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Health inequities in the age of austerity: The need for social protection policies

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ABSTRACT

This commentary assesses the impacts of the global austerity drive on health inequities in the aftermath of the global financial crisis of 2008. In doing so, it first locates the origins of austerity within the 40 year history of neoliberal economic orthodoxy. It then describes the global diffusion of austerity since 2008, and its key policy tenets. It next describes the already visible impacts of austerity-driven welfare reform on trends in health equity, and documents how austerity has exacerbated health inequities in countries with weak social protection policies. We finally identify the components of an alternative policy response to the financial crisis than that of austerity, with specific reference to the need for shifts in national and global taxation policies and public social protection policies and spending. We conclude with a call for a reorientation of public policy towards making human health an overarching global policy goal, and how this aligns with the multilaterally agreed upon Sustainable Development Goals.

1. Introduction

The 2008 Global Financial Crisis (GFC) triggered the deepest global recession since the Great Depression in the 1930s. The repercussions of the crisis were, and continue to be, felt worldwide. Shortly after its onset, many commentators predicted that, as with prior regional financial crises, the GFC would result in negative and disequalizing social and economic impacts, compromising major social determinants of health (SDH) and producing harmful health impacts, particularly on mental health (Banoob, 2009; Labonté, 2009; Marmot and Bell, 2009). In the same year as the crisis struck, the WHO Commission on Social Determinants of Health released its final report, calling for action on social determinants of health to address health inequities (WHO Commission on Social Determinants of Health, 2008). The report argued that a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics were responsible for a major part of health inequities, defined as systematic differences in health between and within countries which are avoidable by reasonable action, including a reduction in inequalities in the distribution of socio-economic factors (or structural determinants of health) through targeted social policy interventions, such as progressive taxation policy and government subsidies for health-promoting goods and services.

In this commentary, we discuss the health impacts of the global austerity drive that governments adopted (or were compelled to adopt) shortly after the GFC. The commentary first locates the origins of austerity within the almost 40 years of a dominant neoliberal economic orthodoxy. It then describes the global diffusion of austerity in the aftermath of the GFC and its key policy tenets. We next summarize the known and potential future effects of austerity budgets, welfare reforms and other policy measures on health equity, by drawing on previous and current data and research in this area with a focus on how austerity measures might inequitably impact social determinants of health pathways. We describe the already visible impacts of austerity-driven welfare reform on trends in health equity, and document how austerity has exacerbated health inequities in countries with weak social protection policies. We then identify the components of an alternative policy response to the financial crisis with specific reference to the need for shifts in national and global taxation policies and public social protection policies and spending. Despite the increasing evidence that neoliberalism and its post-crisis austerity agenda is failing even on its own theoretical terms (i.e. to reduce government debt and stimulate economic growth), such evidence has yet to shift noticeably the austerity policy reform efforts led by the

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European Central Bank, the European Union, and the international financial institutions (IFIs) (Lawson, 2016). We conclude with a call for a radical reorientation of public policy towards making human health an overarching global policy goal, and how this aligns with the multilaterally agreed upon Sustainable Development Goals.

2. A short history of neoliberal austerity

It would be a gross misconception to attribute the beginnings of the politics of austerity to the GFC and its recent effects. Rather, the origins of the current austerity drive can be traced back to the early 1970s, a period of economic stagnation and profit decline amidst a third world debt crisis and run-away inflation (Labonté and Stuckler, 2016). This led to the development of a policy consensus in the corridors of power (often referred to as the Washington Consensus) broadly aligned with neoliberal economics and its focus on privatization, deregulation, tax reform (i.e. lower corporate and income tax rates to attract foreign investment), trade and financial liberalization, and deficit reduction (usually understood as reducing budget deficits in economic downturns by decreasing public expenditure, particularly through welfare spending cuts) (Williamson, 2004). The driving forces behind this new consensus were Conservative governments which ascended to power in the early 1980s, including Ronald Reagan in the United States and Margaret Thatcher in the UK. The main pillars of this emerging neoliberal economic paradigm were reduction of growth in government spending, reduction of the federal income and capital gains taxes, trade and investment liberalization and tightening of monetary supply.

