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Global Healthcare Policy and the Austerity Agenda

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Introduction

Healthcare policy has long been impacted by actors and governance processes outside of the control of national jurisdictions and governments. As part of neoliberal reform processes promoted by various multilateral organizations in the aftermath of the 1982 debt crisis, especially the international financial institutions (IFIs) (the World Bank and the International Monetary Fund, IMF), social policy choices have been increasingly circumscribed by structural adjustment programmes (SAPs). In consequence, the World Bank and the IMF became important agenda-setters in global healthcare policy. While some of the emerging criticisms of SAPs undermined the authority and legitimacy of the IFIs throughout the 1990s and 2000s, with the onset of the global financial crisis in 2008, their relevance has (again) increased significantly, especially when they were made the main vehicles to fight the global financial crisis by the Group of 20 countries (G20). Yet, the role of the IFIs in the setting of global healthcare policy, especially in low-income countries, often remains unacknowledged in debates about healthcare policy and governance.

In this chapter, we first trace the historical origins of SAPs and discuss the influential role of neoliberal macro-economic conditionalities in the setting of healthcare policy. Neoliberal conditionality refers to the funding conditions attached to SAPs to promote various pro-market reforms, including privatization, deregulation, and liberalization. We document the various impacts of SAPs on healthcare policy and identify direct and indirect pathways that link SAPs to healthcare policy (Figure 3.1). These include loss of control to set the domestic policy agenda, privatization of health systems, fiscal austerity, and the replacement of the underlying principle of equity in and social responsibility for healthcare with individual responsibility.

We then document the transition from structural adjustment to poverty reduction strategy paper (PRSP) approach in the early 2000s, an attempt by

E. Kuhlmann et al. (eds.), *The Palgrave International Handbook of Healthcare Policy and Governance*

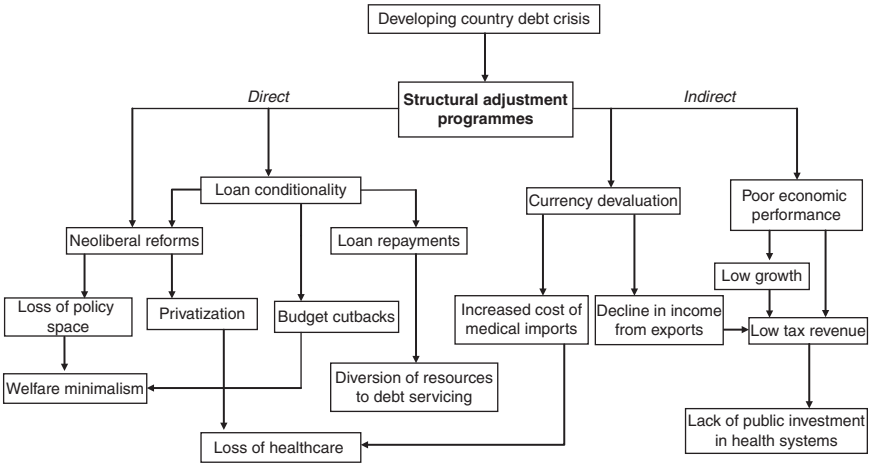

Figure 3.1 Health-relevant structural adjustment policy pathways

the IFIs to respond to some of the criticisms surrounding the SAP paradigm and its multiple failures. We probe the similarities and differences between SAPs and PRSPs, with specific regard to how healthcare policy has been affected by this transition. We finally assess the impact of the global financial crisis of 2008 and attendant austerity drive on healthcare policy, which represents a resurgence of the IMF in international affairs and a return to more traditional forms of structural adjustment, including in many high-income countries. We conclude by suggesting that neoliberal macro-economic policies promoted by the IFIs under the mantle of global austerity remain a powerful force in health today that limit the ability of governments to freely set healthcare policy, with largely negative health consequences.

