# 12

# NEOLIBERALISM AND HEALTH IN GLOBAL CONTEXT

## The role of international organizations

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The global COVID-19 pandemic stretched health systems to their limits and threatened to unravel decades of socio-economic progress. As governments struggled to safeguard the well-being of their people, intergovernmental organizations (IGOs) stepped up their efforts to help mitigate the crisis (Hanrieder 2020; Kentikelenis *et al.* 2020; Stubbs *et al.* 2021). Yet, IGOs have long shaped country responses to socio-economic crises, exerting profound influence on global health via policy prescriptions attached to structural adjustment lending programs and through more subtle processes of policy norm diffusion (Chorev 2012; Hanrieder and Kreuder-Sonnen 2014; Kentikelenis and Stubbs 2023).

This chapter examines how IGOs act as 'agents of neoliberalism' (Babb and Kentikelenis 2018) in global health. We define neoliberalism as a set of policies promoting market-oriented solutions for a range of policy problems. Of course, not all IGOs are carriers and transmitters of neoliberal ideas about appropriate policy, but a subset of IGOs has been central in globalizing this paradigm. We focus on the role of three especially powerful such organizations: the World Health Organization (WHO), International Monetary Fund (IMF), and World Bank.

### IGOs as carriers of neoliberal ideas

The global ascendancy of neoliberalism has its roots in the 1980s. Structural changes in the world economy, following the collapse of the Bretton Woods system and the 1970s oil crises, posed a range of economic challenges for developing countries. To adjust to the new global economic system, these countries – commonly facing high debt burdens and national or regional economic crises – turned to IGOs' policy advice to reform their economies. At the same time, IGOs – under the influence of their most powerful members, like the US – became increasingly committed to economic ideas about the merits of free markets in driving sustainable growth and development (Kentikelenis and Babb 2019). Consequently, IGOs acted as key agents in designing and overseeing market-oriented reforms of developing countries (Babb and Kentikelenis 2018; Forster *et al.* 2022; Kentikelenis and Stubbs 2023). Numerous countries restructured their domestic political economies according to neoliberal doctrine: privatizing state-owned enterprises, deregulating markets, and liberalizing trade (Harvey 2005). IGOs prompted this transition via two key channels of influence: normative pressures through IGOs' policy advice and technical assistance (Simmons *et al.*

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2008), and coercive pressures through loans in exchange for policy reforms (Babb and Carruthers 2008). We discuss each of these channels in turn.

### *Policy norms*

IGOs foster the adoption of neoliberal policies through normative processes – spreading policy norms by using their authority to define what policy ideas are 'appropriate' (Simmons *et al.* 2008: 31–40) as seemingly impartial actors (Heinzel *et al.* 2021). IGOs derive this authority from the knowledge and expertise their bureaucracies build through formal training and socialization. These organizations commonly recruit a narrow band of technocrats with degrees in orthodox economics and related social sciences from elite Anglo-Saxon universities (*e.g.* for the IMF, see: Weaver *et al*. 2022). In turn, these experts possess the credentials in neoclassical theories of trade, finance, and development to define contemporary issues, as well as to propose universally applicable neoliberal solutions to address them with professional legitimacy (Barnett and Finnemore 2004).

Neoliberal policy norms are diffused by IGOs through various means. For example, the process of normative emulation suggests that similar organizational structures and norms determine converging behavior (DiMaggio and Powell 1983). Or, more directly, IGOs engage in transnational policy training to disseminate norms to national officials, thereby increasing the number of domestic reformers who are sympathetic to their prescriptions for policy change (Broome and Seabrooke 2015).

### *Coercive pressures*

In addition to normative processes, the diffusion of neoliberalism from IGOs to domestic policy is commonly achieved through the practice of conditional lending by international financial institutions (IFIs), a subset of IGOs. Among IFIs, the IMF and World Bank are the most influential (Babb and Kentikelenis 2018): granting loans to governments suffering from economic imbalances in exchange for a range of policy reforms, collectively known as 'conditionality' (*e.g.* Babb and Carruthers 2008; Kentikelenis and Stubbs 2023).

