The financial crisis and global health: the International Monetary Fund’s (IMF) policy response

ARNE RUCKERT* and RONALD LABONTÉ
Department of Epidemiology and Community Medicine, Institute of Population Health, University of Ottawa, 1 Stewart St., Ottawa, Ontario, Canada K1N6N5
*Corresponding author. E-mail: aruckert@uottawa.ca

SUMMARY
In this article, we interrogate the policy response of the International Monetary Fund (IMF) to the global financial crisis, and discuss the likely global health implications, especially in low-income countries. In doing so, we ask if the IMF has meaningfully loosened its fiscal deficit targets in light of the economic challenges posed by the financial crisis and adjusted its macro-economic policy advice to this new reality; or has the rhetoric of counter-cyclical spending failed to translate into additional fiscal space for IMF loan-recipient countries, with negative health consequences? To answer these questions, we assess several post-crisis IMF lending agreements with countries requiring financial assistance, and draw upon recent academic studies and civil society reports examining policy conditionalities still being prescribed by the IMF. We also reference recent studies examining the health impacts of these conditionalities. We demonstrate that while the IMF has been somewhat more flexible in its crisis response than in previous episodes of financial upheaval, there has been no meaningful rethinking in the application of dominant neoliberal macro-economic policies. After showing some flexibility in the initial crisis response, the IMF is pushing for excessive contraction in most low and middle-income countries. We conclude that there remains a wide gap between the rhetoric and the reality of the IMF’s policy and programming advice, with negative implications for global health.

Key words: global health; global governance; economic analysis; global health governance

INTRODUCTION
It is widely accepted that under the terms of neoliberal globalization to which most nations have subscribed, health outcomes are shaped by factors and events beyond the direct control of nation states and their governments (Labonté and Togerson, 2005; Labonté et al., 2009; De Vogli, 2011). The financial crisis of 2008 and the more recent European sovereign debt crisis represent such external events, as both crises have the potential to have long-lasting and deep health impacts. The greatest risks exist for those living in developing countries that are particularly vulnerable due to high levels of poverty and illness and lack of social protection mechanisms (Mohindra et al., 2011). Financial crises have a tendency to slow down capital flows to the developing world, lead to deep cuts in official development assistance (ODA), and generate years of sub-par economic growth, if not outright economic decline (Reinhart and Rogoff, 2009; Eurodad and TWN, 2010). However, the impacts of financial crises on health outcomes are mediated by the policy response, both at the domestic and the global level. In low-income countries that heavily rely on financial support from the international financial institutions (IFIs), policy conditionalities stipulated in
lending agreements play a decisive role in determining government decision-making. Such conditionalities also provide external leverage over the policy making process, with important implications for the health of populations (Okunonzi and Macrae, 1995).

The IMF has long been criticized for prescribing to crisis-stricken countries policies that have had negative effects on health (Breman and Shelton, 2001; Stuckler and Basu, 2009). Structural adjustment policies (SAPs), commonly prescribed during the 1980s and 1990s, undermined the health of populations through two principal avenues: the dismantling of health care systems in line with the slimming of the state and the general deterioration of socio-economic conditions linked to contractionary macro-economic policies (Mohindra, 2007). This led to reduced gains in life expectancy and increasing mortality and morbidity rates in many low-income countries, especially in Sub-Saharan Africa (Hopkins, 2006; Stuckler et al., 2008; De Vogli, 2011). However, in the early 2000s the IFIs responded to their critics by introducing the Poverty Reduction Strategy Paper (PRSP) approach, a novel lending facility that is ostensibly more poverty sensitive and flexible, with a reduction in the number of conditions attached to funding arrangements (Ruckert, 2009). In the response to the financial crisis of 2008, the IMF has been vocal about its resolve to be even more flexible than in the recent past and to promote counter-cyclical macro-economic policies that properly balance fiscal accommodation and social spending with the need to manage fiscal deficits so that they do not spin out of control (IMF, 2009a). [Counter-cyclical macro-economic policies refer to those that run counter to the business cycle, specifically increases in government spending and money supply (managed through central banks) during periods of economic contraction]. This article sets out to interrogate the financial crisis response of the IMF, by surveying a range of recent IMF policy documents and by drawing on a number of studies recently conducted both in academia and among civil society organizations (Batniji, 2009; CEPR, 2009; Stuckler and Basu, 2009; TWN, 2009; Eurodad and TWN, 2010; Ortiz et al., 2011; UNESCO, 2011). The main focus of the paper is on the experiences of low-income countries, with the occasional reference to middle-income countries. Understanding and assessing the potential effects of IMF policies on global health are particularly relevant at the current conjuncture as the IMF has emerged with additional responsibilities and enhanced lending capacity. Its policy prescriptions in the post-crisis setting will have far-reaching health consequences globally, especially for the most vulnerable segments of society in low-income countries.