Historical origins of structural adjustment

In the 1980s, the IMF and the World Bank assumed a leading role in determining the direction of development policy and practice, marked by a firm belief in the ideals of neoliberal economics and the free market's ability to alleviate poverty and efficiently distribute goods and services. SAPs were a response to the debt crisis of developing countries that began in 1982 with Mexico's announcement to default on its international debt obligations. Ostensibly addressing growing structural imbalances in the global economy and restoring debt sustainability in the periphery, SAPs were hastily introduced across the developing world.

> [B]y 1987 the World Bank had approved 52 structural adjustment loans and 70 sectoral adjustment loans. During the period 1980–89, 171 SAPs were introduced in sub-Saharan Africa; a further 57 had been initiated by the end of 1996. (Simon, 2008: 89)

Often summed up as the 'Washington Consensus', structural adjustment combines liberalization, privatization, and deregulation policies (see Box 3.1) which were attached as loan conditionalities to IMF and World Bank lending agreements to ensure their implementation. The emergence of SAPs represented a turnabout in development thinking that began in the 1970s. Until then, statist approaches and understandings of development had been dominant ever since the Keynesian revolution in economics. This had important implications for global healthcare policy and practice, as it was widely accepted that the state must play a central role in healthcare markets, including as service provider, due to pervasive market failure in its private provision (Arrow, 1963).

Box 3.1 Structural adjustment programmes

Main goals of SAPs:

- restructure and diversify the productive base of the economy;
- achieve fiscal stability through a positive balance of payments;
- set the scene for a sustained non-inflationary or minimal inflationary growth; and
- reduce the dominance of unproductive investments in the public sector (Obansa, 2005).

Main policies pursued to achieve these goals:

- budget-deficit reduction strategies;
- privatization of state-controlled industries and enterprises (including healthcare);
- removal of subsidies;
- currency devaluation;
- removal of trade barriers;
- deregulation of labour market;
- trade and financial market liberalization (SAPRIN, 2003).

But during the economic recession of the early 1970s, the neoliberal critique undermined traditional notions of state behaviour. The state was increasingly seen as a self-interested bureaucracy inclined towards predatory behaviour, and

as such the main impediment to development. The IMF went as far as suggesting that the debt crisis itself was the product of disruptive state involvement in the economy and inefficient and irresponsible debtor governments, ignoring the role played by US-led monetary policy to control inflation that led to huge increases in interest rates, rising to over 20 per cent in 1981. This caused debt-servicing costs to skyrocket and debt loads to accelerate (Lugalla, 1995; Simon, 2008). Following the IMF's logic, SAPs required debtor countries under IFI assistance to liberate, deregulate, and privatize their economies and to reduce their involvement in economic activities to free up space for market actors (Shandra et a., 2012; Simon, 2008).

This change in policy direction had lasting effects on how healthcare was understood. Under the neoliberal rationale, healthcare is a private good that ought to be bought rather than a public good that is funded and administered by the public sector. Considerations of social equity, democracy, or sustainability are always trumped by the pursuit of economic growth as endowed by the free market (McGregor, 2001). The responsibility of the state is reduced to ensuring the freedom of markets with only a residual 'welfare minimalism' with respect to the health and well-being of its citizens. The SAP phase of international development (running from the mid-1980s through to the late 1990s), by embracing the ideals of neoliberalism, had broad and largely constraining effects on the healthcare policy cycle, especially in IFI-dependent developing countries.

Direct and indirect impacts of SAPs on healthcare policy and governance

In our discussion of the impacts of SAPs on healthcare policy and governance, we distinguish between direct and indirect effects (Figure 3.1). Direct effects include loss of control over the policy agenda, widespread budget cutbacks, diversion of resources away from healthcare, and privatization of health systems, while indirect effects encompass poor economic performance, inflation targeting, and currency devaluation.

