Unit 3 Debt and health

OBJECTIVES

1) To give students an overview of how international debt affects people's health in poor nations.

2) To provoke discussion of how international development is financed.

Method

This short unit can be used flexibly as a background paper for discussion in a seminar or for a special study module. Debt raises a number of ethical issues which are always interesting to debate, for example related to governance and corruption, or the right of Northern governments to demand money from countries which have been colonised in the past. The questions at the end can be used to set up such a debate. The rationing game for health services could also be played as part of a seminar on debt and its effects on health and health services.

ORIGINS OF THE DEBT CRISIS

The immediate cause of the debt crisis can be found in the sudden rise of the price of oil in 1973. The price rise was engineered by OPEC (the Organisation of Petroleum Exporting Countries), and as a result, its member nations soon found themselves awash with large amounts of "petrodollars", which they then proceeded to deposit in commercial banks in the developed world.

Interest rates were low and those developing countries that had not adjusted well to the sudden rise in the price of oil were glad to borrow money from financial institutions in the rich world. For their part, the banks lent the money willingly, as they also had to make a profit, and demonstrated little concern for how the money was going to be used. Loans were sometimes made to undemocratic and corrupt states, such as the Marcos regime in the Philippines or to President Mobutu's cleptocracy in Zaire, and the money spent on arms or on "prestige" development projects which rarely benefited the poor.

Despite the huge amounts of money flowing to developing countries, the international financial community did not immediately foresee a serious debt problem developing. However, a second rise in the price of oil in 1979, coupled with interest rate rises and deep recessions in the developed world, had an enormous impact on poorer countries. Interest payments on their debts increased

Health professionals and medical students protest about Third World debt, June 1999. Andrew Wiard

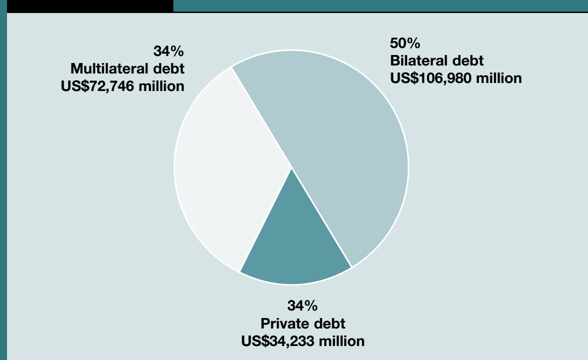
steeply, while developed country demand for their exports declined. As a result, many countries teetered on the verge of bankruptcy.

In 1982 the Mexican government threatened to default on it debt repayments, throwing the world financial system into crisis. Commercial banks made a substantial reduction in their lending to developing countries, who then turned in desperation to the World Bank and IMF for new sources of money with which they could repay their debts. However, these new loans only added to the debt burden and, pushed on by high interest rates, their debt grew and grew. Between 1983 and 1990, developing countries repaid $1,000 billion to their creditors, while during the same period, their debt burden rose from $800 billion to $1,500 billion. The total debt now stands at around $2,000 billion.

Many observers realised during the 1980s that the poorest developing nations were caught in a classic debt trap. They were unable to grow enough to ever think of fully paying back the huge amounts they owed, and had to postpone payment or borrow more and more in order to meet their debt servicing obligations. Some degree of debt cancellation was therefore essential for the poorest countries, but it was only in 1996 that the creditors decided to push forward with a comprehensive cancellation scheme which for the first time involved all categories of lenders. This scheme is known as the Heavily Indebted Poor Countries (HIPC) Initiative.

WHO OWES HOW MUCH TO WHOM?

FIGURE 3.1 HIPC external debt stock



There are three major types of debt: multilateral, bilateral and private. **Private debt** covers loans made by private companies and commercial banks; **bilateral debt** is owed by one government to another; and **multilateral debt** is owed to international financial bodies such as the **World Bank** and the **International Monetary Fund** (**IMF**).

The **World Bank** was founded in 1944. It aims to stimulate long-term economic growth which will help to improve standards of living and reduce poverty. It provides loans at both market and concessionary interest rates.

The **International Monetary Fund** (IMF) was established at the same time as the World Bank. It can provide financial assistance to any of its 182 members who have balance-of-payments problems. The IMF plays an important role in monitoring its members' economies and macroeconomic policies. IMF loans are usually short term, interest is paid at near-market rates, and assistance is nearly always dependent on the member state adhering to strict economic conditions.

