STRUCTURAL ADJUSTMENT AND HEALTH IN ZIMBABWE

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1 Introduction

The evolution of Zimbabwe's economic problems and policies since 1980 both encapsulates the post-colonial experiences of many African countries and also reflects changing views in wider debates amongst academics and policy makers. In this paper, I wish to review that evolution, focusing particularly on the issue of health-care provision, with a view to casting some light on issues in the wider debate.

My main argument is that there has been a decline in the factors determining health, and probably in health status, since 1990 and that the proximate cause of this is the implementation of ESAP; however, there were many signs of deterioration prior to ESAP, suggesting that there may be long term structural problems; these I locate in the political sphere and argue that neither ESAP nor pre-ESAP approaches to economic and health policy address these problems. I also argue that many of the critics of ESAP make the same mistake.

2 Some Preliminary Considerations

a) Structural Adjustment Programmes

Structural adjustment programmes evolved out of earlier and narrower macroeconomic stabilization policies. These were designed for countries with fundamental balance of payments problems. They focused on a range of policies concerned with both reducing domestic aggregate demand and switching it away from tradable goods: depreciating the exchange rate and restricting the expansion of domestic credit, particularly to the public sector, were the two main instruments. The latter entailed cutting government budget deficits, normally by cutting expenditure, especially on social services and subsidies.

Experience and theoretical criticism showed that these policies ignored the supply side of the story and were too short-term in their horizons. Thus, while structural adjustment programmes still contain short-run stabilization measures and are motivated by balance of payments deficits, they also contain a broader range of measures intended to improve domestic supply incentives particularly for the production of tradable goods: decontrol of prices, removal of quantitative restrictions on trade and reduction in trade barriers generally, deregulation of interest rates, commericalization and/or privatization of parastatals. Some of the measures used earlier in stabilization programmes are now seen to be more important for their supply consequences than for their original demand management purposes. Most of the programmes are associated with the World Bank and the International Monetary Fund because they are initiated with balance of payments crises which require short term external financing, and because the programmes themselves require external capital to avoid short-term supply bottlenecks.

The critics of SAPs fall along a continuum. First are those who, while accepting the underlying premises of orthodoxy, argue that the design and implementation of the programmes impose high short run costs on "vulnerable groups". These costs arise because the measures are inflationary in the short-run (devaluation coupled with import dependence and removal of price controls causes cost push inflation) and because some of the cost cutting measures have an adverse direct impact on the poor (removal of subsidies on basic goods, the introduction of fees for many previously free public services) and raise prices directly. Programmes can be designed (particularly by phasing them over longer periods) so that, while still satisfying their primary economic objectives, they minimize short-run costs. Where even these minimal costs are unacceptable, they should include measures to mitigate the impact of these costs on vulnerable groups.[2] The multilateral financial institutions have partially accepted this set of criticisms, with a growing concern for social costs of adjustment, although some critics point out that measures taken have not in practice significantly protected the poor.

Critics have also pointed out that even when judged by their own standards, SAPs have not been successful. Greenaway and Morrissey citing other studies find that the effect on the current account balance is probably positive; on GDP growth is unclear but is at best modest; and on investment is negative (Greenaway and Morrissey, 1992). The problem with judging the outcome of the programmes is that in principle the appropriate benchmark is what would have happened to the economy in the absence of the programmes. If the pre-adjustment economy was in some sense unsustainable, then it is not appropriate to argue that the programme is responsible for the deterioration.

A second set of opponents argue that the agenda of SAPs is to raise the importance of "market forces" and to re-integrate SSA into the world economic system.[3] In fact there is little disagreement between these critics and the proponents of SAPs that this is indeed the aim; rather they disagree as to whether the achievement of this aim would be beneficial in development terms. In other words there is disagreement about the underlying development paradigm. These critics argue that the effect of SAPs is to retard - if not to block completely - the economic development of SSA. Measures to mitigate short run social costs are thus beside the point, since there are no long run benefits. Indeed, trying to soften the short-run costs is detrimental to their solution, since they soften the opposition to the global system which needs to be changed if there are to be any prospects of really solving the question of poverty. These opponents would argue that the first set of reformist critics do not face up to the fact that it is the international capitalist world system which is at the base of underdevelopment, and until that is tackled there is no prospect of permanently and significantly mitigating the lives of the poor in the third world.

This criticism has been voiced in Zimbabwe. For example, MacGarry, in his paper on ESAP and the economy, writes:

> ESAP, as imposed on country after country around the world, is designed to support a new 'global division of labour', with the already developed countries supplying all the manufactured goods the poorer countries of the South need, while those countries try to pay for the imports, and pay their debts, by selling food and other raw materials to the rich. The IMF/World Bank master plan has no place in it for the development of manufacturing industry in countries like Zimbabwe, so it would not be realistic to look to an adjustment programme designed according to their principles to serve our industrialization. It is more likely that some of our advanced industrial firms, such as ZISCO, may have to close and such machine components as we now manufacture for ourselves will need to be imported; we might still be allowed to assemble machinery from imported parts. (MacGarry,1993: 31)

The contrast between these two critiques captures the dilemma of the conflict between the short-run amelioration of the lives of the poor and the longer-run creation of a better system. It is clear that the longer-term radical solution does not address the short-run problem; however, short-run amelioration may undermine the attainment of the long-run solution.

b) The Determinants of Good Health: "Inside" and "Outside" Factors

The connection between the economy, health-care provision and health status has been widely examined (see for example Kim [1992]). These studies suggest that the link is complex and difficult to quantify. It is useful to distinguish between those factors inside the health service sector (building of hospitals and clinics, the training of doctors, nurses and other medical personnel, the provision of drugs, immunization, health education programmes) and those outside it (the economic situation including income levels and distribution which is probably the most important, education, environmental context, etc.). Outside factors feed into the "health production function" directly (e.g. higher incomes improve nutritional status) and indirectly (through the provision of health-care services and by affecting the use made of those services). Outside factors are significantly more important than inside factors.