We begin by briefly reviewing the contours of the global policy response articulated by G20 leaders at various global summits. We next focus on the IMF’s policy response to the financial crisis, comparing and contrasting the rhetoric of fiscal expansion and flexibility with the reality of little-modified austerity and conditionality. We conclude by suggesting that health promoters would be well-advised to pay close attention to the IMF’s largely unchanged policy prescriptions, and to lobby for a meaningful overhaul of the (in academia increasingly discredited) neoliberal macro-economic policies that remain at the heart of the IFI’s policy regime.

**MAPPING THE GLOBAL CRISIS RESPONSE**

Despite having had little role in causing the global financial crisis, many low-income countries have been deeply affected by it. Given the close integration of most low-income countries into the global economy, the economic downturn experienced in high-income countries was bound to transmit through various channels to developing countries, despite initial hopes that some parts of the world could decouple from the epicentre of the crisis. While most low-income countries have not directly experienced their own financial crises, public balance sheets have nevertheless been impacted through the global decline in trade volumes, the drying up of remittances, the decline in foreign direct investment and the squeezing of aid budgets (ODI, 2008; IMF, 2009c). Once the financial crisis had fully erupted in 2008, it became clear that emergency funding was urgently needed to address the massive shortfalls in the current accounts of many low-income countries, in most cases related to a steep drop off in external demand for exports. In March 2009, the IMF estimated that in a worst case scenario globally between 22 and 48 countries would need between $25 and $138 billion to cover balance of payments shortfalls in 2009 (IMF, 2009b).
(unless otherwise stated, all dollar figures are in USD). Similarly, the World Bank estimated that external financing needs (in the form of private capital flows) of 59 countries would not be met in the near future, leaving a gap of \( \sim \$352 \) billion (World Bank, 2009a). What is more, this external financing gap has not been closed yet, as UNCTAD recently noted that the 2010 external financing gap for all developing countries was \( \sim \$300 \) billion, with the 2011 gap likely to be almost as large (UNCTAD, 2011). At the same time, the ongoing economic crisis is threatening to undo the progress that has been made towards achieving the Millennium Development Goals (MDGs), especially in the health sector. For example, the 50% drop in average GDP growth in low- and middle-income countries, relative to the pre-crisis rate, is expected to lead to an additional 1.4–2.8 million infant deaths in these countries between 2009 and 2015 than would have otherwise been the case (World Bank, 2009b). From the outset, it has been acknowledged that the global financial crisis requires global solutions through an internationally coordinated policy response (G20, 2009; Ortiz, 2009). The IFIs have been front and centre in the attempt to halt the financial crisis and return the world onto a path of sustainable economic growth (whether such growth is environmentally sustainable is a question rarely addressed by the IFIs). At the G20 summit in London in April 2009, world leaders committed to providing an additional \$1.1 trillion in emergency financing—with \$750 billion to be channelled through the IMF. Some \$250 billion has already been issued to all IMF member countries in the form of special drawing rights (SDRs), the IMF’s reserve asset. For the remainder, high-income and reserve-rich governments are lending the IMF up to \$500 billion for loans at market interest rates to countries in need. However, of the \$1.1 trillion committed, only \$240 billion is expected to actually go to developing countries and, what is more important, only \$50 billion is earmarked for low-income countries to support social protection, boost trade and safe-guard development (Eurodad, 2009). The IMF is supposed to channel at least \$6 billion into concessional and flexible finance to low-income countries [(APF, 2009), p. 5]]. Subsequent sections of this paper will determine in more detail how some of these pledges have played out. However, this financial commitment to support low-income countries seems rather unambitious when compared with the amount that G20 countries have dedicated to boost their own economies, and woefully inadequate given the shortfalls in financing that both the IMF and World Bank have identified.

