

Further Debate on the International Monetary Fund and Health

**HEALTH IMPACT ASSESSMENT AS AN ACCOUNTABILITY
MECHANISM FOR THE INTERNATIONAL MONETARY
FUND: THE CASE OF SUB-SAHARAN AFRICA**

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Health impact assessment (HIA) is both an effective tool for promoting healthy public policies and one that has the potential to help hold accountable for their actions those who create unhealthy public policies. This article identifies some of the issues that arise in considering the application of HIA to the operation of the International Monetary Fund (IMF), especially in the context of sub-Saharan Africa. The authors do this in the belief that the IMF's lending conditionalities and macroeconomic policies constitute an important social determinant of health. The recent report of the Commission on Social Determinants of Health has created helpful and timely policy space for the development of a health equity- and human rights-oriented accountability framework for the IMF.

IMF and World Bank economic policy in the 1980s and early 1990s took little account of how these policies would potentially impact poor people in Africa. Many health and education systems began to break down. And all of this came just as AIDS began to take its deadly toll.

—Commission for Africa, *Our Common Interest* (1, p. 23)

Under the pressure of an ascendant global package of market-oriented economic policies, including significant reduction in the role of the state and levels of public spending and investment, a different development model was pursued from the 1980s. That model has been the target of a great deal of deserved criticism. Structural adjustment programmes, following the Washington consensus, had—and continue to have, in other policy and programme forms—an overreliance on markets to solve social problems that proved damaging.

—World Health Organization, *Closing the Gap in a Generation* (2, p. 33)

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Health impact assessment (HIA)—which we define as the estimation of the effects of a specified action on the health of a defined population, and their distribution within that population—is not just an effective tool for promoting healthy public policies (3). It also has the potential to help hold accountable for their actions those who create unhealthy public policies. This article identifies some of the issues that arise in considering the application of HIA to the operation of the International Monetary Fund (IMF), especially in the context of sub-Saharan Africa. We do this in the belief that the IMF's lending conditionalities and macroeconomic policies constitute an important social determinant of health. Among major determinants of global health, we also include hierarchies of power with respect to control over the material means to life, access to knowledge, and societal regulation. As a crucial player in the regulation of finance, the IMF requires an accountability framework that includes health and health equity.

Public health commentators addressed the influence of the World Bank on health following publication of its health-focused *World Development Report* in 1993 (4) and the subsequent expansion of its role, eclipsing that of the World Health Organization (WHO). Criticism of the Washington Consensus (generally viewed as encompassing financial deregulation, trade liberalization, and mass privatization of public goods and services) employed by the World Bank and the IMF was followed by a rethinking of the development model by former Bank economists, notably Stiglitz and Stern. With the financial crisis currently engulfing the world, and with the global South most likely to suffer its damaging consequences, IMF policymakers do not have the 15 years of critique that their World Bank colleagues required to learn about the shortcomings of their model. The argument that follows is informed by the ideas of those who have worked on the ground in sub-Saharan Africa to develop conceptual frameworks to make sense of the operation of global determinants of health, and who have produced positive strategies for promoting health in the region (5, 6).

Further context for these reflections is provided by *Closing the Gap in a Generation*, the final report of the WHO-sponsored Commission on Social Determinants of Health (CSDH) (2). As Navarro states, the report is “profoundly apolitical” in that it fails to identify “the category of power (class power, as well as gender, race, and national power) and how power is produced and reproduced in political institutions” (7) as the source of the world's health inequities. What it does do, however, is draw attention to the need for a generic “upstream” attack on “the inequitable distribution of power, money and resources” (2, p. 2) if these inequities are ever to be effectively addressed—in the words of a subsequent WHO discussion document, “to shift [the emphasis] from risk factors to root causes” (8).

While its critics are quite correct in pointing to the weaknesses of *Closing the Gap in a Generation* in areas such as not “showing how the private sector and owners of capital have created and perpetuated much of the health inequity that exists in the world” (9), it is nonetheless true that its (more radical)

Knowledge Network reports (all available online), its text, and its recommendations do provide important legitimation and policy space for progressive action in the pursuit of health equity.

In the present context, we are particularly aware of the strong emphasis on what the report calls health equity impact assessment (HEIA) and, for example, of its recommendation to “institutionalize and strengthen technical capacities in health equity impact assessment of all international and national economic agreements” (2, p. 15). A subsequent WHO discussion document on making HEIA happen (10) emphasizes strengthening of the equity focus in HIA, building global capacity for undertaking HIA, and strengthening equity-focused policy development.

What needs to follow in the space created by these modest proposals is the development of HIA methods capable of engaging with root causes of global inequity, such as unequal power structures and decision-making processes; cross-border flows of health determinants of all types (human, pathogenic, trade, fiscal); and, of course, IMF lending conditionalities and macroeconomic policies. New HIA methods should similarly address more general political determinants of health such as ideology, social class, patriarchy, social institutions, and interest groups; and they should be piloted on important causes of global inequity such as climate change and the World Trade Organization’s policy framework.

HEALTH IMPACT ASSESSMENT IN AFRICA: INTEREST AND CAPACITY

In what follows, we point to two aspects of HIA in sub-Saharan Africa (hereafter, “Africa”)—namely, interest in HIA and questions regarding capacity; and we suggest that the capacity deficit leaves Africa open to problems in the application of HIA. We then turn to the question of the place of equity within HIA and argue that right-to-health concepts and processes should be put at the heart of HIA development.