These different channels are important to understand for the health and adjustment debate. Adjustment is often seen as having a negative effect on health status because public provision of health services is often cut in attempts to reduce government expenditure, i.e. through their effects on the inside factors. However, proponents argue that to the extent that health expenditures contribute to macro-economic constraints on growth, they reduce

the rate at which outside influences can improve. Critics point to the collapse in incomes which often occurs with the introduction of the SAP. This affects health status because increasing poverty directly makes people sicker and poor people use health services less. Proponents argue that the decline in real incomes is transitory and that in the longer run, unadjusted economies harm health more because they will have lower growth rates. This argument depends on the impact of adjustment on long-term growth. Even if long-term growth rates of adjusted economies are higher than those of unadjusted ones - and there is little clear evidence to suggest they are - the difference would have to be large to be justified in cost-benefit terms if there is a significant short-term deterioration of living standards. If one takes the view that intergenerational comparisons of utility are not possible, even the prospect of substantial future gains would not justify large "transitional" costs.

SAPs have a differential impact on women. With shrinking formal employment, women are more at risk than men. Furthermore, the concentration of women in the informal sector means that in times of hardship women's incomes decline. If they lose their jobs, there is a differential impact on the intra-household distribution of income, which can significantly affect child nutrition. Additionally, the burden of coping with adjustment in the household generally falls disproportionately on women: more of their time is spent seeking ways to stretch the shrinking budget, cope with sick children who can no longer be taken to health care institutions, etc. In the longer run, introduction of fees in education tends to lead - and there is evidence that this has happened in Zimbabwe - to higher drop-out rates for girls; given the well-established link between female education, health and fertility, the consequences of this are likely to be negative.

3 Economic Performance and Health in Zimbabwe since 1980

a) Outside Factors: Economic Performance 1980-1994

At Independence in 1980, Zimbabwe's government proclaimed "transition to socialism" as its goal.[5] Welfare measures designed to redress inherited inequalities were introduced: national minimum wages, rapid expansion of education, free health-care services for low income earners, improved rural credit facilities, a (limited) land resettlement programme, expanded government programmes on water, sanitation and drought relief. It also used a range of policy instruments and institutions - many inherited. Extensive price controls were used to protect low income groups from inflation in basic wage goods; this entailed subsidizing basic foodstuffs. The Grain Marketing Board and the Agricultural Finance Corporation were used to extend services and to channel credit to small scale agricultural producers. New parastatals were introduced to give the state more control over private businesses.

The budgetary implications of these programmes were accommodated initially by the economic growth (stimulated by relaxation of sanctions, import expansion and good agricultural seasons) around independence. However, growing balance of payments deficits led to the adoption of stabilization measures in 1983: an IMF Stand-by Credit in 1983/84; minimum wage legislation began to be used to curtail wage costs; an active exchange rate policy was adopted, although quantitative import controls remained the central instrument for current account management.

Central to this story was the government budget deficit. Government attempted to sustain its social programmes. Expenditure cuts were made, but on capital rather than recurrent expenditure. It was thus difficult to avoid a growing budget deficit. Simultaneously government approached foreign debt prudently, using direct foreign exchange controls to bring the current account deficit into surplus. This combination of a high public-sector deficit and low foreign savings could only be accommodated through a high private-sector surplus, which was achieved through compression of consumption and investment in the private sector - induced by a combination of import, wage and price controls and by financial crowding out (Davies and Rattsø, 1993).

Through the eighties it was recognized that lack of foreign exchange constrained growth and various *ad hoc* measures were introduced to stimulate exports while retaining the quantitative controls on imports. Although these programmes achieved some success (replicating policies successfully used in Korea), pressure built up from various quarters for a more systematic revision of economic policy. With hindsight, the experiments with various

ad hoc macro economic and trade policies can be seen as constituting an unevenly paced evolution towards the more systematic adjustment programme adopted in 1990 (Shaw and Davies, 1991).

Table 1 summarizes some relevant economic performance indicators for the 1980s. As Row 5 shows, after an initial increase, per capita income was relatively stagnant. Real average earnings in the formal sector (Row 8) were more than 5 per cent lower in 1990 than they had been in 1982. We do not have good measures of how income distribution changed over the period. Although peasant incomes had been raised by government policies in the early eighties, there is evidence that this favoured approximately 20 per cent; rural household differentiation appears to have been increasing. The decline of formal employment as a percentage of the population, [Table 1, Row 25] suggests that the numbers relying on other forms of income earning have increased. Although the successive reduction and removal of food subsidies, aimed at reducing the impact on the budget deficit of losses by marketing boards, may have helped that small percentage of farmers who are net producers of food, it contributed substantially to the inflation which eroded real earnings through the 1980s. Rows 11 and 12 show that average earnings declined relative to the poverty datum line. In absolute terms there were more people below the poverty line in 1990 than there were in 1983. It thus seems that by the end of the eighties, real incomes had fallen for the majority of the population since 1983.

b) Inside Factors: the Health Sector 1980-1990

The elitist, racist character of the health care sector in colonial Zimbabwe was one of the main inheritances of Zimbabwe at independence in 1980 (Loewenson and Sanders, 1988; Davies and Sanders, 1988). Government implemented a number of specific health-sector policies to tackle this inheritance, broadly adopting a primary health care (PHC) approach (MOH, 1984; MOH, 1986). Among the policies implemented were the integration of preventive with curative services; the introduction of free services for those earning less than $150 per month; the expansion and upgrading of health-care facilities particularly in rural areas; an expanded programme on immunization (ZEPI); diarrhoeal disease control mainly through oral rehydration therapy (ORT); the establishment of a national nutrition department; a village health worker and traditional midwife training programme; child spacing and family planning; an essential drugs programme; and a disability programme.