Both of these institutions are controlled by a Board which contains representation from both developing and developed nations. However, voting power at the World Bank and IMF is proportional to financial contribution, and therefore favours the rich nations. In the IMF, the ten most industrialised countries have 53% of the vote.

TABLE 3.1 **The World Bank considers 40 countries in need of major debt relief** (known as Highly Indebted Poor Countries or HIPCs)

Angola	Cote d'Ivoire	Liberia	Senegal
Benin	Equatorial Guinea	Madagascar	Sierra Leone
Bolivia	Ethiopia	Mali	Somalia
Burkina Faso	Ghana	Mauritania	Sudan
Burundi	Guinea	Mozambique	Tanzania
Cameroon	Guinea Bissau	Myanmar	Togo
Central African Republic	Guyana	Nicaragua	Uganda
Chad	Honduras	Niger	Vietnam
DR Congo	Kenya	Rwanda	Yemen
Congo	Laos	Sao Tome e Principe	Zambia

The Jubilee 2000 Coalition, the international campaign for debt cancellation, argues that there are an additional 12 countries who desperately need debt relief:

Bangladesh	Haiti	Morocco	Peru
Cambodia	Jamaica	Nepal	Philippines
Gambia	Malawi	Nigeria	Zimbabwe

THE EFFECTS OF DEBT ON HEALTH

The heavily indebted poor countries bear the brunt of the appalling statistics of global poverty. Average life expectancy in these 40 countries is 12 years lower than in other developing countries, and 27 years lower than in industrialised countries. In HIPCs the literacy rate is 55%, in other developing countries it is 71% and in industrialised countries, 98%. Every year 3.4 million children in HIPCs under the age of 5 die from easily preventable diseases.

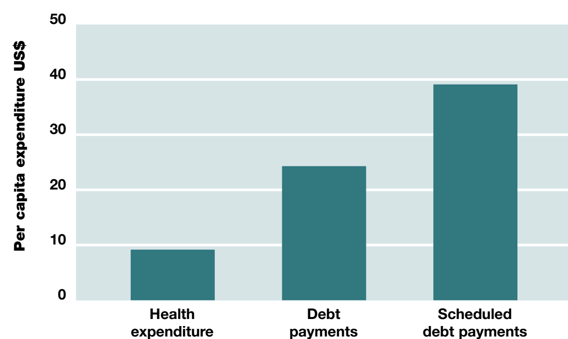
Debt affects health in these countries both directly and indirectly, through its effects on the prospects for economic growth and poverty reduction, and through its impact on government social expenditure.

Effects on health services

> ***"First we cut the food for patients,* then we have emergency-only operations. We have not paid the phone *bill. We have no ambulances."***
>
> ***(Hospital Director, Zambia)***

Many HIPC governments spend over 20% of their budgets on debt repayment. A UNICEF-UNDP study has shown that six HIPCs in sub-Saharan Africa spend more than one-third of the national budget on debt servicing, and only 4-11% on basic social services, including health and education. As figure 3.1 makes clear, the 40 HIPC countries spend nearly three times more on debt repayments than they spend on health services – and that is only the debt repayments which they are able to

FIGURE 3.1 **HIPC expenditures** (average across 40 nations)



Sources: World Bank, *Global Development Finance 1999*; UNDP, *Human Development Report 1999*

make. If they could afford to pay what is actually due (their scheduled debt service), they would be paying more than four times what they spend on health. **On average, per capita expenditure on health in HIPC countries is just $9 per capita.** This is less than one-hundredth of what we spend per person in the UK, which is around $1,200.

This extraordinary squeeze on public expenditure levels, and the financial instability and insecurity it brings with it, severely disrupts health sector planning and management. In situations where countries are spending less than $10 or even $5 per capita on health – considerably less than the amount the World Bank argues countries need to finance the most basic package of health services – attempts to build functional health systems become increasingly futile. Short-term thinking dominates, and there are few incentives and opportunities for ministries to move away from traditional patterns of resource allocation and decision-making.

Salaries can be hit particularly hard by government shortages, and the health sector is further undermined as doctors and other health professionals take on extra jobs outside the public sector or leave the country. Patients suffer twice over as the quality of publicly-provided health care diminishes and they are forced to pay user fees for the little they do receive. This may then lead to further impoverishment and further episodes of ill-health for poor households. As major consumers of foreign exchange for day to day needs such as drugs and vehicle replacement parts, health sectors are hit particularly hard by debt repayments which are a priority for governments and which have to be made in hard currency.

