of the major health programs, that is salaries and materials and supplies.

Disaggregating the expenditures on selected major health programmes into salaries and materials and supplies we find that in general salaries take away an exceptionally large proportion of the expenditures in all the activities under the public health sector. The ranges (1992-93 budget) and means (three-year average) of the proportionate share for both categories of expenditures in the eight states for selected programmes is given in Table 8. It is evident that disease control programmes and rural health programmes have very high salary expenditures which leaves a very small sum for other supportive expenditures without which the health care programmes are rendered ineffective.The urban hospitals and teaching hospitals are relatively better looked after and this is reflected in their overutilisation which creates its own problems. In contrast the gross underfunding and the poor allocative efficiency of rural health programmes leads to very low levels of utilisation of these facilities, thus causing a lot of wastage of the assets created and personnel employed.

In conclusion one can add that rural health care programmes are grossly underfunded, and what little resources are deployed are inappropriately utilised leading to the poor efficiency and use of the rural health infrastucture. At the other end, though urban areas are better endowed and allocations have relatively a much better mix, the urban health care system suffers from an unnecessary pressure, including an influx of patients from less endowed rural areas leading to overcrowding, which also makes it inefficient. If even the existing resources available are better distributed both geographically and in terms of input composition of expenditure (salaries, materials & supplies, maintenance, equipment, etc) the present system too can become more effective and responsive to the health care needs of the people. But this should not be taken to mean that the public health sector does not need more resources. On the one hand allocative efficiencies need to be drastically improved but perhaps more importantly the overall resource allocations to the public health sector, especially to rural areas, needs a substantial enhancement if people have to be served better and more effectively.

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Structural Adjustment and Health Policy in Africa

Rene Loewenson

World Bank-International Monetary Fund structural adjustment programmes (SAPs) have been introduced in over 40 countries of Africa. This article outlines the economic policy measures and the experience of the countries that have introduced them, in terms of nutrition, health status and health services. The evidence indicates that SAPs have been associated with increasing food insecurity and undernutrition, rising ill-health and decreasing access to health care in the two-thirds or more of the population of African countries that already lives below poverty level. SAPs have also affected health policy, with loss of a proactive health policy framework and a widening gap between the affected communities and policy makers.

> Adjustment programmes are rending the fabric of African society. Of the estimated half a million child deaths in 1988 which can be related to the reversal or slowing down of development, approximately two-thirds were in Africa.
>
> UNICEF 1989.

THE economic structural adjustment programme, ESCAP or SAP has many names in Africa. To banking and financial interests, these words spell economic growth and development. For the poor majority of Africa, they spell hardship and struggle.

Africa is a continent that is often portrayed as being at best irrelevant to the international economy. It has been commented that if Africa north of Johannesburg sank below the seas, the international markets would not notice. It is true that Africa provides a small fraction of the global gross national product. But Africa is also a continent of social ideas, aspirations, and struggle. It is a continent where ordinary peasants and workers have in this century waged successful liberation struggles to shake off centuries of colonialism and racism and where a second wave of democratic action is being waged against one-party or one-man governments. Africa is a crucible of change, fertile ground to nurture the best that human development has to offer, but often victim to the worst that it imposes.

This is particularly important for people working in the health sector. Health is a product of material well-being, but it is also a consequence of the social organisation to obtain or produce those material resources. There are many examples of how popular organisation and community mobilisation have contributed to health, even against a background of scarce material resources. They exist in the primary health care gains in Mozambique in the early years of its independence; in the substantial

reductions in infant mortality in many African countries in the early post-independence period; or in a rate of expansion of primary education in Zimbabwe in the 1980s that is unequalled in the world[1]. These achievements were a product of the combined impact of resource allocation and social mobilization. How have SAPs affected health policy and the social development central to improvements in health ? The answer cannot be found in policy documents, where harsh reality is often disguised in acceptable policy terms. While producing a wake of retrenchment, price increases, social decline, and hardship, the Zimbabwean SAP states its commitment to "improve living conditions, especially for the poorest groups" [2]. It is more relevant to examine actual changes in health and social organisation after the introduction of structural adjustment, and from this derive the de facto impact on health policy.