In line with the PHC approach, the Ministry of Health's budget was increased and its internal allocation altered. Table 3 shows how the Ministry's allocation per capita grew in real terms until 1987 and in total until 1988. By 1988 preventive services were taking over a quarter of the ministry's total allocation, up from a twentieth in 1980 (this understates the amount going to preventive services because of the integration with curative services). There was also an attempt to shift expenditure away from central urban hospitals. A national referral hospital system was established, converting what had previously been white hospitals into fourth level hospitals at the apex of a national referral system.

Zimbabwe's record in health care has been good. Disease and mortality indicators showed an improvement through the 1980s, particularly when compared with the pre-independence situation. However, the record is not entirely one of continuous improvement. Surveying the outcomes of health policies in the 1980s, Davies and Sanders state:

> In summary, therefore, after substantial initial improvements, the mid-eighties saw stagnation and erosion of both 'outside' and 'inside' inputs to health. There are not yet the data to examine the net outcome of this erosion. The patchy data available up to the mid-eighties indicate that significant progress was made in addressing Zimbabwe's legacy of ill-health. Most observers agree that there has been a sharp decline in both IMR and U5MR since the late 1970s. For example, while the precise levels are not known, a review of extant studies suggests that IMR currently lies between 60 and 75. Levels of under nutrition appear to have declined significantly between 1980 and 1983/84, although there is less firm evidence of a decline thereafter. In 1982 a national nutrition survey of under three year-olds showed 17.7% were underweight, 35.6% stunted (under height) and 9.1% wasted (significantly thin). In 1984, another national survey showed 14.5% of 1 to 5 year olds to be significantly under weight. However due to differing methodologies these two surveys are not strictly comparable. By 1988 the CSO Demographic Health Survey found national levels of 11.5% underweight 29% stunted and 1.3% wasted. While the situation appears to have improved with respect to wasting, levels of

> stunting remain high. Once again the comparison with 1982 and 1984 data is made difficult because of differences in anthropometric cut-offs and the different age groups sampled. (Davies and Sanders, 1991: 12)

They conclude that, although data are sketchy, the improvement in mortality indicators was accompanied by discrepantly high levels of childhood undernutrition which seem to have remained static or improved only marginally despite the health-care drive. This is attributed to the economic stagnation of the mid- and late-1980s.

It should also be observed that, insofar as Zimbabwe adopted PHC as an approach to health care, it was the selective rather than the comprehensive variant; an example of UNICEF's GOBI approach, with selective targeted interventions. Furthermore, this programme relied heavily on external support. A World Bank study showed the main contributors to total health financing for 1986-87 were MOH (48.8 per cent), insurance schemes (16.5 per cent), foreign assistance (11.7 per cent) private individuals (10.0 per cent), and private firms and farms (8.0 per cent). These figures do not capture the full contribution made by donors and NGOs, whose contribution is often through donations of equipment, vehicles, drugs and volunteer workers. Further, the role of foreign donors was often crucial in sustaining specific programmes. For a time, not only vehicles but also vaccines, syringes and needles on ZEPI was funded by donors. In 1989, a report for the Ministry of Health, noting this and the intention for the MOH to gradually take over this financing, commented, "In light of the likely future deteriorating economic situation there must be serious doubts as to the feasibility of this and the future of ZEPI - surely the most successful health programme in independent Zimbabwe". (MOH, 1989)

Foreign support for the health sector has also been important in terms of personnel. The number of registered doctors (including expatriates) increased by 131 (11.3 per cent) between 1981 and 1989, despite 462 local doctors graduating in the period and an annual employment of about 75 expatriate doctors. Furthermore, the majority of provincial and district government posts were filled by expatriates (Ministry of Health, Dept of Manpower Planning, 1989). Expatriates thus played an import role in filling both public sector and rural posts that those Zimbabwean doctors who had not emigrated did not wish to fill.

Questions have also been raised about the operational efficacy of the national referral system. The central hospitals, which continued to receive disproportionate public funding (on the grounds that they were the fourth level referral hospitals) in fact continued to be used as primary hospitals. (Sanders *et al.*, 1989).

c) Economic and Health Sector Performance under ESAP

Zimbabwe's formal adjustment programme (ESAP) was announced in a policy statement (GOZ, 1990) along with the 1990 Budget and elaborated in *Framework for Ecomomic Recovery* (GOZ, 1991) in February 1991, timed for a meeting of donors in Paris. The programme contains components of orthodox SAPs, although there are some differences, mainly in the length of time over which it was to be phased. Seven main areas were targeted for policy reform. In what follows I outline the main intentions of the programme in each of these areas and briefly comment on their implementation.[6]

Public Finance: the aim was to reduce the budget deficit to 5 per cent of GDP by 1994/95 through, *inter alia*, eliminating subsidies to parastatals except for targeted subsidies, introducing fees for education, enforcing the limits for free health more effectively, rationalizing defence expenditure, reducing the size of the civil service and making public sector investments more efficient, commercializing or privatizing parastatals. The tax structure was to be altered to provide greater incentives for productive, and particularly export, activities, although it was not intended to raise tax rates.

The Budget proposals put forward in July 1992 forecast a reduction in the deficit relative to GDP, but largely through cutting subsidies, fiscal drag and some new taxes, rather than reducing the number of civil servants. Although government claims to have retrenched 13,000 civil servants by the end of 1992, these claims are disputed by most analysts. Primary school fees were introduced for urban schools in January 1992 and a wide range of fees have been introduced for health care. The proposal to raise the ceiling income for free health services from $150 per month (the level it has been since introduced in 1980) to $400

not yet been implemented. Subsidies to parastatals have been cut, but moves to make them operate on more commercial lines have been slow.