Direct impacts of SAPs

Prior to the onset of SAPs, sovereign governments in developing countries determined health policy within their own jurisdiction without much external interference. In the international arena, the World Health Organization (WHO) was the dominant source of information and advice on national health policy decisions, but by the late 1990s, the World Bank had overtaken the WHO as the largest funder of health sector activities (Lister and Labonté, 2009). With funding came policy influence, and with the implementation of SAPs in developing countries governments were increasingly constrained by

the policy prescriptions of the IFIs, with deep implications for domestic policy space.

Policy space can be defined as freedom, scope, and mechanisms that governments possess to choose, design, and implement public policies to fulfil their desired aims (Koivusalo et al., 2008). Loss of policy space is related to the ways in which the IFIs, directly through loan conditionalities, and indirectly through their influence on private financial markets, set limits around the policy options available to governments. Given globally integrated financial markets (another outcome of neoliberal economics), governments require the confidence of the IFIs to fund their operations through sovereign debt markets. Financial markets generally remain closed to governments lacking IMF support, fiscally coercing them to remain on track with IMF lending agreements and to follow IMF policy advice. Loss of policy space includes a wide range of policy areas, but in our subsequent discussion we focus on pathways directly related to healthcare.

The welfare minimalism of structural adjustment and associated fiscal retrenchment are the most important pathways by which SAPs impacted health policy. It was one of the primary goals of SAPs to eliminate, or at least significantly reduce, budget deficits in order to return a developing country at risk of sovereign default to a balanced budget position over time. In many countries, this meant significant cuts to healthcare spending. For example, a report by the Centre for Global Development on the effect of IMF policies on healthcare observed that 'in countries with weak budgetary processes, the burden of short-term expenditure cuts can fall disproportionally on health spending, causing disruptions in the availability of resources' (Goldsborough, 2007: iv).

Another study by the Structural Adjustment Participatory Review International Network (SAPRIN, 2003) documents the overall downward trend in health spending for a range of countries under the yoke of SAPs, including Zimbabwe, Hungary, Mexico, and the Philippines, with cuts of more than 20 per cent in some instances. In a 1993 report looking at 20 countries under SAPs, the World Bank itself acknowledged that public per capita health expenditure decreased more in adjusting than non-adjusting countries early in the economic reform process (World Bank, 1993). Public deficit reduction strategies have also brought about salary caps and lay-offs for doctors and nurses working in the public sector, often causing them to emigrate in search of better employment opportunities (Reubi, 2013). In a context of existing and severe health worker shortages, this further loss of public health workers (to the private sector serving elites or, through migration, to high-income countries) in many countries under SAPs compounded an already critical lack of facilities and treatments (see also Chapter 17 by Gilles Dussault, and Chapter 21 by James Buchan).

The influence of SAPs on national policies moreover resulted in resources being diverted away from healthcare due to IFI pressure to pay off debts first. At times, even development aid for health has been found to be diverted by

developing countries to the repayment of national debts (Stuckler and Basu, 2009). The SAPRIN study notes that

> [the Ecuadoran government's] budget and its components are permanently constrained by the ever-increasing amounts devoted to payment of the public external and internal debts. The implementation of structural adjustment policies in Ecuador, which was supposedly aimed at improving the balance of payments, has only reinforced this trend. (SAPRIN, 2003: 154).

Instead of decreasing over time, Ecuador's public external debt rose from 49 per cent of GDP in 1982 to 115 per cent of GDP in 1999, tripling in absolute terms to USD 16.4 billion. Debt service in the country reached 52 per cent of government expenditure in 2000, while the budget dedicated to all social spending remained at 20 per cent of total expenditures under the SAP regime (SAPRIN, 2003).