## MORE MONEY AND NEW LENDING FACILITIES AT THE IMF

In return for having received a massive influx of capital, the IMF has promised to deliver more money with less conditionality and more flexibility than ever before (see table 1). To achieve this, the IMF pledged to double the size of both its Poverty Reduction and Growth Facility (PRGF) and Exogenous Shocks Facility (ESF), and to expand technical assistance funded by donors through multi-donor trust funds (IMF, 2009a). And indeed, by late 2009 the IMF had already put its new resources to work and had approved 18 new (emergency) lending arrangements in the amount of \$48 billion, mostly channelled through its ESF [(Woods, 2009), p. 8]]. However, almost 70% of the total went to three countries, Romania, Ukraine and Hungary, and >82% went to European countries in general (Halifax Initiative, 2009). The IMF itself has acknowledged that it will provide only \( \sim \)2% of the external gross financing needs of low-income countries, highlighting the need for other multilateral development banks to fill the gap [(Halifax Initiative, 2009), p. 8], even though, the availability of IMF concessional resources for low-income countries did go up significantly since the onset of the financial crisis. As the IMF noted in 2010, its Executive Board approved measures that will boost the Fund’s concessional lending capacity by up to \$17 billion through 2014, including up to \$8 billion in the first 2 years. This exceeds the G20 call for \$6 billion in new lending over 2–3 years (IMF, 2010a). Also, the IMF has signalled its willingness to provide exceptional relief on interest payments due to the IMF through 2011 (IMF, 2010a).

In relation to its much-contested policy of conditionality, the IMF has responded in two ways. First, conditionality in IMF programmes has been further streamlined to focus on core objectives. This flexibility applies particularly to structural reforms as countries will not need to
seek waivers if such reforms are not completed by a specific date [(IMF, 2009a), p. 2]. However, the implications of this for lending arrangements with low-income countries remain unclear, as discussed below. Second, the IMF has designed a range of new lending tools, including the Flexible Credit Line (FCL), which aims to provide quick (non-conditional) disbursements for countries that meet strict qualification criteria through what the IFIs call ‘prior actions’ [(IMF, 2009a), p. 1]. This reversal in conditionality has been celebrated by the IFIs as a partial cessation of conditionality. However, the introduction of the FCL must be understood not as a break with conditionality but rather as a move from post hoc to ex ante, or ‘advance conditionality’, as countries essentially need to demonstrate that they have internalized the IFI’s policy stance and have already applied ‘sound macro-economic policies’ before even approaching the IFIs.

There is a range of countries which have already made use of the new FCL, with Poland, Mexico and Colombia having received access to a total of >$100 billion as of August 2011 (IMF, 2011). Modelled on the FCL, the IMF is also currently entertaining the idea of providing ‘front-loaded’ resources to low-income countries based on advance conditionality, or ‘prior actions’, through a novel High-Access Precautionary Stand-by Arrangement (HAPA).