Trade liberalization and export promotion: it was proposed to dismantle the system of administered allocation of foreign exchange for imports over the five years of the programme, and to substitute it with a tariff-based system. This was to be done by selectively moving imports onto open general import licence. Some of the already-existing export incentives were to be enhanced.

This is one of the first areas in which action was taken. However, initial implementation was somewhat chaotic, and there was over-importation of the first items placed on OGIL, largely due to speculation against further devaluation of the dollar. There has however been a noticeable increase in the availability of imported goods. In part this is due to the policy of allowing foreign exchange earned under the export retention scheme to be freely transferrable. It is debatable whether the policies can be regarded as "liberalizing" imports, since most imports competing with domestic production are still not on OGIL; the reforms have rather added a further category to the system for allocating foreign exchange to imports. There has been a large devaluation of the Zimbabwe dollar [see Table 1, Row 10].

Economic Regulation: price controls were to be removed on all save a few basic food prices. In the labour market collective bargaining on wages was to be extended, and the procedures for employers to obtain permission to fire workers streamlined.

There has been extensive implementation in this area, with almost all price controls removed.

Investment Promotion and Incentives: Government investment was to be concentrated on infrastructure in transport, power and telecommunications. Government was also to borrow to ensure supplies of capital goods. Investment and dividend repatriation regulations were to be streamlined.

The maximum size for investments not requiring processing by the Zimbabwe Investment Centre has been raised and measures to streamline the procedures have been passed into law. However, there appears to have been very little investment.

Monetary Policy and Financial Sector Reforms: Monetary policy was to be geared toward fighting inflation, through managed interest rate and credit policies.

Interest rates have risen substantially, following the policy of keeping them positive in real terms. Tight monetary policies have also been implemented, with many firms facing a credit squeeze.

Social Aspects of Adjustment: a "social fund" was established as the basis for protecting "vulnerable segments of the society", through targeted subsidies and the promotion of employment, especially in the informal sector (GOZ, 1990:19).

Although a fund has been established, its initial capital of $20 million was derisory and little action appears to have been taken to protect vulnerable groups. The policy of exempting the very poor from some of the newly introduced education and health fees has largely been ineffective because of the bureaucratic procedures required in order to qualify.

Financing of the Economic Adjustment Programme: it was recognized that the programme would require external funding.

Donors at the Paris meeting in April 1991 agreed to shift previously promised project aid into quicker disbursing programme aid. There has also been a large inflow of new donor money, largely related to drought assistance. As Rows 13 to 16 of Table 1 shows, Central Government foreign debt grew from 31.9 per cent to 41.3 per cent of GDP between 1990 and 1991.

Assessment of ESAP at this stage must be tentative, since data is not yet available and the drought complicates matters. However, there seems little doubt that the immediate impact has been negative for most Zimbabweans.

Inflation was the most immediately visible result of ESAP. Between July 1990 and October 1992 (latest figures), the low income CPI rose by 106 per cent; the food component rose by 116 per cent. Constant price average earnings in the formal sector fell by 12.5 per cent in 1991, and by slightly more relative to the poverty datum line. A survey of a high density suburb in Harare suggests that the households below the poverty line rose from 23 per cent in 1991 to 43 per cent in 1992 (Kanji, 1993). Employment rose by 4.2 per cent in the same year, mainly in agriculture, manufacturing and distribution.

Expenditure in the Ministry of Health has declined significantly in real terms. Although the total allocation increased by 13 per cent in 1990, it declined by 15 per cent in 1991 and 13 per cent in 1992. In per capita terms this decline was greater; in the 1992/93 budget planned expenditure was $12.26 per head in constant 1980 dollars, compared with $18.35 in the 1990/91 budget.

A major policy of ESAP in the health sector has been cost recovery in the form of fees for public health-care services. By 1992, the income for those qualifying for free health was 20 per cent of the urban PDL for a family of five. Several studies have shown that there has been a sharp rise in maternal deaths since 1989. "Nationally the number (of maternal deaths) increased by 88 per cent between 1989 and 1990 and then by 27 per cent between 1990 and 1991. National maternal mortality rate increased by 39 per cent from 251 deaths per 100 000 total births in the whole of 1991 to 350 deaths per 100 000 between January and June 1992." (Chisvo, 1992: 9) There have been similar increases in admission and death rates of babies born before arrival. These appear "to be closely linked with the introduction of health charges and the application of strict criteria for exemption. The drop in utilization of health facilities after cost recovery measures was also evident from data collected under the Ministry of Health Essential Drugs Action Programme from 21 Primary Health Care Facilities countrywide. The statistics collected for a three month period, March to June, 1991, showed that the average case load dropped by 25 per cent at these facilities over the three months due to cost recovery." (Chisvo, 1992: 9). Similar reductions in utilization rates have been noted by Renfrew (Renfrew, 1992).

In fact, except for those earning less than $150 per month, there had been fees throughout the 1980s, although these had not been rigorously implemented. Furthermore, the erosion of the free service through inflation meant that whereas in 1980 the ceiling was 137 per cent of the PDL for urban families of five, by 1990 it was 40 per cent. Furthermore, in the late 1980s, prior to ESAP, medical officials were being exhorted by the Ministry of Health to implement the procedures for exemption more rigorously. Thus, the gains that had been made in the early eighties had been eroded before ESAP was formally introduced.