Budgetary cutbacks under SAPs in many respects have been a vehicle for a more comprehensive transformation in most of the countries undergoing adjustment, whereby the social sector has been subjected in significant ways to market pressures (Lister and Labonté, 2009). These changes have entailed a redefinition of the state's redistributive role in health, leading in many cases to a partial privatization of healthcare. Controls on spending were often accompanied by revenue-generating schemes that required users to share in the cost of services. In many IFI loan agreements, SAPs conditionalities called for healthcare subsidies to be cut and for healthcare provision to be partially privatized through the introduction of user fees and private health insurance. For instance, Ghana's Economic Recovery Programme of 1983–1986 required the removal of general subsidies, which led to an intensification of fee collection for services and enforcement of the Hospital Fees Act (SAPRIN, 2003).

Privatization schemes have led to an increasing number of hospitals and healthcare centres being managed by the private sector or through public–private partnerships (Reubi, 2013). In these circumstances, it is poor populations that are usually the ones who are the most likely to be unable to access adequate health services because of the user fees introduced through SAPs (Hossen and Westhues, 2012; Shandra et al., 2012). In Tanzania, the cost of treatment for a case of malaria, a basic service, was found to be as much as half a month's wage in low-cost private hospitals (Lugalla, 1995).

Privatization also led to the fragmentation of health systems, which were becoming increasingly dependent on NGOs as non-profit service providers (Hossen and Westhues, 2012; Shandra et al., 2012). Such fragmentation in Mozambique led to delays in that country's efforts to create a stable primary healthcare system, which in turn have been blamed for increased levels of fatal diseases in infants (Shandra et al., 2012).

Indirect impacts of SAPs

Fiscal austerity is complemented in most IMF agreements by a focus on inflation-targeting and restrictive monetary policy, aimed at price stability above all else. Such a narrow focus on price stability has a number of negative side-effects on healthcare. On the one hand, fiscal austerity, coupled with contractionary monetary policy, weakens the revenue base of governments. Policies that are overly concerned with macro-economic stability may lower economic growth from its optimal (equilibrium) level and thus lead to poor economic performance (Rowden, 2012). Poor economic performance, in turn, will limit tax revenues and reduce the fiscal capacity of governments to invest in public healthcare systems.

The poor economic performance of developing countries under SAPs (primarily in Latin America and Africa) throughout the 'lost decade' of the 1980s affirms this risk. Even the World Bank raised concerns in a 2005 retrospective on economic growth in which it suggested that the IMF's efforts to tame inflation may have come at the expense of unnecessary lower growth and tax revenue generation (World Bank, 2005). On the other hand, monetarist thinking inside the IFIs, especially the focus on inflation targets in the low single digits, has prevented meaningful public investments in health systems and the hiring of health workers, due to a concern that large investments could stoke run-away inflation (Rowden, 2012).

The devaluation of local currencies against the US dollar is another frequently required element of SAPs that indirectly undermines healthcare provision, as most medicines and medical equipment must be imported by developing countries. Devaluation, by decreasing the value of domestic currency, increases the cost of imported goods and services, while simultaneously lowering the price paid by foreigners for goods and services exported outside the country (Peabody, 1996). In the case of the Philippines, devaluation that was part of a structural adjustment loan in 2007 to address the Asian financial crisis resulted in a 25–30 per cent increase in the price of drugs and a 40–60 per cent increase in the cost of small medical equipment (SAPRIN, 2003).

Currency devaluation can also increase the outstanding foreign debts owed by such countries, since these debts are borrowed in US dollars and converted to local currencies that are then devalued. But the debts must be paid back in US dollars that now cost considerably more to purchase, leaving fewer government resources for public healthcare. Given these direct and indirect impacts, it is unsurprising that a 2001 review of 76 articles studying the health effects of SAPs found that only 8 per cent recorded positive while 45 per cent demonstrated negative health results (Breman and Shelton, 2001).