> The World Bank and the IMF are in breach of the Charter of the UN in that they have not promoted higher standards of living, full employment and conditions of economic and social progress and development, nor have they promoted a universal respect for the observance of human rights and fundamental freedom for all.
>
> –Verdict of the Permanent People's Tribunal on the Policies of the IMF, September 1988 [3].

Since 1980, money has been flowing internationally from South to North. In 1979, there was a net flow of U.S. $40 billion from North to South. Today about $60 billion are transferred from poor to rich countries, excluding the repatriation of private profits. From the 28 least developed countries in the world, their foreign debt equals 91 percent of their gross domestic product. The African debt has become totally unpayable; in sub-Saharan Africa it represents over one-third of export earnings[4]. With rising political and economic tensions, developing countries have been encouraged to adjust their economies to increase their external funds for debt repayments, mainly through cuts in domestic expenditure and an increase in exports. This has led to a tide of International Monetary Fund/ World Bank SAPs across the continent. In the first half of the 1980s, three-quarters of African countries had implemented IMF/World Bank SAPs. In many African countries, so called "homegrown" SAPs have included classical World Bank policy measures that have been allied in an almost uniform form in over 40 African countries, as well as in countries in Asia and Central and South America. Under SAPs, the economy is adjusted structurally to manage the balance of payments, reduce the fiscal deficit, increase economic 'efficiency', and encourage private sector investment and export-oriented production.

The major measures include:

Currency devaluations and control of the money supply;
Reduction of public borrowing and government expenditure, particularly in the social sectors;

Trade liberalisation, reduction of tariff rates, and other incentives for foreign investment;
Abolition of price controls;
Privatisation of public enterprises or reduction of subsidies to parastatals;
Withdrawal of subsidies on food and other commodities; and
Retrenchment of workers; wage freezes, and deregulation of laws protecting job security.

In 1989, based on the experience of countries already implementing an SAP, the UN Economic Commission for Africa outlined the potential negative economic and social impact of these policy measures, as shown in Table 1[5]. The World Bank (and many of the implementing govern-

TABLE 1: STRUCTURAL ADJUSTMENT POLICY MEASURES AND THEIR IMPACT

Policy Instrument	Effect
Budget reductions, especially on social services and essential goods.	Undermines human conditions, especially the environment and future potential for development; necessities massive sector retrenchment.
Indiscriminate promotion of traditional exports; price only to tradeables.	Undermines food self-sufficiency; can lead to environmental degradation; oversupply can reduce prices.
Across the board credit squeeze.	Overall contraction of the economy; decline in capacity utilisation; closure of enterprises; accentuated shortage of critical goods and services.
Currency devaluation.	Socially unsupportable increases in prices of goods and services; raises domestic cost of imported inputs; triggers inflation; diverts foreign exchange to speculative activities and enchances capital flight; worsens income distribution patterns.
Unsustainable high real interest rates.	Shifts the economy toward speculative and trading activities and fuels inflation.
Total import liberalisation.	Leads to greater and more entrenched external dependence; intensifies foreign exchange contraints; jeopardises national priorities such as food self sufficiency; erodes capacity of infant industries.
Dependence on market forces for getting prices right in structurally distorted and imperfect markets.	Worsens inflation through sharp rises in production costs; distorts production and consumption patterns and may derail transformation.
Doctrinaire privatisation.	Undermines growth and transformation; jeopardises social welfare and human conditions.

Source: References [5].

ments) warn of the short-term harsh impact of SAPs: retrenchment, cutbacks in public expenditure and social services, charging fees for social services, rising prices, and shrinking real incomes. The palliative is that at some undefined point in time the economy will "pick up" and the growth generated will not only pay back the debt but will also trickle down and improve the lot of the poor.

By the mid 1980s, increasing evidence began to emerge of these negative effects of SAPs on the conditions of the poor majority. Falling real incomes, higher costs of living, and reduced government expenditures on social services produced a severe deterioration in the living standards of the majority. In sub-Saharan Africa, per capita incomes fell by over 25 per cent in the 1980s, and unemployment increased in most countries [6, 7]. In UNICEF's 12-country study of the impact of SAPs, unemployment increased, to over 25 per cent in Jamaica, 16 per cent in Chile, and from 5 to 11 per cent in Peru. Declining formal sector employment was reported to push people into the informal sector [8]. The special session of the UN General Assembly on International Economic Co-operation on April 23-28, 1990, concluded that SAPs had in many instances exacerbated social inequality without restoring growth and development and with threats to political stability. The brunt of the programmes has been acknowledged to fall on the poorest, who have been repeatedly urged to "tighten their belts". In many African countries, this constitutes that two-thirds of the population already impoverished by economic inequities and recession, whose response is often, "we have no belts left to tighten!"