4 Structural Adjustment, Health Care and Health: Some Lessons from Zimbabwe

Although the data are sketchy, there seems little doubt that the immediate impact of ESAP in Zimbabwe has been to cause a serious deterioration in living standards for a large number of middle and low income households. Evidence suggests that this has had a negative effect on health care provision, on the utilization of health care services and on mortality indicators. This experience, combined with perceptions of the effects of SAPs elsewhere in Africa, have rightly provoked a number of criticisms in Zimbabwe. Thus MacGarry lists the potential winners and losers from ESAP:

Winners:

1 International bankers they collect on our debts.
2 Multinational corporations: . they own our industries and control the markets through which we try to sell our products.
3 Our commercial farmers: marketing and transport services will be concentrated on serving them under "cost-cutting" proposals.

Losers:

1 Landless unemployed: ESAP offers them nothing.
2 Ordinary workers: ESAP offers them lower wages, less security and higher prices for the necessities of life.
3 Peasant farmers: cutting allegedly "unprofitable" services means their crop marketing depots will close and their roads will deteriorate so they cannot get produce to market. (MacGarry, 1993: 31)

Father Peter Balleis, in his foreword to Renfrew's pamphlet says, "The increase and new introduction of medical fees in hospitals and clinics is part of cost-recovery under ESAP. It directly affects the life and health of the majority of poor people in Zimbabwe. The decline in the health standard of the people is not just due to medical fees but also to the general decline in real income... For the sake of peoples' health and life and for long term economic growth health care must remain a political and economic priority as it used to be in the programme of the 80s." (Balleis, in Renfrew, 1992).

These writers, like other more radical critics of SAPs, thus not only clearly attribute the decline in real incomes and health care to ESAP, but also see it as undermining a successful pre-ESAP system. In this final section I wish to raise a number of points which need to be taken into account in making such a judgement. Firstly, by rejecting not only ESAP as a package, but all of the components of that package individually, I believe that the critics allow the proponents of ESAP to determine the agenda for debate. It is clear to any Zimbabwean or observer of Zimbabwe that there was a need for policy reforms of some nature. Many of the components of ESAP are economic policy instruments which need to be used to manage the economy. One should not allow them to be removed from the policy tool-kit simply because they are misused elsewhere, Thus, to take the most demonized, it seems to me that cost-recovery in health not only is necessary when resources are constrained, but can also be arranged so as to increase equity in the access to health care.[7]

Secondly, I do not agree that one can portray the economic policies followed since 1983 as successful in sustaining incomes and health status, or in promoting sustainable equity. Despite policy statements to the contrary, it is apparent that prior to the introduction of ESAP not only had average incomes stagnated but also that distribution had worsened. For the poor in Zimbabwe, the late 1980s saw a decline in the quality and quantity of most services - education, transport, housing, health - publicly provided to the poor. The wealthy increasingly protected themselves by leaving the public schooling system for private schools, relying on private cars rather than buses, used private rather than public medical services and bought private houses.

Furthermore, I think it is incorrect to argue that health-sector policies in the 1980s were adequate. The gains made in the early 1980s were substantially eroded by the end of the decade. It is not clear that the public health-care system was achieving the objectives set out in PHC-oriented policy statements. I have already noted that those aspects of policies which contributed to the improvements in mortality and morbidity indicators were based on selective interventions and relied on substantial foreign assistance. It is not correct to portray them as following what Wisner has called strong comprehensive PHC (Wisner, 1988). The central element of the PHC approach is participation by local communities in deciding what their health needs are. The health system in Zimbabwe did not adopt this approach.[8] The system remains one in which "experts" impose an external definition of need on a community, in which local organizations are seen as important instruments for the delivery of health care information and technology, rather than as transformative institutions. On the contrary, as David Sanders has argued, the central government acted soon after independence to destroy those incipient autonomous health organizations which had developed during the liberation war.

I would argue therefore that one cannot see the formal ESAP as the *fons et origo* of the decline in living standards in general and health-care provision in particular. The origins are to be found in policies followed earlier, which had cumulatively contributed to the unsustainability of initial welfare gains.

Some critics of ESAP do indeed trace the problems back to 1982-84, when Zimbabwe first flirted with the IMF and the World Bank first began to become involved in economic policy. However, these criticisms play down the relevance of macro-economic resource constraints. Part of the reason why Zimbabwe has embarked upon a programme which undermines its earlier welfare gains - in fact has been on such a programme since 1983 - is that it did not pay sufficient attention to this constraint when implementing these programmes in the post-independence period. It is tautological that a country can only use more goods and services (for current consumption and investment by the public and the private sector) than it produces if it is able to borrow, i.e. persuade foreigners to let it use some of their goods and services. One can (and should) argue that the international economic system should transfer more resources to the third world. But achieving this is neither a short-run

solution nor one that is part of the range of policy instruments available to the Zimbabwean government. In these circumstances, attention has to be paid to the overall resource constraints, and arguing that there is a moral obligation to provide adequate incomes and access to health for all, as a basic human right, does not circumvent the constraint.

Zimbabwe's early policies set up programmes that required either borrowing or growth in order to be sustained. Furthermore, much of its borrowing, both domestic and foreign, did not go in adequate quantities into growth promotion. Once government decided, in 1982, that the debt implications of the then levels of foreign borrowing were unacceptable, and used quantitative controls to compress imports, it started on the path to ESAP. On trade policy, as Davies and Rattso (1993) have argued, it was increasingly faced by a trade-off between domestic production levels and investment. On the budget deficit, when faced with constraining expenditure it tended to cut investment rather than recurrent expenditure, reducing the crowding-in effects on private investment.

To understand why this happened, one has to consider the political economy of the state in Zimbabwe. The initial welfare programmes, based as they were on optimistic expectations of what was possible, were in some sense understandable. No government that had achieved state power after the liberation war could have survived for long without satisfying some of the expectations of the Zimbabwean people. However, while the policies did expand access for many Zimbabweans, there was little institutional reform to change the structure of the economy.[9] What were essentially income redistributing measures substituted for wealth and ownership redistribution. The perceived constraints of the Lancaster House constitution and the threat of South African intervention to prevent radical transformation, were used to justify this. However, as I have argued elsewhere, it is difficult to sustain the argument that institutional reforms were operating on the frontier imposed by these constraints (Davies, 1988).