Finally, the IMF (more so than the World Bank) has been criticized for acting with very little relevant analysis or information pertaining to different countries and their differing development problems and for making macro-policy

decisions with very little understanding of the potential costs and effects that could result for health spending. This leaves the IMF with little clarity regarding the policy tradeoffs inherent to SAPs (Goldsborough, 2007). The lack of developing (recipient) country policy ownership of SAPs has been reluctantly acknowledged by the IMF, and country ownership was made a central plank of the PRSP approach that emerged in the late 1990s as an ostensible replacement for SAPs.

From structural adjustment to PRSPs

The introduction of the PRSP approach was a response by the IFIs to the growing criticism surrounding structural adjustment in the 1990s. The accumulation of negative evidence of SAPs on the health and the welfare of the world's poorest populations eventually led to a rethinking of development policy and practice, culminating in the articulation of the Post-Washington Consensus (Stiglitz, 1999). The Post-Washington Consensus more openly acknowledged market failure and the need for governments to address markets' adverse distributional side-effects. This implies a stronger role for the state in the provision and regulation of healthcare, also because health has increasingly been identified as an important ingredient for improving productivity and stimulating economic growth.

As part of this rethinking process, the international community announced at the G7 summit in Cologne in 1999 that SAPs would be replaced by the PRSP approach (see Box 3.2), led by the IMF and the World Bank and with a new focus on poverty reduction (Bradshaw and Linneker, 2003). In theory, PRSPs place greater emphasis on social aspects of the development process, especially health and education (Mouelhi and Ruckert, 2007), and PRSP guidelines call for

Box 3.2 Poverty reduction strategy papers

An effective PRSP is expected to

- focus on faster and broad-based economic growth, which requires macro-economic stability;
- reflect a comprehensive understanding of poverty and its various determinants;
- assist in choosing public actions with the highest poverty impact, which are fully costed and prioritized;
- establish outcome indicators that are set and monitored in a transparent way.

Source: Adapted from World Bank, 2001: 1.

the papers to be country-driven, comprehensive, results-oriented, partnership-oriented, and based on a long-term perspective (Dijkstra, 2011). The PRSP process was also linked up with debt-relief initiatives; countries wishing to qualify for debt relief, debt assistance, or concessionary loans under the Heavily Indebted Poor Country (HIPC) programme of the IFIs are required to complete a PRSP. In consequence, PRSPs have become somewhat of an 'industry-standard' and are now required by most bi- and multilateral donors before they consider providing any foreign aid.

Despite being notionally committed to poverty reduction, most reviews of the PRSP process suggest that it has ultimately not strayed far enough away from the neoliberal macro-economic framework of its predecessor to make a real difference (Cammack, 2004; Dijkstra, 2011). Although poverty reduction–related public spending in Heavily Indebted Poor Countries rose during the implementation of PRSPs from 6.4 per cent to 8.1 per cent of GDP (between 2001 and 2008), most of this was channelled into education (Taylor, 2007). Moreover, assessment of the impact of PRSPs suggests that the effect of reorienting public spending towards the needs of the poor has been the exception rather than the rule. Instead, health sector plans and budgets implemented through national PRSPs 'often perpetuate historical patterns of spending' and 'do not fully deliver on their potential to influence change' (World Bank and World Health Organization, 2003: 7, 10). In a comprehensive review of the impacts of PRSPs on health and health policy, the WHO arrived at a similar conclusion, noting that 'it is clear from budgets presented in PRSPs – and from independent analysis performed by others – that PRSPs will not result in large increases in resources available for health' (WHO, 2004: 18).

The World Bank's guidelines state that PRSPs should include health data on the poor and a clear analysis showing the determinants of ill-health and detailing pro-poor health strategies. A recent study of the health content of three PRSPs, however, found that none of these comply with the World Bank's guidelines, and they neither adequately portray the health situation within the country nor recommend the necessary policy actions to improve the health situation of the most vulnerable members of society (Bartlett, 2011). Despite increasing recognition that poverty reduction strategies must have a social basis and should not undermine social goals, there is a tendency for adding on a social policy approach as an afterthought to traditional neoliberal macro-economic conditionalities, instead of moving towards a transformational approach that would mainstream social policy into macro-economic policies and thus produce better coherence between macro-economic and social policy objectives (Mohindra, 2007).

