Nathan Boyle

Macroeconomic Models and Their Impact on Health in Developing Countries.

As the world threw off the shackles of colonialism in the twentieth century and freedom overspread the earth, it came into the hearts of the benevolent in the West to elevate the health and welfare of the impoverished in newly freed countries. According, organizations were established to manage and direct the flow of money from wealthy donors and nations to the most needy. Among such organizations were the World Bank (WB), International Monetary Fund (IMF), and the Gates Foundation. But, along with the desire to help those in the "Global South" came a new form of "colonialism." In particular, powerful and wealthy nations, particularly the United States, attempted to impose their form of government and macroeconomics on developing nations. Since the earliest days of the United States, politicians and economic theorists have debated to what extent the government should be involved in citizens' affairs, what services it ought to provide, and how involved it should be in the domestic market. However, most economists fall generally into either of two camps.

These two primary macroeconomic models that will be juxtaposed in this paper are Keynesian and Austrian economics. Keynesian economics is a model created by John Keynes in the early 1900s. Keynesian economics, hereinafter democratic socialism, supports increased government investment as a way of solving economic crisis — they would put it, "supply creates its own demand." Austrian economics, promoted by Friedrich Hayek and Milton Friedman, among others, promotes limited government size

and intervention (letting the market correct itself) as the way to solve economic downturn.

Following the economic failure of Keynesian economics in the US and Britain in the 1970s, there was a distinct turn to Austrian economics (hereinafter neoliberalism), politically cemented by the election of Ronald Reagan in the United States and Margaret Thatcher in the UK (Pfeiffer and Chapman). Armed with neoliberalism, WB, IMF, and others embarked on a mission to improve economies and health around the world. They began to lend vast amounts of money to poor countries, while placing stipulations on their national budgets intended to limit their spending. In theory, the system worked: countries begin by cutting federal expenses to ~20% GDP, they receive an injection of wealth to kickstart their economy, and with that their financial decline is averted, leading to widespread improvements in real wages and quality of life. Except, it wasn't that straightforward in real life. In some countries, Hong Kong for instance, the economy showed remarkable growth (Li, 35). In others, such as Mongolia, the economy tanked, then rebounded to become one of the world's fastest growing national economies, while still facing internal problems with poverty (Sneath). However, in some countries, particularly in sub-Saharan Africa, it has had adverse effects on both the national economy and public health (Thompson, et al; Foley).

Given neoliberalism's varied track record, it might seem that the evidence lies in favor of democratic socialism. But it's not that simple, either. Centralized healthcare, a key component of democratic socialism, was established in Venezuela in 2003. Championed as pointing to the "importance of moving beyond free market dogma in

order to realize social, economic, and health rights," this development was seen as a triumph for universal health care (Yi). However, according to Rafael Muci-Mendoza, President of the Venezuelan Academy of Medicine, "[the] constitutional right to have access to health care is a fantasy in our country today." As for the centralized health care system which provides free medical services to the poor, "70% of the…modules were abandoned or not functioning" (Tami). On the contrary, reports on the universal health care system in the USSR were more sanguine. Friedenberg found that in Leningrad, "universally available free medical care" was being provided. However, despite the notion of universal health care as a solution to inequality-based disparities in health outcome, Norman Daniels argues that even UHC does not mitigate the effects of social status on health. Overall, democratic socialism, too, is a mixed bag.

Economists and medical anthropologists are hard put to find the best way to help the impoverished, while ensuring they do no harm, in accordance with the Hippocratic Oath. Sensible and erudite people have held (and still adhere to) both perspectives. Thus, the question is posed: acknowledging that macroeconomics has an impact on public health, which economic system best maximizes both public health and standard of living, while ensuring that no harm is done?

One particular topic central to the debate is structural adjustment programs. Beginning in the 1980s, the World Bank and IMF began to systematize neoliberalism and impose its principles on countries as conditions for offering them loans (Pfeiffer). Pfeiffer argues that these programs have further impoverished poor countries and undermined public health infrastructure; he argues instead for nations to undertake

publicly funded universal health care. Farmer notes that in order to meet budget restrictions stipulated by the WB and IMF, some countries began curtailing contributions to public health (87). However, not all scholars fully agree. The World Bank released a report revealing that countries that had received structural adjustment loans did not present worse health outcomes than those who did not, stating that "it appears that the adjustment process can produce the favorable economic environment in which the system-wide health care problems can be addressed adequately" (Gaag).