Once the state accepted this approach to redressing the past, I would argue that it moved along a path of convergence with private capital. As political leaders and senior state functionaries accumulated private wealth, using their state positions, so their concern for radical redistribution of wealth receded.[10]

Does the above argument mean that ESAP should be exonerated? I believe not. There are fundamental problems with both the design and the implementation of the current reforms. At the economic level, ESAP proceeds on the premise that because previous state interventions have been harmful, there should be no intervention. The case against proper selective intervention to promote industrialization has not been proved theoretically or empirically. Similarly, ESAP still relies on the stagnationist elements of earlier stabilization policies; demand deflation coupled with a failure to recognize the elements of cost push inflation. In its implementation of the programme, the excessive reliance on restrictive monetary policy, particularly given continuing government deficits and inflows of foreign assistance, has severely restricted the ability of firms to respond to any positive shift in production incentives that might have occurred.

On the social front, Zimbabwe's ESAP suffers from similar problems to other SAPs: policies to "mitigate the effects on vulnerable groups" are being introduced too late. It is not yet clear whether in fact government has designed any such policies, so that, even if they could reduce social costs, their introduction will be too late.

As suggested in the earlier discussion of SAPs, one's assessment depends crucially on whether growth rates are significantly raised in the long run. In Zimbabwe's case, it is not at all clear that any growth which might come out of the current programme will be sufficient to compensate for the short-term costs. It is clear that foreign debt will be substantially higher at the end of the programme than it was at the start; it is not yet clear that her production and exports will be. In addition, even if there is growth, it is unlikely that the distribution of the benefits will be adequate to satisfy even a conventional economist's criteria for a welfare improvement.

In addition to these criticisms, the ESAP is based on a flawed paradigm; a non-structural view of market systems. As with the advice being given by some western economists to reformers in the former Soviet bloc, there is an underlying presupposition that all that is needed for markets to work is that agents should be freed of any regulation on the pursuit

of their own self interest. This confuses the notion of a market with that of a market system. Even if it is true that individual agents might seek to do the best they can when dealing with other agents, this does not mean that resources will be allocated within the economy according to "market principles". The existence of institutions and infrastructure integrating fragmented markets, the creation of "free" labour and competition amongst capitals are all pre-requisites for this to happen. The role of the state in creating these capitalist institutions historically is denied by orthodox structural adjusters. Rather than creating these, the freeing of "market forces" will allow a private, oligopolistic, mercantilist and rentier class to substitute for a mercantilist state.

Specifically referring to cost recovery measures in health, it should be noted that these do not create a market in the health sector. The "prices" are administered and do not perform fully the functions that prices are supposed to play. Rather they are a tax. The allocation of resources within the health-care sector remains a bureaucratic process; there is not a sense in which prices can act as signals to bureaucrats, indicating "consumer preferences".

To return to the opponents of ESAP in Zimbabwe. Their focus on the short-run costs, and their failure to recognize the problems entailed in pre-ESAP policies, leads them away from the basic problem underlying both sets of policies: the underdeveloped nature of civil society in Zimbabwe. Wisner observes that "The chief danger of selective primary health care, is that it helps to slow or to divert the growth of local organizations capable of articulating these demands for change at an historical turning point that can only lead to change or to disaster." (Wisner, 1988: 968) This criticism can be generalized to Zimbabwe in the 1980s. The nature of its political processes blocked the growth of such organizations in most spheres of life. A pervasive state privileged itself to articulate these demands on behalf of "the people"; where this privilege was not recognized, it acted to suppress autonomous articulation. Thus while the problems are perceived as economic, and have important economic dimensions implications, the underlying causes are political. It is not clear that ESAP addresses these causes, particularly in an economy characterized by inequalities.

I believe that this observation is relevant also for the more radical opponents of ESAP. The changes to the global economy which they argue are necessary before third-world poverty can be addressed will surely only come about when the people of the third world are able to "articulate these demands for change".

NOTES

1 Currently visiting Department of Economics, School of Oriental and African Studies, University of London. This paper has been written in London, where it has been difficult to obtain up-to date information on Zimbabwe. I would like to thank Sara Davies, Colin Stoneman and Carol Thompson for help in filling some of the gaps.
2 This is the thrust of much of the work on adjustment coming from UNICEF (see Cornia *et al* 1987, 1992). One can find similar views in some World Bank publications (World Bank, 1990).
3 See for example Kanji *et al* (1991) for a cogent statement of this critique.
4 These matters have been more extensively reviewed in, *inter alia*, Davies and Rattsø (1993) and Shaw and Davies (1989).
5 In practice it introduced a relatively mild form of welfarism through redistribution: the policy statement, *Growth with Equity* (GOZ, 1981) is hardly a milestone in socialist literature. An assessment of the socialist content of government programmes can be found in Davies (1988).
6 This is not intended as a comprehensive assessment of the implementation of the programme to date but rather focuses on those aspects most relevant for this paper.
7 We should perhaps note that there has always been an element of cost recovery in the health-care system in Zimbabwe: a substantial, fee-paying private health care system caters for the rich. A comprehensive public system, which collected the same fees from the same people, would surely be more equitable.
8 It is perhaps (im)pertinent to note that even the government statements declaring PHC as a policy were drafted with a large input from foreign consultants. They did not reflect an organic outgrowth from political processes involving the disempowered people of Zimbabwe.

9 For example, the early (and limited) land resettlement programme was one of the first victims of government expenditure restrictions in 1983. Land reform was seen as a political rather than an economic measure.