The IMF and World Bank, founded in 1944, are mandated to maintain global financial stability and finance development projects, respectively. Both organizations have been instrumental in promoting market-liberalizing reforms as part of their lending operations from as early as the 1980s (Babb and Kentikelenis 2018). Against a background of debt crises, their 'structural adjustment programs' – the vehicles through which conditionality is administered – achieved notoriety for coercing indebted developing countries to adopt four key neoliberal pillars: stabilization, liberalization, deregulation, and privatization of the economy (Babb and Kentikelenis 2018; Kentikelenis and Babb 2019). First, stabilization entails fiscal, monetary, and exchange rate policies aimed at resolving balance-of-payments issues and controlling inflation, including fiscal consolidation measures (or 'austerity'). Second, liberalization involves easing restrictions on flows of goods and capital to facilitate a higher degree of integration with the global economy and a more efficient allocation of capital. Third, deregulation encompasses measures enlarging the scope of free markets to limit state interference and corruption in economic processes, such as through reducing the number of procedures, time, and costs to register a company. Finally, privatization entails the commodification of state-owned enterprises and natural resources to private interests to promote the economic growth of industries hitherto sheltered from market forces.

Following extensive controversy over their handling of the Asian Financial Crisis during the late-1990s (Babb and Carruthers 2008), the IMF and World Bank claimed to have reformed

the *modus operandi* of structural adjustment. According to them, revised programs incorporated 'flexible' policy design, 'streamlined' conditionality, adopted a 'pro-poor' orientation, and enabled borrowing-country 'ownership' (IMF 2009; World Bank 2009). Yet, at least for the IMF, studies find the advertised changes are not consistent with their actual lending practices (Kentikelenis *et al.* 2016; Mariotti *et al.* 2017; Forster *et al*. 2019). Instead, neoliberal-type conditionality has remained common in cross-country experiences of structural adjustment programs (Babb and Carruthers 2008; Kentikelenis *et al.* 2016; Labonté and Stuckler 2016; Kentikelenis and Stubbs 2023).

## IGOs, neoliberalism, and global health

Since the 1980s, IGOs have encouraged and frequently compelled countries to adopt neoliberal policy reforms. These have had significant consequences on global health. From as early as 1987, in a landmark report on structural adjustment and child health, UNICEF acknowledged that the IMF and World Bank had engendered detrimental effects on health outcomes (Cornia *et al.* 1987). As the two most powerful IFIs (Babb and Kentikelenis 2018), the IMF and the World Bank warrant particular attention. In addition, we discuss the role of the WHO, as the IGO formally tasked with promoting human health and well-being.

Figure 12.1 depicts three main pathways through which neoliberalism affects health outcomes. First, direct effects originate from two nodes: IGOs deploy structural adjustment programs to impose conditions directly related to health systems, and draw on their expert authority to influence health policy discourse and reforms. Second, indirect effects on health systems stem from macroeconomic and institutional policies and norms. Third, the social determinants of health, such as