### Table 1: Evolution of IMF facilities and lending instruments

<table>
<thead>
<tr>
<th>Facility</th>
<th>Purpose</th>
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<tr>
<td><strong>Exogenous shocks facility (ESF)</strong></td>
<td>Provides financial assistance to low-income countries facing exogenous shocks. It is accessible to countries eligible to the PRGF but that do not have a PRGF in place. The ESF has a rapid access component (RAC) which in principle does not have conditionality attached, and a high access component (HAC). The ESF-HAC provides access up to 150% of quota for each arrangement in normal circumstances. Resources are provided in phased disbursements based on reviews, and programmes are 1–2 years in length.</td>
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<tr>
<td><strong>Flexible Credit Line (FCL)</strong></td>
<td>New credit line introduced in 2009 for countries with very strong fundamentals, policies, and track records of policy implementation. The FCL is intended for crisis prevention purposes and disbursements under the FCL are not phased or conditioned to policy understandings but require countries meeting pre-qualification criteria</td>
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<tr>
<td><strong>Poverty Reduction and Growth Facility (PRGF)</strong></td>
<td>Until recently, the PRGF was the IMF’s main instrument for financial assistance to low-income countries. The PRGF was supposed to make the IMF’s support more flexible and tailored to country needs, in line with the objectives of a country’s own poverty reduction strategy. The PRGF has recently been superseded by the Extended Credit Facility (ECF) but for now, a number of PGRF programmes are still in place</td>
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<tr>
<td><strong>Policy Support Instrument (PSI)</strong></td>
<td>The Policy Support Instrument (PSI) supports low-income countries that do not want—or need—fund financial assistance but seek to consolidate their economic performance with IMF monitoring and support. This non-financial instrument is a valuable complement to the newly established lending facilities under the Poverty Reduction and Growth Trust. The PSI helps countries design effective economic programmes that, once approved by the IMF’s Executive Board, deliver clear signals to donors, multilateral development banks, and markets of the Fund’s endorsement of the strength of a member’s policies</td>
</tr>
<tr>
<td><strong>Extended Credit Facility (ECF)</strong></td>
<td>The Extended Credit Facility (ECF) provides financial assistance to countries with protracted balance of payments problems. The ECF was created under the newly established Poverty Reduction and Growth Trust (PRGT) as part of a broader reform to make the Fund’s financial support more flexible and better tailored to the diverse needs of LICs, including in times of crisis. The ECF succeeds the Poverty Reduction and Growth Facility (PRGF) as the Fund’s main tool for providing medium-term support to LICs, with higher levels of access, more concessional financing terms, more flexible programme design features, as well as streamlined and more focused conditionality</td>
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This would effectively introduce advance conditionality as a \textit{modus operandi} into IMF interactions with low-income countries. To sum up, the IMF has grasped the opportunity to step in rapidly and provide loans to countries in crisis. However, these loans have largely been extended to middle-income countries in Eastern Europe and countries on Europe’s borders, while many parts of the least developed world have been left behind. At the same time, conditionality has been streamlined, with the provision of novel lending facilities that have transformed conditionality from \textit{post hoc} to advance conditionality. To further assess the impact of IMF lending on health outcomes, the discussion will now turn to the nature of recent IMF lending arrangements and a discussion of fiscal space in post-crisis lending.

**CHANGING POLICY CONDITIONALITY, OR BUSINESS AS USUAL?**

A major concern about the IMF’s crisis response has been the perceived gap between the expansionary rhetoric, on the one hand, and the practice of prescribing little-modified contractionary macro-economic policies and loan conditionality, on the other. The IMF has forcefully acknowledged the need for expansionary fiscal policies ever since the financial crisis broke out in 2008. For example, then Director of the IMF Dominique Strauss Kahn noted in 2009 that ‘[f]or a year now, since I spoke at Davos, the Fund has advocated fiscal stimulus to restore global growth. There is now a broad consensus on this’ [(Strauss-Kahn, 2009), p. 2]. This broad consensus has translated into unprecedented stimulus spending in high-income countries where governments racked up enormous deficits, in many cases as high as 10% of GDP, and put together stimulus packages in order to avoid a complete collapse of global effective demand. There is now a broad consensus on this’ [(Strauss-Kahn, 2009), p. 2]. This broad consensus has translated into unprecedented stimulus spending in high-income countries where governments racked up enormous deficits, in many cases as high as 10% of GDP, and put together stimulus packages in order to avoid a complete collapse of global effective demand. Examples for this include the US stimulus package, with $787 billion (5.52% of GDP) the largest fiscal stimulus in absolute terms, and China’s fiscal stimulus at $585 billion (13.30% of GDP), the largest in relative terms [(Zhang et al., 2010), p. 5]. In a recent analysis, UNDP finds that the 48 countries it analysed spent a total average of 4.3% of world GDP on fiscal stimulus [(Zhang et al., 2010), p. 5].