10 I would suggest as a plausible hypothesis (although I am not sure how one would test it) that this accumulation was initially through rent-seeking - essentially accumulation through redistribution. However, as it proceeded so interest has shifted to accumulation through production; hence the willingness of policy-makers to move from mercantilist to *laissez faire* policies.

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TABLE 1: GENERAL ECONOMIC INDICATORS

		Notes	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
1	**POPULATION**	a	7.36	7.6	7.61	7.73	7.95	8.17	8.41	8.64	8.88	9.12	9.37	9.6	10.4
	GROSS DOMESTIC PRODUCT (Factor Cost)														
2	Current Prices ($ million)	b	3224	4049	4657	5432	5649	6503	7408	8019	10183	11903	14494	19013	na
3	Constant 1980 Prices ($ million)	b	3224	3537	3588	3459	3540	3803	3881	3833	4143	4332	4425	4587	na
4	Per Capita Current Prices ($)	b	438	533	612	703	711	796	881	928	1147	1305	1547	1981	na
5	Per Capita Constant 1980 Prices ($)	b	438	465	471	447	445	465	461	444	467	475	472	478	na
	GROSS FIXED CAPITAL FORMATION														
6	Current Prices ($ million)	b	528	830	1039	1238	1185	1133	1312	1673	2031	2350	na	na	na
7	Constant 1980 Prices ($ Million)	b	528	722	788	765	618	505	518	601	686	750	na	na	na
8	Share of GDP Current Prices	c	16.4	20.5	22.3	22.8	21.0	17.4	17.7	20.9	19.9	19.7	na	na	na
9	Share of GDP Constant Prices	c	16.4	20.4	22.0	22.1	17.5	13.3	13.3	15.7	16.6	17.3	na	na	na
10	**EXCHANGE RATE: Z$1 = US$**	d	0.63	0.72	0.92	1.11	1.50	1.64	1.68	1.66	1.94	2.27	2.45	3.43	5.42
11	**NET BARTER TERMS OF TRADE**	b	100	111	108	104	121	123	120	106					
12	**INCOME TERMS OF TRADE**	e	100	107	107	109	122	129	149	143					
	CENTRAL GOVERNMENT FOREIGN DEBT														
13	Total Foreign Debt ($)	b	415	514	841	987	1438	1829	2223	2184	3099	3554	4618	7854	na
14	Total Foreign Debt (US$)	f	658	717	915	892	957	1114	1325	1313	1595	1566	1886	2291	na
15	As percent of GDP	g	12.9	12.7	18.1	18.2	25.5	28.1	30.0	27.2	30.4	29.9	31.9	41.3	na
16	Share of Foreign Debt in Total Debt	e	22.5	24.5	33.9	34.6	38.4	39.4	40.8	36.1	39.0	37.7	40.8	52.2	na
	AVERAGE EARNINGS														
17	Current prices ($)	e	1863	2307	2789	3067	3358	3771	4160	4631	5205	5776	7040	7617	na
18	Constant Output Prices ($)	h	1863	2016	2149	1954	2104	2205	2179	2228	2118	2102	2149	1839	na
19	Constant Consumer Prices ($)	i	1863	2027	2138	1965	1851	1903	1839	1830	1921	1909	2014	1761	na
	POVERTY DATUM LINE														
20	Family of 5	j	109	121	133	161	191	208	239	267	285	323	379	470	736
21	Family of 7	j	144	159	175	213	254	277	316	355	380	430	506	627	996
	AVERAGE EARNINGS AS PROPORTION OF POVERTY DATUM LINE														
22	Family of 5	k	17.0	19.1	20.9	19.0	17.6	18.1	17.4	17.3	18.3	17.9	18.6	16.2	na
23	Family of 7	k	12.9	14.5	15.9	14.4	13.2	13.6	13.2	13.1	13.7	13.4	13.9	12.1	na
	EMPLOYMENT														
24	Total Formal Employment ('000)	b	1010	1038	1046	1033	1036	1055	1081	1085	1131	1167	1192	1243	na
25	Total as Share of Population	l	13.7	13.7	13.7	13.4	13.0	12.9	12.9	12.6	12.7	12.8	12.7	12.9	na
	INFLATION														
26	GDP Deflator	m	10	14	13	21	2	7	12	9	18	12	19	26	na
27	Lower Income CPI	n	5	13	11	23	20	8	14	12	7	13	17	24	53
28	Lower Income Food Inflation	n	4	12	11	29	24	7	13	15	9	14	18	25	65

SOURCES AND NOTES
a) CSO(1988a); EIU (1993)
b) CSO (1988b); CSO (1992)
c) calculated from Rows 2, 3, 6 and 7
d) Reserve Bank Quarterly Bulletin (various dates)
e) estimated from CSO (1988a); CSO (1991)
f) calculated from Rows 10 and 13
g) calculated from Rows 2 and 13
h) calculated by deflating Row 17 by GDP deflator
i) calculated by deflating Row 17 by Higher Income Consumer Price Index
j) estimated by inflating 1978 PDL (Cubbitt, 1979) by relevant Low Income CPI
k) calculated from Rows 17, 20 and 21
l) calculated from Rows 1 and 24
m) calculated from Rows 2 and 3
n) estimated from CPI for Lower Income Urban Families:
1992 = inflation between October 1991 and October 1992