Another major difference is over primary health care. Neoliberals insist that public health is best managed by private organizations and benefactors, while democratic socialists maintain that centralized government control of health infrastructure is most effective. Pilote, et al, found that socioeconomic status (SES) did not have a significant effect on outcomes in heart attack patients — which contrast strikingly with the United States, where SES directly correlates with heart attack outcome. They did recommend that additional universal drug coverage might eliminate remaining inequalities. However, Thoresen isn't so sure — his findings after the implementation of universal healthcare (UHC) in Thailand revealed that while UHC increased access to healthcare, it created inequalities and tensions when health care professionals disproportionately sought out urban and/or private establishments, "where workloads are perceived to be less demanding."

The question of which economic system leads to better health outcomes is relevant in an increasingly globalizing world.

Works Cited

Carson, Scott Alan. “Health, Wealth, and Inequality: A Contribution to the Debate about the Relationship between Inequality and Health.” *Historical Methods: A Journal of Quantitative and Interdisciplinary History*, vol. 42, no. 2, 7 Aug. 2010, pp. 43–56., doi:10.3200/HMTS.42.2.43-56.

Daniels, Norman. “Rescuing Universal Health Care.” Hastings Center Report, vol. 37, no. 2, Project Muse, 2007, pp. 3–3. Crossref, doi:10.1353/hcr.2007.0019.

Farmer, Paul. *Reimagining Global Health: An Introduction*. University of California Press, 2013.

Foley, Ellen E. “Neoliberal Reform and Health Dilemmas.” *Medical Anthropology Quarterly*, vol. 22, no. 3, 1 Oct. 2008, pp. 257–273., doi:10.1111/j.1548-1387.2008.00025.x.

Friedenberg DS: Soviet health care system. West J Med 1987 Aug; 147:214-217

Gaag, Jacques Van Der, and Tania Barham. “Health and Health Expenditures in Adjusting and Non-Adjusting Countries.” *Social Science & Medicine*, vol. 46, no. 8, 15 Apr. 1998, pp. 995–1009., doi:10.1016/s0277-9536(97)10019-3.

Li, Kui-Wai. Capitalist Development and Economism in East Asia: the Rise of Hong Kong, Singapore, Taiwan and South Korea. Routledge, 2016.

Muci-Mendoza, Rafael. “Venezuela: Violence, Human Rights, and Health-Care Realities.” The Lancet, vol. 383, no. 9933, Elsevier BV, June 2014, pp. 1967–1968. Crossref, doi:10.1016/s0140-6736(14)60947-8.

Pfeiffer, James, and Rachel Chapman. “Anthropological Perspectives on Structural Adjustment and Public Health.” Annual Review of Anthropology, vol. 39, no. 1, 2010, pp. 149–165., doi:10.1146/annurev.anthro.012809.105101.

Pilote, Louise, et al. “Socioeconomic Status, Access to Health Care, and Outcomes After Acute Myocardial Infarction in Canada’s Universal Health Care System.” *Medical Care*, vol. 45, no. 7, July 2007, pp. 638–646., doi:10.1097/mlr.0b013e3180536779.

Sneath, David. “The ‘Age of the Market’ and the Regime of Debt: The Role of Credit in the Transformation of Pastoral Mongolia.” Social Anthropology, vol. 20, no. 4, Wiley, Nov. 2012, pp. 458–473. Crossref, doi:10.1111/j.1469-8676.2012.00223.x.

Tami, Adriana. “Venezuela: Violence, Human Rights, and Health-Care Realities.” The Lancet, vol. 383, no. 9933, Elsevier BV, June 2014, pp. 1968–1969. Crossref, doi:10.1016/s0140-6736(14)60948-x.

Thoresen, Stian H., and Angela Fielding. “Universal Health Care in Thailand: Concerns among the Health Care Workforce.” *Health Policy*, vol. 99, no. 1, Jan. 2011, pp. 17–22., doi:10.1016/j.healthpol.2010.07.010.

Thomson, Michael, et al. “Structural Adjustment Programmes Adversely Affect Vulnerable Populations: a Systematic-Narrative Review of Their Effect on Child and Maternal Health.” *Public Health Reviews*, vol. 38, no. 1, Oct. 2017, doi:10.1186/s40985-017-0059-2.

Yi, Ilcheong. Towards Universal Health Care in Emerging Economies: Opportunities and Challenges. Palgrave Macmillan, 2017.