Impact on Health

"Belt tightening" has been a euphemism for a fundamental attack on the basic elements of social well-being. African countries undergoing an SAP have been reported to have experienced rising rates of ill-health and mortality in both the urban and rural poor. Diseases that had reportedly been eliminated, such as yaws and yellow fever in Ghana, reappeared during the SAP period [4,8,9]. Not only have SAP policies ignored this increase in ill-health, but they do not include the profound economic and social impact of the AIDS epidemic at the household, community, or national level.

Infant and child health, often taken as a sensitive indicator of community well-being, has shown marked declines. The infant mortality rate, which had begun to decline in many African countries, rose by 4 to 54 per cent in the SAP periods of the seven African countries shown in Table 2[6]. Increases in under-five-year mortality rates of 3.1 to 90.9 per cent were observed in these countries in the same period[6]. In 1988, the UN was informed during the review of its Program of Action for African Economic

Recovery that one million African children had dies in the 'debt war' (quoted in 7).

Nutrition and food security are major contributors to the health of the population. Although one of the major policy tools of an SAP is to raise producer prices of export crops to stimulate production, there is evidence that poor rural house-holds have not benefitted from these measures. Producer price increases have been offset by increases in costs of inputs to production. In Zambia, for example, maize producer price increases of 142 percent dropped to a real increase of only 6 per cent after taking input cost increases into account[10]. There are no incentives for food crop production, which occupies the majority of the poorest peasants, particularly women farmers, and provides for a substantial part of rural food security[11-13]. In addition, incentives are often given through credit facilities, which tend not to be used by the poorest farmers.

Real wage reductions, rising prices, especially for food, and the cutback in public subsidies have stressed the ability of urban incomes to meet minimum subsistence needs. In Mozambique, for example, removal of food subsidies caused a real increases in food prices of 400 to 600 per cent. In January 1989, a kilogram of tomatoes or onions cost 5 per cent of an office worker's wage[14]. Any real increase in food prices take a heavy toll on low-income groups, some of whom spend up to 80 percent of their income on food. The mid-1980 average wage in Ghana was sufficient to buy only 30 per cent of food needs[8]. Households try to cope with their declining purchasing power by shifting food consumption to poorer quality, high-bulk, and low-energy food, leading to chronic nutritional deprivation, particularly in young children.

In some countries governments introduced food ration systems as part of a "safety net" for the poorest. In Zambia a coupon system was introduced for maize meal, initially for urban households, and then for those earning below K 20,500 (kwacha) a year. Many problems were experienced with the coupon system. It was restricted to certain outlets,

Table 2: Infant Mortality Rates in Countries with IMF/World Bank Programmes

	Infant Mortality Rate			Percent Change,
	1965	1980	1985	1980-85
Ethyopia	165	146	168	+15.1
Mali	200	154	174	+26.5
Madagascar	na	71	109	+53.5
Uganda	121	97	108	+11.3
Tanzania	138	103	110	+ 6.8
Somalia	165	146	152	+ 4.1
Kenya	112	87	91	+ 4.6

limiting the access of low-income house-holds, and it left out rural consumers and those in the informal sector, among the poorest Zambian households[15]. A more direct subsidy on roller meal in Zambia, thought to be of more direct benefit to low-income groups, resulted in millers shifting production to more high-cost cereals and meant that roller meal became unavailable[16].

A 10-country study published by UNICEF on the effects of adjustment on health concluded that the nutritional status of children had declined in all but two of the ten countries[8]. Data from Zambia indicate that at the height of the adjustment period between 1980 and 1984, hospital deaths due to malnutrition increased from 2 to 6 per cent in the 0 to 11 month age group and from 38 to 62 per cent in the 1 to 4 year age group[17]. In a 1987 survey in the University Teaching Hospital in Lusaka, almost 60 per cent of the child admissions were from the low-income areas of Lusaka and 37 per cent were from malnutrition[15].