TABLE 2: HEALTH SECTOR INDICATORS

		Notes	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
1	**HEALTH SECTOR EMPLOYMENT ('000)**	a	15.2	16.3	18.9	19.0	19.9	19.7	21.8	22.0	22.8	23.6	25.0	26.5	na
2	**HEALTH SECTOR DEFLATOR**	b	100.0	107.9	120.5	121.3	124.7	147.4	164.0	185.9	206.5	232.7	306.9	375.8	540
3	**INFLATION IN THE HEALTH SECTOR (%)**	c	na	8	12	1	3	18	11	13	11	13	32	22	44
4	**CEILING FOR FREE HEALTH AS % OF PDL**	d	137	124	112	93	79	72	63	56	53	46	40	32	20
	VALUE ADDED IN HEALTH SECTOR														
5	Current Prices ($ million)	a	71	82	106	108	116	143	164	184	221	256	356	481	na
6	Constant 1980 Prices ($ million)	a	71	76	88	89	93	97	100	99	107	110	116	128	na
7	Per Capita Current Prices ($)	e	10	11	14	14	15	18	20	21	25	28	38	50	na
8	Per Capita Constant 1980 Prices ($)	f	10	10	12	12	12	12	12	11	12	12	12	13	na
	SHARE IN GDP														
9	Current Prices:	g	2.2	2.0	2.3	2.0	2.1	2.2	2.2	2.3	2.2	2.2	2.5	2.5	na
10	Constant Prices:	h	2.2	2.1	2.5	2.6	2.6	2.6	2.6	2.6	2.6	2.5	2.6	2.8	na
	AVERAGE EARNINGS														
11	Current prices ($)	a	3197	3417	4011	4000	4558	5440	5961	6427	7171	8322	10556	10883	na
12	*Constant Output Prices ($)*	i	3197	2985	3091	2549	2856	3181	3123	3092	2918	3029	3223	2627	na
13	Constant Consumer Prices ($)	j	3197	3001	3074	2563	2512	2746	2635	2540	2646	2751	3020	2516	na
14	Sector to Average Earnings in the Economy	k	172	148	144	130	136	144	143	139	138	144	150	143	na
15	**SHARE OF EARNINGS IN VALUE ADDED (%)**	l	68	68	72	70	78	75	79	77	74	77	74	60	na

SOURCES AND NOTES
a) CSO (1988a); (1991)
b) Deflator used for Health Sector in GDP estimates; calculated from Rows 4 & 5: 1992 value estimated using regression of health deflator and CPI.
c) calculated from Row 2
d) estimated by dividing Table 1, Row 20 by 150
e) calculated from Row 4 and Table 1, Row 1
f) calculated from Row 5 and Table 1, Row 1
g) calculated from Row 8 and Table 1, Row 2
h) calculated from Row 9 and Table 1, Row 3
i) estimated by deflating Row 11 by GDP deflator
j) estimated by deflating Row 11 by Higher Income Consumer Price Index
k) calculated from Row 11 and Table 1, Row 17
l) calculated from Rows 1, 5 and 11

TABLE 3: CENTRAL GOVERNMENT BUDGET ALLOCATIONS TO HEALTH

		Notes	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
	ALLOCATION IN CURRENT PRICES ($ million)														
1	Total	a	84	109	132	139	159	196	241	293	328	353	528	549	689
2	Administration	a	3	4	6	5	5	14	12	14	12	16	na	14	20
3	Medical Care	a	75	96	107	114	131	154	196	231	260	284	na	466	557
4	Preventive Services	a	6	8	17	19	22	27	32	47	54	51	na	67	109
5	*Research*	a	1	1	1	1	1	1	1	2	2	2	na	3	3
	ALLOCATION IN CONSTANT 1980 PRICES ($ million)														
6	Total	b	84	101	109	115	128	133	147	157	159	152	172	146	128
7	Administration	b	3	4	5	4	4	10	7	7	6	7	na	4	4
8	Medical Care	b	75	89	89	94	105	104	119	124	126	122	na	124	103
9	Preventive Services	b	6	8	14	16	18	19	19	25	26	22	na	18	20
10	Research	b	1	1	1	1	1	1	1	1	1	1	na	1	1
	Annual Increase in Real Allocation			21	8	5	12	4	10	7	1	-5	13	-15	-13
	COMPOSITION OF HEALTH BUDGET (%)														
11	Total	c	100	100	100	100	100	100	100	100	100	100	100	100	100
12	*Administration*	c	3	4	5	4	3	7	5	5	4	4	0	3	3
13	Medical Care	c	89	88	82	82	82	78	81	79	79	81	0	85	81
14	Preventive Services	c	7	8	13	14	14	14	13	16	16	14	0	12	16
15	Research	c	1	1	1	1	1	1	1	1	1	1	0	1	0
	ALLOCATIONS PER CAPITA														
	Current Prices ($)														
16	Total	d	11.38	14.33	17.30	17.98	20.05	24.02	28.61	33.86	36.94	38.69	56.31	57.23	66.22
17	Medical Care Services	d	10.18	12.61	14.11	14.70	16.47	18.80	23.26	26.69	29.26	31.15	na	48.50	53.53
18	Preventive Services	d	0.76	1.11	2.26	2.47	2.80	3.34	3.79	5.39	6.08	5.57	na	6.93	10.45
	Constant 1980 Prices ($)														
19	*Total*	d	11.38	13.28	14.37	14.82	16.07	16.29	17.44	18.22	17.88	16.63	18.35	15.23	12.26
20	Medical Care Services	d	10.18	11.68	11.72	12.11	13.20	12.75	14.18	14.36	14.16	13.39	0.00	12.91	9.91
21	Preventive Services	d	0.76	1.03	1.88	2.03	2.24	2.27	2.31	2.90	2.94	2.39	0.00	1.84	1.94
22	Increase in real allocation per head		na	16.8	8.1	3.1	8.5	1.4	7.1	4.4	-1.8	-7.0	10.4	-17.0	-19.5

SOURCES AND NOTES
a) GOZ (various dates)
b) Rows 1 to 5 deflated by Table 2, Row 2
c) calculated from Rows 1 to 5
d) calculated from appropriate Rows 1 to 10 and Table 1: Row 1