Finally, the PRSP process seems to have sidestepped the issue of invasive conditionality which was found to be ineffective during the implementation of SAPs. Each PRSP still requires strict macro-economic policy reforms from debtor countries which largely reflect the conditions of SAP loans (Cammack, 2004).

The link between approval of a PRSP and debt relief has provided a powerful incentive for developing countries to implement often controversial policies of liberalization, deregulation and privatization that had previously been rejected. The conditionality of PRSPs, as well as the lack of input from affected communities, parallels the gap between policy-makers and those affected by the policies which was identified as a major problem of SAPs. In an early review of the health dimension of interim PRSP proposals for 23 Heavily Indebted Poor Countries, researchers found that the majority of countries neglected to consider the interests of the poor in their proposed health policies and that even fewer countries had considered efforts at enhancing equity in their healthcare design (Laterveer et al., 2003).

The global financial crisis and the politics of austerity

The onset of the global financial crisis in 2008 led to a return of SAPs in its more traditional form, with widespread consequences for health policy globally. It was apparent from the onset of the crisis that its resolution would require a global solution through an internationally coordinated policy and fiscal stimulus response. At the G20 (2009) summit in London in April 2009, world leaders committed to providing an additional USD 1.1 trillion in emergency financing – with USD 750 billion to be channelled through the IMF as it was made the principal firefighter after the crisis erupted (Ruckert and Labonté, 2012).

The IMF would provide emergency funding to a wide range of countries, in both the developed and developing world. In return for this influx of new capital, the IMF promised to deliver more money with less conditionality and more flexibility than ever before (IMF, 2009a). To achieve this, the IMF pledged to double the size of both its Poverty Reduction and Growth Facility, responsible for overseeing PRSPs, and its Exogenous Shocks Facility, aimed at relieving financial pressure in times of a severe exogenous shock. It also agreed to expand technical assistance funded by donors through multi-donor trust funds (IMF, 2009a). The IMF also introduced a host of new lending tools, including the Flexible Credit Line, which provides quick (non-conditional) disbursements.

Far from abandoning conditionality, however, the Flexible Credit Line is restricted to countries whose track record already met strict qualification criteria through prior actions embodying neoliberal macro-economics, and which has been described as 'advance conditionality' (Ruckert and Labonté, 2012: 360). Importantly, the IMF initially acknowledged the need for fiscal stimulus in the context of a global demand crisis, noting that 'macro-economic policies should, to the greatest extent possible, sustain short-term activity and protect the poor by accommodating the increased financing needs', while at the same

time 'preserve hard-won macro-economic stability' (IMF, 2009b: 9). However, a short period of stimulus spending from 2008 to 2010 quickly gave way to an austerity drive that started in 2010, with many developing countries cutting government spending below levels seen before the crisis (see Box 3.3).

Box 3.3 Examination of IMF expenditure forecasts for 181 countries

Crisis phase I, Fiscal expansion (2008–2009):
Nearly all countries engaged in fiscal stimulus and expanded public spending as a countercyclical measure to cushion the impacts of the global financial crisis. Overall, 80 per cent of countries (or 144 in total) increased expenditures, with the average expansion reaching 3.9 per cent of GDP.

Crisis phase II, Onset of fiscal contraction (2010–2012):
Despite the fragile state of economic recovery and the World Bank reporting rising levels of poverty, in 2010 governments started to withdraw fiscal stimulus programmes and scale back public spending. When comparing expenditure levels in the second phase of the crisis (2010–2012) to the expansionary phase (2008–2009), 40 per cent of countries (or 73 in total) reduced total spending by 2.3 per cent of GDP, on average, with fiscal contraction strikingly larger among developing countries: 56 developing countries cut their budgets by an average of 2.7 per cent of GDP compared to 17 high-income countries at 1.0 per cent of GDP.

