would not work anyway—impoverished and illiterate patients would not be able to comply with complicated drug regimens (Sachs, 2005).

Authorities rarely blame the resurgence of disease on the inequalities that structure our society. Instead, cultural and psychological barriers that result in noncompliance are used as an excuse (Farmer, 2003). “Doctors may instruct their patients to eat will, but patients will ‘refuse’ if they have no food. They may be told to sleep in an open room away from others, and they will be ‘noncompliant’ if they do not remodel their miserable huts. If hospital care must be paid for in cash, and patients have no money, they will be deemed ‘grossly negligent’” (Farmer, 2003, 151). By blaming ill health on individuals, rather than on structural inequality, the world community perpetuates the same racism evident in the argument for corrupt governments.

Grassroots Organizations

Community health workers and other lay health specialists may be the answer to the missing infrastructure. Full community participation also assures that priorities are set locally, usually by health care personnel and the people they serve, not by demographers and family

planning consultants visiting (Maternowska, 2006). Grassroots movements tend to define problems and solutions differently than development institutions and national governments. They organize productive activity more grounded in local technology, culture, and traditions. The small-scale at which these projects operate allow them to be easily absorbed into the biological and social environment (Borrini, 1985). The following examples demonstrate the effectiveness of such organizations.

The Indian state of Kerala has achieved impressively high life expectancy, low fertility, high literacy and so on despite its low income level per head. Despite the rather moderate record in economic growth, Kerala seems to have had a faster rate of reduction in income poverty than any other state in India. While some states have reduced income poverty through high economic growth, Kerala has relied a great deal on expansion of basic education, health care, and equitable land distribution for its success in reducing penury (Sen, 1999). This demonstrates that the quality of life can be vastly raised, despite low incomes, though an adequate program of social services. In Bolivia, there is great difficulty in accessing health services, particularly in rural areas. In this program, specially trained instructors teach army conscripts health topics and aim to help them share the knowledge they gain. Since its beginning, 239,105 conscripts have been trained, becoming a valuable complement to the assistance offered by national health services (Chelala, 2002). Finally, Paul Farmer's (2003) clinic Zanmi Lasante devised a tuberculosis treatment program that was aggressive and community based, relying heavily on community health workers for close follow-up. It also responded to patients' appeals for nutritional assistance. The patients argued that to give medicines without food was tantamount to washing one's hands and then wiping them dry in dirt. Between February 1989 and 1990, Farmer devised a study of patients at the clinic: a

control group that would receive tuberculosis care without community based services and financial aid, and a group that would. The difference in outcomes was startling. While the group receiving assistance had a cure rate of 100 percent, the control group cure rate was barely half that of the first group (Farmer, 2003).

International Aid

In order to combat poverty, international aid needs to increase. However, there is a pervasive idea in America that we are already doing all that we can do to help the poor. Public opinion research revealed that Americans on average believe that foreign aid accounts for twenty percent of the federal budget, yet this is roughly twenty-four times the actual figure (Sachs, 2005). Economist Jeffery Sachs (2005, 199-200) describes the economic crisis in Africa and explores how donor aid has drastically underestimated the costs of fighting malaria and AIDS.

Africa is especially unlucky when it comes to malaria: high temperatures, breeding sights, and mosquitoes that have evolved to bite humans rather than cattle... Malaria and poverty are intertwined because poor countries lack the means to fight malaria, and malaria contributes to extreme poverty because of pernicious effects on human capital... Household spraying, insecticide-treated nets, and antimalaria medicines all work in Africa just as they do in other parts of the world. They would control the disease, reducing decisively the number of deaths from malaria... Surely the world community would not simply be standing by while millions of children were dying each year; yet the level of help totaled tens of millions, when \$2 to \$2 billion is needed.

In order to realistically fight poverty, donor aid ought to rise from \$6 billion per year to \$27 billion per year. With the combined GNP of donor countries equal to around \$25 trillion dollars as of 2001, this would amount to an investment of one thousandth of the rich world income (Sachs, 2005).

Rather than contributing to aid, developed countries continue to back military spending. According to Keifer (1992, 721), "at the world military spending rate, thirty-five seconds could build classrooms for 30,000 children, or feed 22,000 people for a year. Twelve minutes could

build 40,000 village pharmacies. Two and a half hours equals the entire world budget of the World Health Organization. Seven days could eradicate world hunger, and twelve days could create water supplies for the entire Third World.” Perhaps this disparity arises because of the difference in what is spin and reality in how the world is fighting poverty. An official IMF letter published in the *Financial Times* noted that health and education spending was up 2.8 percent between 1985 and 1996. The fact is, although the IMF official was correct technically, health spending was disastrously low in African countries with IMF programs. In most cases, public health spending was below \$10 per person, compared to over \$1000 per person in developed countries (Sachs, 2005).

Privatization

Finally, the elimination of privatized health care and implementation of subsidized food programs would drastically improve health outcomes. The state must be brought back into development, even if only to make structural adjustment more effective. Furthermore, the less developed a country is, the greater its need for state intervention (Rapley, 1996). While it may be unrealistic to advocate for socialized medicine worldwide, it is realistic to advocate for greater state intervention. A continued neoliberal approach toward health punishes the vulnerable and translates to increased mortality.

Conclusion

Today, the World Bank and International Monetary Fund are ubiquitous with Third World debt. While these institutions were not created for this purpose, after a series of economic shocks in the 1970s, they swept in order to alleviate the economic difficulties Third World countries faced. By following a strict regime of neoliberal inspired policies, these two institutions attempted to alleviate the debt crunch. Despite intentions, the World Bank's and

IMF's involvement has exacerbated poverty in the Third World. As demonstrated, key factors in structural adjustment programs have impeded health care delivery and have contributed to increased rates of morbidity and mortality. As Paul Farmer (1998, 14) states,

For many, tuberculosis is as lethal as AIDS. Childbirth involves mortal risk. In an age of explosive development in the realm of medical technology, it is unnerving to find that the discoveries of Salk, Sabin, and Pasteur remain irrelevant to much of humanity. Many are uncomfortable acknowledge these harsh facts, for to do so, one must admit that the majority of premature deaths, as the Haitians would say, "stupid deaths." They are completely preventable with the tools already available to the fortunate few. These deaths are a great injustice and a stain on the conscience of modern medicine and science.

By continuing with structural adjustment programs in the face of mounting evidence that they are inefficient, millions will succumb to hunger and disease. There are prescriptions to alleviate poverty and improve the lives of nearly two billion people, but action must be taken.

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