Despite increased ill-health, health sector expenditure has been cut under SAPs. For example, per capita expenditure on health was reported to have fallen by 40 per cent in Jamaica, 23 per cent in Ghana and 8 per cent in Brazil[8]. Cuts in public expenditure have been associated with the introduction of 'cost recovery' – a World Bank euphemism for fee charging. In Ghana for example, fee charging was introduced for ward admissions, first visits to specialist clinics, casualty and polyclinic services, drugs and tests. Fees initially introduced at low levels immediately rose rapidly, with increases of 800 to 1000 percent in 1985 alone[18].

Fee charging has been reported to improve the quality of services and provision of drugs, but it has also decreased accessibility, particularly in low-income groups. In Mozambique, for example, fee charging was reported to depress outpatient visits in Maputo by 24 per cent between 1986 and 1987, while contributing to a minimal 1.6 per cent of the state health budget[14]. While many countries (including Mozambique and Ghana) have exemptions for the poorest, in practice poor households have found these difficult to claim.

Health workers have also been affected. Cutbacks in public expenditure have in many countries squeezed expenditures on salaries, while price increases have reduced real earnings of health workers, so that there has been a loss of personnel, particularly from the public health sector. In Ghana, for example, of 1,700 doctors working in the public health sector in 1982, only 665 were in post in 1987, most having left for Nigeria and Saudi Arabia[18]. Health workers in the public sector are increasingly pressured to perform private work for extra income, and use public resources to support these practices[14]. Many skilled and experienced professionals, in health and other sectors, move to donor agency employment, where their incomes, conditions of work, and facilities are much

better. Donors in their turn provide selective support to sepcific programs under their own management, many without addressing broader infrastructural support of the public sector[19]. With declining public sector infrastructures and worsening conditions of service, demoralized health workers have resorted to strike action, such as in the health worker's strikes in Mozambique in 1990 and Zambia in 1991.

The negative impact of SAPs on health and health care described above is an indication of a profound, if unstated, change in health policy. The detailed measures and effects vary, but there are consistent broad features of this change: A proactive health policy is replaced by health sector measures to accomodate the SAP. There is a widening gap between affected communities and policy makers, leading to alienation and social tension, with the social response ranging from individual coping mechanisms to social resistance; and health as a right (with its inherent principles of equity) is changed to health as a commodity (for the rich) or a charity (for the poor).

Nowhere is there articulation of the new 'Health policy under SAPs', not surprisingly as it generally implies a reversal of principles of equity in, participation in, and access to health care that were fundamental to health care progress in Africa. Ministries of health are not being asked to shape policies for the health sector, but rather to define ways of making the health sector accommodate to the economic policy measures in the SAP. One effect of an SAP is thus perhaps the loss of a proactive health policy. The policy debate in the health sector shifts markedly from demand-oriented questions on what the population needs and what would be feasible and effective to meet those needs, toward supply-oriented questions of what is affordable and cost effective.

Individual versus Social Roles in Health

Health is both a product of and a contributor to social development. A central aspect of health policy in post-independent Africa has been the importance of social and community mobilisation. The introduction of SAPs has affected this social element in two major ways.

First, it has placed a much greater emphasis on the individual household's ability to buy services or to find ways of dealing with economic problems. The rising cost of living and problems in obtaining employment and basic needs under an SAP preoccupy households, often to the exclusion of other social activities. Economic poverty creates psychosocial stress even within households, between men and women, as well as between different sections of family or community[20]. Individualism is fostered in the market place, where competitiveness is more appropriate than cooperation. Workers and peasants are easily divided by selective benefits to the better off, and by the fear of economic insecurity. Social mobilisation is

more difficult to achieve under conditions where every service has its price.

These individual responses are summarised in Ghana as "suffer-manage; beat-the-system; escape-migrate and return-to-the-farm"[9]. Suffer-manage refers to the endurance strategy of cutting back, while beating-the-system refers to finding every possible way of cheating the state or expoliting others. The escape-migration solution is to leave the country in search of brighter prospects, while the back-to-the-farm group packs up and returns to peasant life, in the hope of avoiding the price war of urban areas.