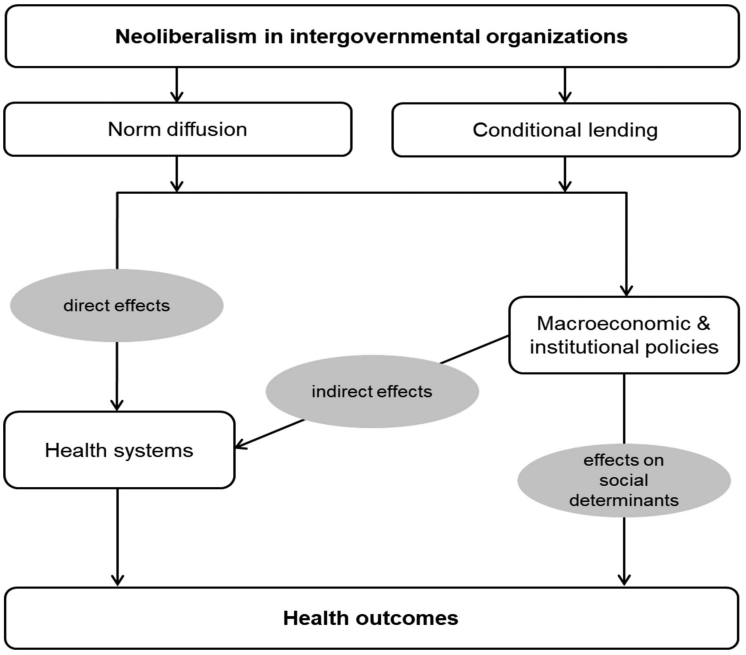



*Figure 12.1* Impact of neoliberalism on health – overview of mechanisms.

*Source:* Authors, adapted from Kentikelenis (2017).

education and income, are impacted by a country's macroeconomic and institutional framework. We first provide evidence on the effects from norm diffusion, and then turn our attention to the relationship between structural adjustment and health.

### *Norm diffusion and health*

IGOs utilize their 'expert' authority (Barnett and Finnemore 2004) to disseminate neoliberal policy ideas to affect global health. The normative nature of these processes in relation to health has received relatively little attention (for an exception, see: Murdie and Hicks 2013), partly because of empirical difficulties associated with identifying non-coercive diffusion of norms. For instance, policy reports might use deliberately vague language that invites ambiguity in the specificities of their proposals, and sometimes favor ideological principles over science (*e.g.* Navarro 2000). Still, the three pathways in Figure 12.1 have explanatory power. The framework can illuminate how neoliberal norms affect health. To demonstrate, we discuss how the WHO, World Bank, and IMF have consistently advocated for a wider role of the private sector in the provision of healthcare.

First, during the late-1990s, the WHO faced a crisis on three fronts: limited financial resources, alternative agencies competing in health governance, and uncertainty about its leadership. The WHO adopted a new agenda with various neoliberal features, responding selectively and strategically to these exogenous pressures (Chorev 2013). A 'neoliberal transformation was evident in every layer of operation' of the WHO (Chorev 2012: 187), and the organization supported market-oriented solutions and the involvement of the private sector. The *World Health Report 2000* on health systems (WHO 2000) – written by a team incorporating former World Bank economists to strengthen its legitimacy – was supposed to address concerns about privatization and market reforms in healthcare (Chorev 2012: 175–6). However, the report failed to achieve this target (Ollila and Koivusalo 2002). Instead, the recommendations were biased toward private health and encouraging competition, while voices criticizing the conventional wisdom at that time were absent (Navarro 2000). While the privatization of health services carries potential gains in terms of cost efficiency, it may reduce access for people who cannot afford to pay for private health services (Stuckler and Basu 2013).

Second, the World Bank, through a series of reports (Akin *et al.* 1987; World Bank 1993; The Human Development Network 1997) – most notably its annual *World Development Report* – promoted some distinctively neoliberal policy advice (Armada *et al.* 2001). The Bank sought to redefine the state's role in healthcare, and promoted private-sector provision (de Beyer *et al.* 2000) to, *inter alia*, increase competition in health service delivery (Ruger 2005). While the Bank has drawn attention to strengthening health systems in an updated *Health, Nutrition, and Population* strategy (World Bank 2007), earlier versions of this policy paper advocated expanding private-sector provision and exposing public providers to greater market competition (McCoy 2007).

Third, the IMF has regularly emphasized 'inefficiencies' in health systems (Coady *et al.* 2012). As a result, the Fund argues that pro-market measures – such as increased competition or greater reliance on private financing – can improve efficiency in both advanced (Cottarelli 2010) and emerging (Jenkner *et al.* 2012) economies. For example, the IMF continues to view many state-owned enterprises as a 'burden to taxpayers and the economy', and thus encourages market-oriented reform (IMF 2020b). Yet as discussed below, these reforms are likely to affect adversely the capacity and structure of health systems (see: Table 12.1).