In Creating Policy Space, the IMF explains that its own crisis response is driven by finding the right balance between fiscal accommodation and adjustment, as ‘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, 2009d), p. 9]. In fact, the IMF argues that it strongly encouraged countries to safeguard social protection mechanisms and avoid cut-backs in poverty-sensitive areas of government spending, while advocating for cut-backs in non-priority areas (IMF, 2009a). According to the Fund, close to two-thirds of the fiscal targets for low-income countries accommodated increases in government spending, primarily because countries were encouraged to safeguard social protection [(IMF, 2009d), pp. 12–21]. At the same time, the Fund notes that it revised upward its inflation targets and has become more flexible in its approach to monetary policy [(IMF, 2009d), pp. 12–21]. One of the criticisms of earlier SAPs was the focus of the IFIs on bringing inflation rates within a country to very low levels. Although high inflation rates can hurt the poor as well as the rich, the very low rates often prescribed by the IFIs were considered of greatest benefit to creditors holding the debt of countries experiencing only moderate inflation rates. Restraining inflation often meant reducing money supply, raising interest rates and cutting government spending, all of which generally had knock-on effects in domestic economic contraction and reduced levels of health and social protection.

Yet, most independent reviews of IMF lending paint a less rosy and somewhat contradictory picture. While the IMF had been initially somewhat more flexible, especially in its early crisis response in 2008, by late 2009 fiscal austerity was forcefully back on the IMF’s agenda (Eurodad and TWN, 2010). As a number of reviews have shown, in its early crisis response in low-income countries, the IMF allowed larger than usual fiscal deficits, in some instances and encouraged counter-cyclical spending if it did not undermine the perceived middle- and long-term macro-economic stability within the country, and if the spending was directed to priority (mostly poverty-reducing) areas. Examples for this are the crisis loans given to Zambia [(IMF, 2010b), p. 79)].
Tajikistan [(IMF, 2009e), p. 109] and Tanzania, Benin, and Senegal (Eurodad and TWN, 2010). However, even in these cases, revisions of macro-economic targets were marginal, especially when compared with fiscal deficits in high-income countries. In most cases, deficits were programmed not to surpass the threshold of −3%, while by 2010 the overall advice has been for further fiscal tightening. In contrast, many high-income countries were still running budget deficits at >5% in 2010, including the USA, Britain, France and Spain.