The retreat to individualism is reinforced by the declining role and credibility of the state. In post-independent Africa, the state was the major instrument for social transformation through public sector driven reform. The state was the arena for idealism and policy change. Unfortunately, the state, in many African countries, also monopolised this role, to the exclusion of the development of civic society. As SAPs "disrobe" the body of the state, cut off its "excess fat", and reduce it to a shrivelled and mean miser, ordinary people are left in bewilderment without effective social organization to protect their interests.

Second, SAPs have distanced the policy makers from the community. Planning has become the prerogative of the very few who sit at the same table and cooperate with the international finance institutions. Even senior national civil servants and professionals with local skills an experience are reduced to 'managers' of policies developed by international consultants, whose exposure to local conditions is a one or two week 'mission'. The population is the last to know the programme. The unpopular measures in an SAP produce a combination of secrecy and lack of consultation that make implementing governments appear authoritarian to ordinary people. The World Bank euphemistically calls for 'strong government' to implement these top-down programs[16], while local scientists see it differently. As Matlosa writes about the introduction of the SAP in Lesotho, "The reliance of the smooth operation of SAP on authoritarianism may be the reason why the IMF loan and its conditionality was never subjected to national debate in Lesotho"[21].

Denied the opportunity to influence policy, individual coping is matched with social resistance to the program. SAPs have led to unrest in almost all countries where they have been implemented. As hardships have increased, people have taken action with varying degrees of organisation or spontaneity. In Nigeria in 1988, petrol price increases and transport fare increases were met with a spontaneous uprising against the SAP, followed by a second demonstration in July 1989. In Cote d'Ivoire, students and workers in 1990 demanded an end to the SAP and for the president to step down. Similar demonstrations took place in Togo, Senegal and Sierra Leone. In Zambia in December 1986 and early 1987, demonstrations

broke out over the Copper Belt when maize meal price increases were announced. Ten workers were killed in these demonstrations. In July 1990, food riots in Zambia again broke out, leading to an abortive coup and about 26 people killed. Lesotho construction workers went on strike to demand reinstatement of 400 retrenched workers and wage increases, the state reacting with police force, shooting two workers and detaining others [21]. When the labour movement in Zimbabwe announced a day of protest marches against the ESAP and its consequent changes in labour laws, the state mounted one of the biggest security build-ups the country had witnessed since 1980. This relationship between resistance and state control further distances the state from the people.

The combined effect of individual coping, social resistance, and the centralisation of planning is one of alienation from and distrust of the sate and mounting social tension. Where civic society is active, this can motivate much more community-based discussion, which may generate new alternatives for health policy. In most African countries, however, civic organisation is weak, and people are pushed into increasingly individual methods of coping, or not coping, as the case may be.

With the overbearing social costs of adjustment leading to social resistance and tension, the World Bank began to include as an adjunct to its SAP an additional component called the 'Social Dimensions of Adjustment (SDA)' or the 'Social Development Fund'. This was an attempt to implement "adjustment with a human face". The SDA funds aim to both protect "poor and vulnerable population groups" from "transitional hardships," and "alleviate transitional social hardships" seen to be temporary in nature[22]. Included in SDA measures are (a) employment and training programmes for retrenched workers and those in the informal sector, together with small-scale venture funds for small businesses and for labour-intensive, low-wage public works projects in rural and urban areas, and (b) targetted programmes for disadvantaged groups, including the urban and rural poor usually providing funds for health and education fees.

The PAMSCAD programme implemented in Ghana in late 1987 invested $90 million several years after the introduction of the SAP to deal with its social casualties. The programme included redeployment of the unemployed, improved health care, nutrition, literacy, and water supplies. In Mozambique, attempts were made to follow the IMF package with a series of compensatory measures to deal with the negative social impact two years later. These approaches were based on a principle of 'targetting' affected groups, at a time when two-thirds of Mozambicans lived in poverty[14].

Such programmes aimed at mitigating the effects of adjustment are often introduced some time after the introduction of an SAP. They are criticized as having a marginal effect at best, and at worst obscuring the fundamental causes of poverty and ill-health.

They regard vulnerable groups as targetable at a time when 50 per cent or more of the population is living in poverty. They direct resources to the poor as an act of charity and not a basic right. Without challenging the patterns of distribution of wealth, these programmes are criticised as being unstable in the long term, and for increasing dependence on outside financing[23]. SDA programmes reinforce a two-tier system : one tier of service provision according to ability to pay and a second tier according to need, funded from the social fund. The two tiers are segregated, obstructing equity or redistribution of social resources. Health is thus transformed from a social right to a marketed commodity for one section of the population or a targettable charity for another.