In addition to direct effects on health systems, IGOs advocate broader policy norms that dictate best practices in global health governance. By drawing on their expert authority to define the issues at stake, IGOs control and guide debates. For instance, despite external, neoliberal pressures,

*Table 12.1* Structural adjustment and health systems, direct and indirect effects

| *Health(-related) outcome* | *Policy area* | *Mechanism* |
|---|---|---|
| Financing and provision of healthcare | Health spending | Austerity can require governments to reduce public health expenditure or replace public with private – often, aid – financing (Sridhar and Woods 2010; Stubbs *et al.* 2017).<br>Priority spending floors stipulate minimum expenditures on health and education that, in theory, safeguard spending on health from austerity (Gupta *et al.* 2000). However, in practice, they are accorded secondary importance to economic targets (Ruckert and Labonté 2012; Kentikelenis *et al.* 2015; Kentikelenis *et al.* 2016).<br>*Programs have catalytic effects on aid flows for general budget support and debt relief, but not for health aid* (Stubbs *et al.* 2016). |
| | Labor market | Wage bill ceilings lead to redundancies, hiring freezes, or wage cuts (Stuckler and Basu 2009; Kentikelenis *et al.* 2015; Stubbs *et al.* 2017), which lower health system access (Forster *et al.* 2020) and prompt medical 'brain drain' to advanced countries (Lefrançois 2010; Marphatia 2010). |
| | Trade and capital account liberalization | *Removal of tariffs and customs duties lowers trade tax revenues in the short-run. In low-income countries, revenue from domestic taxes tends to be insufficient to recover these losses* (Baunsgaard and Keen 2010)*, which can undermine the fiscal basis of health policy. Further, even if these policy reforms may be neutral with regard to tax revenue, IMF structural adjustment replaces trade taxes with regressive consumption taxes* (Reinsberg *et al.* 2020). |
| | Privatization | *Privatization of state-owned enterprises can raise funds for cash-strapped governments in the short-term. Yet, in the medium- and long-term, this can result in losses of reliable public revenue sources that could otherwise have been used to fund the health sector* (King *et al.* 2009). |
| Coverage and utilization of health services | User fees | The introduction of user fees for healthcare and co-payments for medicines or services (Sen and Koivusalo 1998; Kentikelenis *et al.* 2015) can restrict access for poorer households (McIntyre *et al.* 2006). |
| | Health system decentralization | Fiscal and operational decentralization of health systems to the subnational level (Kentikelenis *et al.* 2015; Stubbs *et al.* 2017) may generate savings in the short-run, but can lead to health system coordination and budget execution problems if local authorities lack technical capacities or divert funds to alternative uses (Djibuti *et al.* 2007). |
| | Privatization | *State-owned enterprises may provide health coverage to employees, which can be withdrawn once privatized* (Stuckler *et al.* 2009; Stuckler and Basu 2013). |

*Note*: Mechanisms in normal font are direct effects on health systems, while those in italics capture indirect effects on health systems.

the WHO advocated for greater investment in health – as opposed to budget cuts – in a 2001 report (Commission on Macroeconomics and Health 2001). This was possible because the organization actively framed health issues in terms of economic growth, deviating from its earlier notion of social development (Chorev 2012: 165–72). According to this conceptualization, better health for the population increases productivity and, thus, stimulates growth. Not only did the WHO respond strategically in economic terms, economists wrote policy papers and applied their own analytical techniques to support this case. As noted earlier, the WHO overcame its internal financial crisis and regained its authority by appealing to, and diffusing, the dominant doctrine at the time (Horton 2002; Chorev 2013). In addition, the strategic response empowered the WHO to engage closely with other agencies, such as the Bill and Melinda Gates Foundation (Chorev 2012: 189). Nonetheless, its immediate success may prove costly in the long-run. While the selective correspondence to neoliberal demands secured financial survival for the institution, its adoption of economic methods and language may engender difficulties in expanding the concept of health to broader social domains at a later stage (Weaver 2010).