Structural adjustment policies (SAPs) were the tools used by the International Monetary Fund (IMF) and World Bank to bring developing countries into alignment with the neoliberal paradigm, while multilateral trade agreements, eventually culminating in the 1995 World Trade Organization, further morphed the welfare state into the competitive state (McBride et al., 2016). Beginning in the early 1980s SAPs were widely introduced across the developing world, and by 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 alone (Ruckert et al., 2015). These transformations had, and continue to have, significant implications for health equity both nationally and globally (Ruckert and Labonte, 2012). While neoliberal policy implementation differed in varying country contexts, it generally included the progressive dismantling of the welfare state, in terms of its fiscal capacity and its related ability to engage in social spending (Benatar et al., 2011). It was one of the primary goals of SAPs to eliminate, or at least significantly reduce, budget deficits in order for countries to meet their international debt obligations, and to return those countries at risk of sovereign default to a balanced budget position over time. In many countries, this meant significant cuts to healthcare and other health-relevant social services spending. Such spending cuts were often accompanied by revenue-generating schemes that required users to share in the cost of services, further undermining equitable access to health care and impoverishing households (McIntyre et al., 2006). As one example, 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 (Bhattacharya et al., 2002).

3. The global financial crisis and the deepening of austerity

The GFC, rather than generating an abdication of neoliberal economics, quickly led to an intensification of its austerity regime. In the direct aftermath of the crisis, most governments and international organizations, including the IMF and the World Bank, acknowledged the importance of counter-cyclical fiscal spending in response to the collapse of effective demand and trade, depressing global economic growth (Ruckert and Labonté, 2012). For a brief period between 2008 and 2009, most governments around the world introduced fiscal stimulus programs and ramped up public spending. According to an expenditure review by UNICEF, when comparing pre-crisis spending levels to this first phase, 80% of countries (144 in total) had increased public expenditures, with the average expansion amounting to 3.9% of GDP (Ortiz and Cummins, 2013). But by 2010, as the private debt crisis turned into a sovereign debt crisis, austerity was back on the agenda, heralding the beginning of the second phase of the crisis response (2010–2013). It was again the IFIs that took the lead in implementing austerity in the developing world through linking access to emergency finance to a new set of structural adjustment programs very reminiscent of the discredited programs of the 1980s and 1990s (Ruckert and Labonté, 2012).

In this phase, despite the fragile state of economic recovery with relative poverty, averaging globally around $2.90/day in consumption according to World Bank metrics, on the rise, governments started to withdraw fiscal stimulus programs and scale back public spending. When comparing expenditure levels in the second phase of the crisis (2010–12) to the expansionary phase (2008–09), 40 percent of countries (or 73 in total) reduced total spending by 2.3 percent of GDP, on average, with fiscal contraction strikingly larger among developing countries: 56 developing countries cut their budgets by an average of 2.7 percent of GDP compared to 17 high-income countries at 1.0 percent of GDP (Ortiz and Cummins, 2013). In the third phase (2012–2015), austerity has somewhat slowed despite various predictions initially that the number of countries affected by spending cuts would jump even further, and that the average contraction size would increase by 2015 (Ortiz and Cummins, 2013). The worldwide drive toward austerity temporarily waned beginning in 2012. During the four year period between 2012 and 2015, a number of countries eased policies to cut expenditures, with 86 countries worldwide continuing to cut their budgets during this phase, but at an overall slower pace. However, recent IMF expenditure projections for 2016–2020 indicate that austerity will likely ramp up significantly beginning in 2017, suggesting that austerity will affect more than 6.1 billion persons or nearly 80 per cent of the global population by 2020 (Ortiz et al., 2015). Ortiz et al. note that compared to a baseline scenario without spending contraction, global GDP will be 5.5 per cent lower by 2020 than without austerity (Ortiz et al., 2015).

The central tenets of austerity encompass policy changes with direct and indirect health equity implications. Directly health relevant aspects include the rationalization and further targeting of social safety nets and social protection spending; health care system reforms to constrain rapidly expanding health budgets; the elimination or reduction of subsidies, for example for food and agricultural inputs; and reforming of age-old pensions through raising of contribution rates and lowering of paid-out benefits (Ruckert and Labonte, 2012). Of indirect health relevance are labour market reforms to further increase labour market flexibility, on the presumption that this would lead to increased employment but with little regards for the negative health consequences (Benach et al., 2014). Such policy responses, even while being promoted by the IMF, contradict the Fund's own recent recognition of the importance to protect social spending in countries under structural adjustment. Some of its recent working papers have argued for stronger collective labour bargaining power and increased public sector spending to stimulate the demand-side of persisting sluggish economic growth (Jaumotte and Osorio, 2015), while questioning the empirical basis for neoliberalism's economic