Health: Cost or Benefit?

It is evident that there is a deep contradiction between the SAP as an economic policy and those policies aimed at building the health of the population. Health workers who point to the social upheaval and human misery around them are faced by smug economists who say, "We told you this would happen, but it's the price you pay for economic growth". For those in the health sector, this raises two challenges: to make human resource development and thus health a more central element of economic planning and policies, and to contribute toward social organisation that will ensure the advocacy and implementation of those policies.

While paying lip service to the importance of health, the SAP has raised a challenge to the social welfare model of health. It has become increasingly clear that it is not enough in these cynical times to have a health policy that strives for social justice. Only if the health of the people is viewed as a necessary input to economic growth and social stability will it be protected and developed. Health becomes an important element of economic growth when human resource development is central to such growth.

One such economic policy, for example is the high skills strategy toward economic growth. Competitive advantage in an economy can be derived from access to natural resources, marketing strengths, technological sophistication, labor skills, the costs of capital inputs, and wage and tax rates. There are usually three main strategies for competitive advantage; resource-based strategies, low-wage strategies, and technological and skill-intensive strategies. As resources have themselves become less important in recent decades than what is *done* with them, it is to the latter two options that we should pay attention.

Low-income/low wage strategies involve low-skill production methods; use informal sector, part-time, and casual labour; and involve weak environmental and health standards, poor social investment, and limited infrastructures. Low wages are maintained by unemployment

and poor social development of labor, which contributes to the erosion of workers' bargaining power. Low wages also lead to a widening inequality in the distribution of incomes and wealth. From the measures described earlier, it is evident that the SAP is a new form of the old low wage/cheap labor that has marked African economies since colonialism.

The second approach to economic growth involves a high skills strategy, which shifts the emphasis to the source of wealth. The high skills strategy emphasises increasing the value added, rather than diminishing labour's real share of the existing value added. In contrast to a low-wage approach, which is based on skirmishes over a static pie, a high skills strategy is based on sustained increases in the pie.

Sustained increases in wealth arise from increases in productivity and in the value added to goods, that is, the difference between the cost of raw materials and of products. Value added comes primarily from technological innovation. However, sustainable innovation can only be based on the growth of skills in the workforce. In Japan, for example, the high skills option was successfully used to penetrate markets dominated by US companies. In Germany and Sweden, public policy has made it impossible to pursue low-wage options and has forced high skills strategies and technological innovation. In Africa, where there are limited resources to import new technology, the need for a sustainable strategy for indigenous technological innovation is even more extreme.

Because the high skills strategy emphasises human resource development as a means to technological innovation and increasing value added, it is consistent with higher wage payments, better working conditions, better social sector provisions, and a reducing inequality in incomes. While this has led to higher quality of life and health indicators, it has also led to economic and productivity growth[24]. In such an economy, health and health care become contributors to development, and not costs. This important choice of a human-centered path to growth and social development was recognised in the Lagos Plan of Action signed by African Heads of State in 1980, which states that, "since Africa's greatest asset is its human resources, full mobilisation and effective utilisation of the labour force for national development and social progress should be a major instrument of development"[25]. These resolutions were further developed in the 1989 UN Economic Commission for Africa's Alternative Framework to SAPs for Socio-economic Recovery and Transformation: (AAF-SAP)[5].

These documents contain noble intentions, but successively stated at the beginning and end of a decade that saw three-quarters of the same heads of state implementing SAPs, with their trail of human waste and misery. This failure of African leaders to implement their own stated policies makes it evident that human-centred policies will not or cannot be implemented without an active and democratic civic society.

This raises the second issue for health workers. It is evident that civic society is beginning to emerge in Africa, in an environment complicated by the poverty and social disruption partially described in this article. Health workers are one section of that civic society. Whether within their own health-related organisations or in support of other representative organisations – including women's groups, resident associations, trade unions, peasant and other producer groups, professional and human rights groups – the extent to which those in the health sector contribute toward, nurture, and advance civic, community organisation may be one of their most important contributions to health.

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