Today, the WHO and World Bank promote universal health coverage (WHO 2013; World Bank 2014), which requires strengthening health systems (WHO 2019). Undoubtedly, these organizations are subject to discourse and policy norms at a global level, such as the Sustainable Development Goals. Yet, they can respond selectively and strategically to external demands and, in doing so, promote their own policy norms. For example, the IMF emphasized the need to strengthen health systems, bolster social safety nets, and scale up public investment in response to the COVID-19 pandemic (IMF 2020a, b). Simultaneously, it emphasized that countries recovering from COVID-19 should prioritize 'unwinding the large public interventions in firms [privatize state-owned enterprises] and managing the associated fiscal risks' (IMF 2020a: 20–1). Further, the IMF and other IFIs have been slow to disburse the financing at their disposal after the outbreak, thereby casting doubt on the efficacy of the proposed changes (Stubbs *et al.* 2021). This illustrates how IGOs' discourse should not be taken at face-value (Mariotti *et al.* 2017; Forster *et al.* 2019).

### *Structural adjustment and health*

In Table 12.1, we identify direct and indirect impacts that structural adjustment has had on two key aspects of health systems. First, conditions pertaining to health spending, labor market reforms, trade and capital account liberalization, and privatization impede – or sometimes strengthen – the capacity of states to finance and provide health services. In turn, sharp changes in public health spending patterns affect the volume and quality of services provided, such as the number of health facilities available (Stuckler and Basu 2009).

Second, deregulation, decentralization, and privatization affect the coverage and utilization of health services. For instance, structural adjustment has mandated the introduction of user fees for access to healthcare and co-payments for medicines or services (Sen and Koivusalo 1998), thereby giving rise to health inequalities (Forster *et al.* 2018).

Structural adjustment programs also have a noticeable impact on health outcomes by reshaping the social determinants of health (Labonté and Schrecker 2007) – that is, the conditions 'in which people are born, grow, live, work, and age' (Marmot and Bell 2012: S4). For instance, neoliberal policies are frequently undertaken with the promise of increasing economic growth. At the same time, in the short-run, structural adjustment programs lead to lower rates of economic growth (Dreher 2006), with ensuing declines in per capita incomes and higher involuntary unemployment. These undermine the social determinants of health in multiple ways, including through increasing

poverty and inequality (Oberdabernig 2013; Forster *et al.* 2019; Lang 2021; Stubbs *et al.* 2022). These effects, in turn, cause a cascade of pernicious health effects (Pickett and Wilkinson 2015).

Moreover, the negative consequences of neoliberal policy reforms on health outcomes occur over time. In addition to short-run appearances, some of these effects only materialize during the medium- to long-term. In particular, neoliberal reforms hollow out state administrative capacities and finances (Reinsberg *et al.* 2018). This explains why governments have failed to respond adequately to the COVID-19 pandemic (Jones and Hameiri 2022). In addition, the effects of structural adjustment are unevenly distributed across the entire population. For example, since UNICEF first drew attention to the gendered impact of structural adjustment (Cornia *et al.* 1987), considerable attention has been devoted to identifying how these policies uniquely and disproportionately affect women. In particular, structural adjustment programs have been associated with increased maternal and infant mortality (Pandolfelli *et al.* 2013; Thomson *et al.* 2017; Forster *et al.* 2020).

## Conclusion

Moving beyond the mainstream literature on the social, political, commercial, and financial determinants of health, this chapter highlighted the international-bureaucratic determinants of health. While these factors interact with other determinants, a comprehensive understanding depends on grasping them as a unique set of factors in global policy-making because they offer a crucial, often neglected piece of the puzzle of 'upstream' determinants of health.