What is more, the Fund’s actions frequently contradict its ostensible endorsement to protect social spending in the aftermath of the financial crisis. Many post-crisis lending arrangements have provisions on cutting back consumer subsidies and raising domestic prices of food and fuel, as for example in the case of Malawi [(IMF, 2009f), p. 11]. A recent UNICEF study found that >50 developing countries are currently considering reducing or removing subsidies as part of fiscal consolidation efforts (Ortiz et al., 2011). The removal of food and fuel subsidies in the midst of a global food price crisis will likely have disastrous health consequences. Another important issue, especially as it directly relates to health outcomes, is setting ceilings on public sector wages. While the IMF has recently been suggesting that such ceilings have been discarded, other than in exceptional circumstances (IMF, 2006), it nevertheless made use of such ceilings in a number of post-crisis lending arrangements, by introducing wage and hiring freezes for public sector workers in a range of countries, for example Benin, Malawi and Zambia [(Eurodad and TWN, 2010), p. 24]. Wage caps can lead to salaries being reduced, hiring freezes and employment retrenchment in the health sector, with adverse impacts on the delivery of health services [(Ortiz et al., 2011), p. 15]. A detailed review of existing studies on the impacts of wage caps of IMF adjustment programmes in Sub-Saharan African countries during the 1990s found that 21 of the 26 countries for which data existed experienced retrenchment of civil service positions, which prevented ‘needs for education and health personnel from being met’ [(McCoy et al., 2008), p. 680]. A UNICEF study of post-crisis effects on salaries of teachers and health workers in low-income and lower-middle-income countries found that salaries in most countries continued to increase or at least did not decline in absolute terms. These increases, however, failed to keep pace with rapidly rising food and fuel costs leading to a decline in relative terms, and in many of their surveyed countries the adjusted salaries for teachers and front-line health workers placed them below the poverty line. The UNICEF study also found that for 34 of 41 low-income and lower-middle-income countries, the post-crisis IMF advice was to cap or cut their wage bills which historic evidence suggests is almost certain to lead to reduced levels of care (UNICEF, 2010). Although both the IMF advises that civil service retrenchments should not apply to health and education sectors, these sectors are often weak in low-income countries and as vulnerable to wage freezes or retrenchments as other sectors.

Finally, in its attempt to reign in deficits, the IMF’s focus has been exclusively on cuts in expenditure, through reduction in non-priority spending, especially through decreases in capital expenditure allowances. Measures to address deficits by raising revenues, for example through progressive taxation of corporations and high-income earners, have remained off the table. Yet, given the extent to which government revenues have been decimated by the financial crisis, with revenues of all low-income countries having been reduced by $52 billion in 2009 and $12 billion in 2010 when compared with 2008, it is clear that additional revenues will have to be raised through new taxation measures within low-income countries [(UNESCO, 2011), p. 23]. What is particularly disconcerting is that comparing the 2010–2012 period with the 2005–2007 period, nearly one-quarter of all low-income countries is undergoing excessive fiscal contraction, with government expenditures dropping even below pre-crisis levels [(Ortiz et al., 2011), p. v]. In other words, the IMF is using the financial crisis to promote a further cutting back of the state in the midst of the ongoing social outfall of the financial crisis. In stark contrast, most high-income countries are still running sizeable budget deficits, in some cases close to 10%, with little intention to immediately produce balanced budgets.

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. 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), p. 24]. Yet, monetary easing has 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 hence put further pressure on governments to reduce health expenditure.

As noted above, the IMF has displayed a limited degree of added flexibility in its macro-economic approach with some low-income countries. However, lending arrangements with most middle-income countries have remained largely contractionary, as a comprehensive review performed by the Centre for Economic Policy Research has unveiled (CEPR, 2009). Prominent examples are deep forced cut-backs to public spending in Latvia, Romania and Ukraine [(CEPR, 2009), pp. 46, 60 and 77; see also (Stuckler and Basu, 2009), p. 775]. In Hungary, the IMF has targeted fiscal deficit reductions from 3.4 to 2.5% of GDP through a fiscal consolidation plan which involves freezing public sector wages, placing a cap on pension payments and postponing social benefits (TWN, 2009). In another example, the IMF’s 2009 Stand By Arrangement (SBA) loan of $532 million to Serbia highlights that there is no scope for countercyclical fiscal loosening in Serbia’s crisis response: ‘Anything less than a tight fiscal stance could also jeopardize the credibility of the programme in the eyes of foreign investors and the Serbian public. Fiscal policy will in addition need to put a tight constraint on nominal wage growth in government sectors and public enterprises’ [(IMF, 2009g), p. 18]. Finally, and most surprisingly, Eurodad and TWN [(Eurodad and TWN, 2010), p. 4] note that many of the agreements continue to promote financial liberalization, in spite of the recent experience of how financial liberalization without proper regulation can unleash uncontrollably destructive forces.

