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Does Neoliberal Structural Adjustment Contribute to Economic Growth and Improved Public Health in Developing Countries?

In the wake of the Great Depression and WWII, as colonies gained independence from European powers, it became a priority to a number of newly-founded international organizations to advance the health and welfare of the impoverished in freed countries. These organizations, including the World Bank (WB), International Monetary Fund (IMF), and the Gates Foundation, were established to manage market conditions and direct the flow of money from wealthy donors and nations to the most needy. But 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, through their influence on the WB and IMF, attempted to extend their form of government and macroeconomics (collectively, neoliberalism) to developing countries as a stipulation for granting them loans (Pfeiffer). Neoliberalism, as used in this paper, is a form of government and macroeconomics that emphasizes limited government size and economic intervention, with a particular focus on privatization of industry (including healthcare). This phenomenon of large organizations lending developing countries money, with stipulations on their national government, became known as structural adjustment, and the programs that implemented them, structural adjustment programs

(SAPs). But forty years after these programs began to be implemented, medical anthropologists and economists are divided as to the beneficence of these programs. This topic should be important to every person because it impacts the livelihood of millions around the world. In this inquiry and forthcoming report, the chronological scope will be limited to 1980 through 2019, and the countries that will be evaluated will be those who received, or were eligible to receive, structural adjustment loans during this time period. This paper will explore whether neoliberal structural adjustment programs achieve their goals of economic growth and improved public health.

The World Bank, one of the major proponents of structural adjustment, found that structural adjustment programs do not contribute to worse economic or health outcomes in early adopters that fully participated in them (Gaag). They also found that countries that waited before accepting SAPs, though they increased federal health expenditure, saw mixed national economic—or GDP—growth. Countries that did not accept SAPs had distinctly clustered results — those that saw GDP growth had economic and health outcomes that were approximately as good as structurally adjusting countries, while those that saw GDP decline experienced overall significantly worse economic and health outcomes, across all metrics (Gaag). From this report, it is reasonable to conclude that countries are, overall, better off choosing structural adjustment, to improve the likelihood that their economy and health care do not suffer needlessly. The World Bank, and particularly Gaag, having been chief economist for the World Bank, have corporate interest in structural adjustment, SAPs having been a cornerstone of their fiscal policy for the last few decades. Sahn and Bernier, in studying structural adjustment in sub-Saharan

Africa, found that neoliberal structural adjustment increased federal health expenditure in most nations, despite deteriorating health indicators. They concluded that this seeming paradox was reconciled by the discovery of systemic bias in the health care system toward funding specialist and curative care as opposed to general health care. Sahn and Bernier further noted that effective progress is being made to reorganize the system and eliminate structural bias. Sahn and Bernier, while holding no personal interest in structural adjustment, were researching for the Cornell Food and Nutrition Policy Program, whose research was funded in part by USAID, a US federal organization. Countries that have adopted the primary position antithetical to neoliberal structural adjustment, guaranteed universal healthcare, have seen mixed, and often poor, results. Universal healthcare was established in Venezuela in 2003. Championed as pointing to the "importance of moving beyond free market [neoliberal] 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." Muci-Mendoza, having a critical first-person view of the crisis in Venezuela, is a poignant voice from front lines of the emergency. And 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). The World Bank has noted 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). Multiple studies have found that adopting structural adjustment has

led to increased health expenditure and, in many cases, overall better health, while not adjusting or engaging in universal health care has led to detrimental results and overall worse health outcomes.

But critics of neoliberal structural adjustment are not without comment. Pfeiffer contends that these programs have further impoverished poor countries and undermined public health infrastructure. Thompson, et al and Foley, in studying sub-Saharan Africa, found that SAPs had adverse effects on both the national economy and public health. Farmer explains that in order to meet budget restrictions stipulated by the WB and IMF, some countries began curtailing federal contributions to public health (87). These voices come are primarily academic, with no direct ties to international aid organizations or the countries themselves. Ooms and Shrecker further found that in some nations, the health expenditure budget agreed upon with the lending organization became an "expenditure ceiling." This led to some governments counting private donations as public expenditure to meet the quota. In some cases, including Mongolia, which underwent structural adjustment, the economy tanked; and while it recovered, Mongolia still faces internal problems with poverty (Sneath). Pilote, et al, found that socioeconomic status (SES) did not have a significant effect on outcomes in heart attack patients in Canada, which guarantees universal healthcare (which contradicts neoliberal reform). This contrasts strikingly with the United States, a bastion of neoliberalism, where SES directly correlates with heart attack outcome (Agarwal, et al). In the USSR, Friedenberg found that in Leningrad, "universally available free medical care" was being effectively provided. Concerned economists and medical anthropologists, primarily from academic

(and non politically-motivated) circles, raise valid questions that challenge the beneficence and economic effectiveness of structural adjustment in all countries.

The question of whether structural adjustment is effective at improving economic and health outcomes is relevant in an increasingly globalizing world. It can be shown that an author's association can influence the way they interpret the data, considering those who had ties to or grants from these large international organizations tended to side with their official views. The topic is urgent because it affects lives, for better or for worse, wherever it is implemented. It is imperative that world health organizations push through the complexity and plethora of contributing factors and come to a satisfactory and holistic solution to solve both poor economic and worsening health outcomes simultaneously.

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