Intergovernmental organizations embody neoliberalism when they promote market-based solutions through both coercive and normative processes. These processes affect population health through a number of pathways. Before discussing their implications, however, two limitations should be noted. First, these pathways are relevant to countries' experiences with structural adjustment and norm diffusion, but they are not all operative at all times. Likewise, not all countries rely on IGO advice to the same extent. Thus, some states find the norms and ideas IGOs disseminate unappealing, or are able to resist external pressures for adoption. Second, the lending activities of other IFIs – such as the African Development Bank – have also been shown to affect health (Coburn *et al.* 2015a, b). However, in-depth assessments of their operations remain scarce. Similarly, other IGOs also engage in norm making and diffusion. Increasingly, actors such as consultants, private foundations, and transnational corporations must be considered, too – on their own merit, as well as their activities within IGOs (*e.g.* Eckl and Hanrieder 2023).

With these caveats in mind, we discussed examples of the most important evidence of how conditionality affects health systems and other upstream determinants of health. The World Bank and the IMF are the most relevant institutions in this respect. In the short-run, the pathways examined link structural adjustment to possibly adverse effects on health, due to both individual-level factors (such as unemployment, economic hardship, psycho-social distress) and institutional factors (such as availability and quality of healthcare services, health system operating principles). Nevertheless, individuals' socio-economic status is a key mediating factor, and the impact of structural adjustment policies varies by class, gender, and race. Equally importantly, the medium- and long-term effects of structural adjustment programs are more difficult to accurately estimate, and have received little attention in the literature. Neoliberal policies like trade liberalization may eventually create new employment opportunities and boost economic performance and tax revenues, but other structural adjustment reforms – like mass privatization – may contribute to long-term unemployment resulting in ill-health (Stuckler and Basu 2013). The underfunding, privatization, or decentralization of health systems may weaken capacity, which requires prolonged investment to be overcome.

IGOs are also empowered by the global trend toward technical rationality, and utilize the ideological power this has to dominate global health debates. The empirical evidence presented here supports the argument that the IGOs diffuse neoliberal policies through their research. IGOs encourage an increased role of the private sector in healthcare provision, and – to a lesser extent – favor the introduction of market mechanisms. Further, framing international health discussions, along with emphasizing the importance of measurement and data collection, reinforces IGOs' authority and offers an opportunity to promote neoliberal solutions. Moreover, we indicated how these IGOs – emanating from their knowledge – could easily extend their influence to other societal issues, such as education. This indirectly affects population health through undermining their broader social determinants.

In sum, the evidence regarding the impact of the reforms mandated and ideas advocated by IGOs to reconfigure global health – promoting market-based solutions over government 'intervention' in various forms – should raise alarm. Middle-income countries, in particular, are projected to face budget cuts in the coming years, thereby potentially compounding the adverse effects of the COVID-19 pandemic (Kentikelenis and Stubbs 2021; Ray *et al.* 2022). However, despite neoliberal dominance on health and its broader social determinants, there are also exceptions. Some policies – like the reliance on user fees – can be easily reversed, especially when governments cooperate with domestic and international partners to design alternative policy arrangements. For instance, user fee removal in Uganda quickly translated into increases in health service utilization, especially by the poor (Yates 2009). Similarly, collaborations with international donors, national-level planning, and appropriate tailoring to health needs have allowed some low-income countries to attenuate detrimental effects of structural adjustment on their health systems, while working to improve coverage (Meessen *et al.* 2006). Thus, options remain for sheltering and strengthening health policy. In addition, many UN Sustainable Development Goals for 2030 relate to health, which reflects member-states' acknowledgement of its global importance. Finally, the IGOs we discussed have sometimes reversed their neoliberal stances, or become more nuanced in advocating their policies, which puts these extant norms under more scrutiny. As the number of relevant actors in global health debates has increased substantially in recent decades – now including nation-states, inter- and non-governmental organizations, civil society groups, multinational corporations, and others – it is as important as ever to evaluate the impact of policy ideas put forward. Thus, researchers need to transcend exclusively mainstream economic evaluations of health systems and, instead, consider the social determinants of health.

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