In 2008, the Global Ministerial Forum on Research for Health, meeting in Bamako, Mali, made explicit its commitment to a social determinants of health explanatory perspective. This commitment was linked to the 2008 Libreville Declaration on Health and Environment in Africa, which identified priority actions including setting up centers for health and development that would develop and deploy an evidence base regarding economic and development processes and the promotion of health impact assessment (11).

In response, the WHO announced an HIA capacity-building package, acknowledging that the “development of natural resources, urban development, expansion of transport . . . change social determinants of health” and noting that “dramatic adverse impacts have been observed in Africa” (12). The WHO highlighted likely developments in Africa regarding water resource management, infrastructure, and the extractive industries. Underscoring the need for capacity development for HIA within Africa itself, in the light of those sectors identified by

the WHO and the role of China in those developments, Erlanger and colleagues (13) noted that HIA expertise resides in and has primarily been related to policy, programs, and projects in the global North. In our view, while assessment of the impact of these development processes represents a step forward, it is crucial to go further, in engaging with and scrutinizing the impact of the global financial framework itself.

Opening IMF policymaking to evidence-based scrutiny could be expected to attract resistance from interested stakeholders: “SDH [social determinants of health] interventions may be seen as potentially threatening the interests of national and transnational companies . . . [which] are inclined to fight government regulation and minimize the sums they must pay in taxes”(14). If evidence-based scrutiny through health impact assessment is accepted, the question arises as to how HIA is carried out and who controls it. In the global North, HIA is carried out largely under the auspices of statutory agencies at national, regional, and local levels. The CSDH’s Measurement and Evidence Knowledge Network points out that in some middle-income countries such as Brazil, academics and national ministries may lead in HIA, but that in low-income countries the lead is often taken by the WHO, the World Bank, bilateral agencies, or international nongovernmental organizations that “invest in programmes of their choice. Thus the development of evidence based guidance may depend on who is paying for implementation, and on what their priorities are. This may also affect equity”(15).

While some HIA practitioners have worked to build capacity for HIA in the global South, questions remain about how far practice has developed. Reviewing development projects (dams in Sarawak, cotton pesticides in Egypt, wastewater in Syria), Birley noted that he “was a contracted consultant who came, wrote a report, and left and as is commonplace with such consultants had no further contact with the client and did not know the outcome” (16).

More recently in his study of major international oil and gas projects in Venezuela, Mexico, Nigeria, Iran, and China, Birley stated that “under certain commercial conditions, consultancy companies derive their profit from *not* providing the service that has been contracted.” He attributed this to “scarcity of competence . . . lack of national or international regulation and the lack of an authoritative quality assurance process” (17).

HEALTH IMPACT ASSESSMENT, EQUITY, AND THE RIGHT TO HEALTH

It would be a mistake, however, to believe that all is right with the conduct of HIA in the global North. In the light of the Gothenburg consensus paper (18), we might expect that all HIAs included careful analysis of the impact of proposed policy on inequalities in health. This is not the case. A major review of 158 HIAs carried out in Europe between 1994 and 2005 (19) found that only 71 reported stratification of the population.

The CSDH recommendations include several proposals to promote health equity impact assessment. We agree with this and believe that the culturally appropriate way to do it is by constructing a method that includes right-to-health accountability mechanisms and processes (20).

In its 2000 Human Development Report (21), the United Nations Development Programme took the view that we need to develop an evidence-based way of holding nations to account. It argued that “statistical indicators . . . can be used as tools for making better policies . . . ; identifying unintended impacts of laws, policies and practices [and] identifying which actors are having an impact on the realization of rights.” This challenge was taken up by the newly established U.N. Special Rapporteur on the Right to Health, Paul Hunt, who developed right-to-health benchmarks and indicators that could be used in HIA (22). Hunt clarified the meaning of the right to health, indicating that social determinants of health were crucial, and engaged with globalization by showing that international law provided a basis for holding countries accountable for the impacts of their policymaking and regulatory decision-making across national borders. He broke new ground by emphasizing the importance of holding actors other than nation states to account by writing reports on poverty-reduction strategies agreed on between the World Bank and national governments, and on the World Trade Organization (23). In the momentum created by the generally favorable reception of the CSDH report, the HIA capacity-building efforts of the WHO and others, coupled with the related refocusing on the root causes of global health inequity, should build on Hunt’s example. The IMF is a clear candidate for early attention.

CONCLUSION

We believe (24) that the impact of global actors such as the IMF on the public and private sectors that shape the nature and distribution of health within and between nations needs to be made transparent. In order to implement the changes this requires, we propose the following actions:

- An accountability framework should be put in place that uses systematic HIA procedures and methods to assess the health impacts of the operations of the IMF.
- The accountability framework should incorporate right-to-health indicators and benchmarks into its HIA methodology. This would meet the requirement identified by the CSDH to ensure that HIA makes health equity integral to its processes.
- The accountability framework should be funded, commissioned, and carried out independent of the IMF.

Within such a framework, a major HIA capacity-building strategy will be required for sub-Saharan African stakeholders.

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