Crisis phase III, Intensification of fiscal contraction (2013–2015):
The scope and depth of austerity is gaining significant momentum in this latest phase of the crisis, with more than half of governments worldwide (or 94 in total) projected by the IMF to cut their budgets by 3.3 per cent of GDP, on average. Again, fiscal consolidation is strongest in the developing world: 68 developing countries are expected to reduce their spending by 3.7 per cent of GDP, on average, compared to 2.2 per cent of GDP in 26 high-income countries, with an alarming number of countries undergoing excessive fiscal contraction, defined as cutting expenditures below pre-crisis levels. Overall, 44 governments (33 developing and 11 high-income, or a quarter of all countries in the sample) are projected to have fiscal envelopes in 2013–2015 that are smaller than those during 2005–2007 in GDP terms.

Source: Adapted from Ortiz and Cummings, 2013: 4–7.

The IMF's actions also frequently contradict its acknowledgement of the importance to protect the social spending envelope of countries under adjustment in the aftermath of the global financial crisis. This is concerning as strong social protection mechanisms can mitigate the health risks associated with economic recessions (Reeves et al., 2013). Many post-crisis lending arrangements have provisions on cutting back consumer subsidies and raising domestic prices of food and fuel (Ortiz et al., 2011).

Another important issue, especially as it directly relates to healthcare policy, is the practice of setting ceilings on public sector wages. While the IMF has long suggested that such ceilings have been largely discarded (IMF, 2006), it nevertheless made use of them in a number of post-crisis lending arrangements and introduced wage and hiring freezes for public sector workers in a range of countries, for example in Benin, Malawi, and Zambia (Eurodad and TWN, 2010). Wage caps can lead to salary reductions, hiring freezes, and employment retrenchment in the health sector, with adverse impacts on the delivery of health services (Ortiz et al., 2011). What is more, a recent study probing whether receipt of IMF loans had an effect on healthcare budgets in 27 European countries found that IMF-recipient countries were 3.9 times more likely to make healthcare cuts than non-IMF recipient countries (Reeves et al., 2013). It also notes that among countries that cut total government spending, those receiving IMF loans were 28 per cent more likely to cut healthcare budgets than non-IMF recipients that also pursued post-crisis austerity.

In addition, there are also a number of prominent examples of excessive and counter-productive SAPs-like responses, especially in the European periphery, with deeply constraining effects on health policy. The case of Greece stands out, with a roughly 20 per cent contraction in economic output since it started implementing SAPs in 2010. This has put extreme pressure on Greece's health budget which has been cut by around 50 per cent since 2007 (Stuckler and McKee, 2012). This, in turn, led to the closure of neighbourhood clinics, with 26,000 public health workers, including 9,100 physicians, losing their jobs. Hospital budgets have also declined steeply by around 40 per cent, leading to shortages in medicines and supplies (Stuckler and McKee, 2012).

Yet, Greece is only the tip of the iceberg, as severe, IMF-prescribed austerity has been found to be common in many other countries of the European core and periphery. A WHO-commissioned study documents that several countries reported steep health budget cuts, including Bulgaria, Romania, the Czech Republic, Estonia, Ireland, Latvia, Spain, and Portugal, in some cases by over 20 per cent (Mladovsky et al., 2012). Several countries also instituted user charges for certain health services to address revenue shortfalls in response to the financial crisis, including the Czech Republic, Denmark, Estonia, Finland, France, Greece, Ireland, Latvia, the Netherlands, Portugal, Romania, and Turkey (Mladovsky et al., 2012).