Ultimately, the biggest concern for international health promoters might well be that, while the neoliberal macro-economic framework has become slightly more poverty-oriented and flexible, the overall support of the IMF for neoliberal and monetarist macro-economic policies, combined with a strong resolve for free markets and free trade, has not been greatly diminished by the global financial crisis. Yet to properly address pressing global health problems, what is needed is a stance that does not perceive macro-economic policy as being solely responsible for producing macro-economic stability, defined narrowly in terms of low levels of inflation and balanced budgets. What is needed is an understanding of how macro-economic policy should, from the outset, balance economic and social considerations, and play an important role in driving public policy towards favourable health outcomes. This could be achieved only if social concerns are integrated from the very beginning into macro-economic policy decisions, instead of being an add-on and afterthought to ameliorate the negative health consequences of macro-economic adjustments.

**CONCLUSION**

Until recently, health promotion proponents have been surprisingly silent on debates surrounding the IMF’s impact on health outcomes in low-income countries (Mohindra, 2007). Yet all IMF-supported macro-economic policies are enacted within a certain set of distributive relations and institutional power structures, and contribute to a variety of health outcomes, which need to be made explicit (Eurodad and TWN, 2010). The neoliberal macro-economic policies that have been promoted under the mantle of SAPs, and are now implemented in a slightly modified form through PRSPs, have had deplorable social and health consequences (Stuckler and Basu, 2009; SAPRIN, 2003). This article has demonstrated that the IMF has been somewhat more flexible in its crisis response than previously, as it acknowledged the importance of shielding the most vulnerable from the impacts of the financial crisis. On the fiscal front, the IMF has allowed marginally higher deficits during the brunt of the crisis, even though there have been significant variations between different countries. However, this added flexibility has remained marginal in size and short-lived, as the Fund has returned to
being the most vocal proponent of tighter fiscal policies globally and returned to promoting inflation targets in the low single digits. What is more, many of the most controversial elements of previous SAPs, such as deregulation of finance and the privatization of state services, have remained present in many post-crisis lending arrangements (Eurodad and TWN, 2010; Ruckert, 2010).

The IMF-driven effort to restore balanced budgets through fiscal austerity arguably represents an immediate threat to global health, especially if public assets sales and the privatization of core state service are proposed as solutions to countries’ debt problems, as can currently be observed in the case of Greece. A recent analysis of the health impacts of the fiscal austerity drive in Greece has already revealed health effects beyond fluctuations in suicides and road-traffic fatalities (Kentikelenis et al., 2011). It suggests that healthcare access has already declined in Greece, as hospital budgets have been cut by \(\sim 40\%\), and it is estimated that 26,000 public health workers, including 9100 doctors, will lose their job. It also notes that there was about a 15% increase in the likelihood of people reporting that they did not go to a doctor or dentist despite feeling that it was necessary [(Kentikelenis et al., 2011), p. 1457]. This suggests that there are grave risks to health from budget cuts, which in developing countries will pose an even greater danger to people’s health. But challenges to health outcomes are also related to the ways in which austerity measure are undermining the wider social determinants of health, especially proper employment.

The biggest obstacle to achieving beneficial global health outcomes arguably lies in the unwillingness to question the narrow (economistic) rationale of neoliberal macro-economic policies and to assess such policies from a broader perspective of social stability (Elson and Catagay, 2000). Yet, whether or not health-related MDGs will be met will depend to a large extent on the policy conditionalities and the macro-economic policies promoted by the IMF. 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 Togerson, 2005). While international health promoters should be encouraged by the IMF’s notional acknowledgement of a need for more macro-economic flexibility, it is clear that they need to continue to engage with the IMF (through their government, or through civil society critics) to push the boundaries of what is considered ‘sound’ macro-economic policies and to engender a real break with the neoliberal policy framework. A key question in this regard is how the IMF can better incorporate concerns about health into its macro-economic framework (Stuckler and Basu, 2009), thus avoiding the adverse public health effects that have been the result of macro-economic policies that have retained a problematically narrow focus on economic stability.

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