Effects on education

Education is an important determinant of health in poorer countries. Research has shown that the mother's education level is the single most important determinant of infant mortality, but in HIPCs, spending on education services has also been devastated by debt. In sub-Saharan Africa, where the vast majority of Highly Indebted Poor Countries are located, the number of children out of school is actually rising – the only region in the world where this is happening. This should not be surprising: according to UNESCO average per capita spending on education (expressed in constant terms) has fallen by over a third in sub-Saharan Africa since 1980.

Effects on economic growth and poverty reduction

The other major impact that high levels of indebtedness make on health is through their depressing effect on economic growth. Without economic growth, and the sharing of the rewards of growth across populations, there are fewer prospects for eradicating poverty and the diseases of poverty. Many leading economists argue that giving people access to health and education services is an important pre-requisite of economic growth, as well as a human right in itself. The absence of effective health care and education services has a negative impact on productivity and the ability of people to enjoy a decent standard of living.

Unsustainable debt burdens also undermine growth by constraining public and private investment in all spheres of economic life. Levels of public investment are restricted by the budgetary constraints on governments. For private investors, the lack of public investment in physical infrastructure (such as roads and telecommunications facilities) is a disincentive to investment. So too is the economic instability caused by high levels of debt, including inflation, currency volatility and higher taxes. It is notable that whilst the debts of HIPCs have risen by 7.4%

annually since 1980, their economies have only grown by 1.1% per year. In sub-Saharan Africa, poverty levels are rising, and around 50% of the population live on less than $0.65 per day.

Rich nations have committed themselves to reducing the incidence of world poverty by half by the year 2015. It has been calculated that to achieve this aim in sub-Saharan Africa, the present economic growth would need to speed up considerably. Many observers believe that debt reduction could help to achieve this acceleration.

Debt, health and structural adjustment

For the past twenty years, poor countries have been forced to comply with strict economic conditions (known as Structural Adjustment Programmes or SAPs) in order to secure new loans. These programmes are developed by the World Bank, the International Monetary Fund and the rest of the donor community, with the aim of helping countries deal with balance of payments problems, to reduce inflation and to prevent future economic crises by promoting longer-term structural reforms.

SAPs usually include measures to cut government expenditures, raise interest rates, liberalise trade and investment and privatise areas of the economy previously controlled by the state. All these measures can potentially damage health, especially where they lead to unemployment (through cuts in public sector jobs), the introduction of user charges (through cuts in health expenditure) and changes in nutritional status (because of rapid devaluation or withdrawing food subsidies). Although in recent years the World Bank and IMF have been careful to stress that their programmes are poverty-focused, there is no evidence that SAPs improve the situation of the poor. In reality, in sub-Saharan Africa these policies have tended to make the poverty worse. Many of the programmes also break down, usually because of the way creditors impose their demands on developing countries.

As part of the new debt reduction deal announced at the G7 Summit in 1999, creditors have called on countries to write poverty reduction strategies papers (PRSPs) before they receive debt relief. This process offers creditors the opportunity to enter into a partnership with developing countries, by letting them choose the policies which they feel will reduce poverty. However, in reality the PRSPs seem to be delaying debt relief, and the World Bank and IMF are still advising countries to stick to structural adjustment policies, despite their short-comings.

For more on adjustment and its implications for health, see unit 4.

society and health

QUESTIONS

1 Outline the main ways in which an unsustainable debt burden affects the health of individuals.

2 Divide into two or more groups and debate the following questions:

(a) Who is to blame for the debt crisis?

(b) How should money released by debt cancellation be spent? Who should say where it goes?

(c) Which is better for poor countries – to receive aid in loans or in grant form? What are the pros and cons on each side?

(d) What role should institutions such as the World Bank and IMF be playing in financing health systems, and in development in general? What should WHO's role be?

Write down you answers and compare them.

3 Play the rationing game (see end of unit 7). How would you cope with the financial shortages in the health sector produced by debt?

4 Is debt the only reason for financial shortages in the health sector? What other factors may be responsible?

References

George, S. *A Fate Worse than Debt*. Harmondsworth: Penguin, 1994

Payer, C. *Lent and Lost: foreign credit and third world development*. London: Zed Books, 1991

UNICEF. *Progress of Nations 1999*. London: UNICEF, 1999

It is also useful to look at websites such as:

Oxfam www.oxfam.org.uk

Jubilee 2000 www.jubilee2000uk.org

World Bank www.worldbank.org

International Monetary Fund www.imf.org