Even in countries not under the yoke of the IMF, austerity is leaving a mark on healthcare. For instance, Italy levied some novel user fees in response to the financial crisis, pushed through parliament by decree by the technocratic caretaker government of Mario Monto. Patients are now required to pay an extra Euro 10 for medical consultations and a Euro 25 fee for non-emergency care at hospitals (Houston et al., 2011). These new healthcare fees are charged irrespective of the income of the patient, and hence will undermine the equitable provision of healthcare.

Some of the indirect pathways that link SAPs to health policy have also changed little in the post-crisis environment of global austerity. For example, with regard to inflation, the IMF has resolutely held on to its misconceived notion that inflation targets in the low single digits are desirable, despite the fact that what has been driving up inflation rates in low-income countries have been external supply shocks and speculation in commodities future markets (Ruckert and Labonté, 2012). The tightening of monetary policy has been prescribed to almost all countries, with some minor exceptions where the IMF has allowed tentative easing, as in the case of Mozambique and Tanzania (Eurodad and TWN, 2010). Yet, quantitative easing and lose monetary policy have been a standard crisis response and practice in the developed world. The main reason why monetary tightening is so dangerous in the current context relates to the fact that the IMF attempts to control the money supply largely through raising the policy interest rate, which could easily choke off any economic recovery underway, and put further pressure on governments to reduce health expenditure.

Conclusion

The global financial crisis of 2008 has returned structural adjustment to the centre of public policy discourse, not only in the periphery but also in the heartland of capitalism. The global health policy community should greet the return of the IMF and the World Bank as the principal crisis fighters through structural adjustment with suspicion. The constraining effects of IMF and World Bank lending on health policy choices have long been documented, with loss of policy space, commodification of health systems, and austere budget environments discussed as the most pertinent pathways in this chapter, notwithstanding their recent (2013) cautions on the limitations of too severe a retrenchment in public spending.

The global financial crisis has made it more important than ever to question the narrow (economistic) rationale of neoliberal adjustment policies and to assess such policies from a broader perspective of social stability. Macro-economic policies mark the keystone of the global context in which health policy is made and represent a powerful health-determining factor

that transcends national boundaries and control (Labonté and Torgerson, 2005). It is clear that the health policy community needs to engage more directly with the IFIs to push the boundaries of what is considered 'sound' macro-economic policies and to engender a break with the neoliberal policy framework. A key question in this regard is how the IFIs can better incorporate concerns about health within their macro-economic framework, avoiding the adverse public health effects that have been the result of policies retaining a problematically narrow focus on economic stability and debt reduction.

This is not to argue for ongoing increases in public healthcare spending, especially in those high-income countries where such spending is consuming a substantial portion of overall public revenues. Efficiency gains through increased effectiveness and equity remain important policy, regulatory, and administrative challenges in already well-funded health systems, and important a priori considerations in low- and middle-income countries seeking to improve the universality of their healthcare coverage. Nor is it to place full responsibility for fiscal contraction on the IFIs, since many countries are embracing austerity for ideological rather than fiscal reasons – for instance, a commitment by their political leaders to neoliberalism's belief in free and open markets, a strong and unregulated private sector, and a small government providing just enough social protection to prevent widespread social protest. But the ongoing incorporation of these neoliberal economic ideas within the prescriptions of the IFIs serves only to reinforce politically the credibility of these policies, which evidence suggests are good neither for public health nor even for the conventional economy.

Summary

- Structural adjustment programmes have impacted the ability of governments to deliver healthcare services and determine health policies through loss of policy space. SAPs are often associated with cutbacks to health budgets and diversion of resources away from healthcare provision.
- Despite acknowledgement of the problematic nature of SAPs, little policy changes have materialized since the introduction of the PRSP approach, which was supposed to replace SAPs in 1999.
- In the global response to the financial crisis, the IFIs and SAPs are playing a leading role in enforcing austerity measures, especially in low-income countries, with deep implications for healthcare policy.
- Health concerns should be central to macro-economic policy decisions and governments should assess likely health implications of SAPs, for example through health impact assessments.

Key reading

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