DEBATE

Healthy public policy in poor countries: tackling macro-economic policies

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SUMMARY
Large segments of the population in poor countries continue to suffer from a high level of unmet health needs, requiring macro-level, broad-based interventions. Healthy public policy, a key health promotion strategy, aims to put health on the agenda of policy makers across sectors and levels of government. Macro-economic policy in developing countries has thus far not adequately captured the attention of health promotion researchers. This paper argues that healthy public policy should not only be an objective in rich countries, but also in poor countries. This paper takes up this issue by reviewing the main macro-economic aid programs offered by international financial institutions as a response to economic crises and unmanageable debt burdens. Although health promotion researchers were largely absent during a key debate on structural adjustment programs and health during the 1980s and 1990s, the international macro-economic policy tool currently in play offers a new opportunity to participate in assessing these policies, ensuring new forms of macro-economic policy interventions do not simply reproduce patterns of (neoliberal) economics-dominated development policy.

Key words: healthy public policy; developing countries

INTRODUCTION
Healthy public policy, a key health promotion strategy, aims to put health on the agenda of policy makers across sectors and levels of government. Healthy public policies are equity-oriented, with explicit concerns for impacts on population health, promoted through intersectoral action and collaborative partnerships (WHO, 1988; Milio, 2001). The rationale is that such an upstream approach accounting for the socio-political context and the larger forces impacting on health will avoid the continuous lifesaving of individual-based approaches (McKinlay, 1993). Linking public policies with health is opening up important avenues of investigation for the creation of healthier populations, Evans and Stoddart (Evans and Stoddart, 2003) argued that ‘...research on the determinants of health will probably have to go beyond extending our knowledge of correlates and pathways and focus much more on identifying specific social and fiscal policies and demonstrating their impact (or lack of it) on health’ (p. 378). The need for macro-level, broad-based interventions is greatest among developing countries, where the burden of ill health is considerably higher than among industrialized nations. These countries struggle to alleviate poverty and promote economic development, while often attempting to meet policy conditions imposed by international donors.

Despite a strong commitment to producing health through public policy and promoting social justice (WHO, 1986, 1988), there is a relative lack of input from health promotion
researchers on debates of public policy and health in poor countries. This paper argues that healthy public policy should not only be an objective in rich countries. The paper begins with an overview of health needs in developing countries, demonstrating that in addition to carrying a disproportionately higher burden of the global burden of disease—and the bulk of communicable diseases—chronic illnesses are on the rise. Healthy public policies are then examined as an intervention for improving population health in poor countries focusing on macro-economic policy. The main macro-economic aid policies are reviewed and the links with population health are outlined. The paper concludes with a plea for greater involvement of health promotion researchers in contributing to economic policy debates in the global South.

HEALTH NEEDS IN DEVELOPING COUNTRIES

Improvements in global health indicators, such as rising life expectancy, have been heralded as a major twentieth century achievement (WHO, 2003). Excessive mortality and morbidity, however, remain in developing countries (Table 1). The epidemiological profile is complex because of a ‘double burden’ of disease. The first burden of communicable diseases continues to plague poor countries and remains the central cause of child mortality. Social inequalities, poor living conditions and malnutrition, compounded by anti-microbial resistance, continue to feed the traditional diseases of the poor, such as tuberculosis and malaria (Farmer, 1999). Emerging infectious diseases, which encompass relatively new diseases (e.g. HIV/AIDS) or previously existing diseases, have rapidly increased in incidence or specific locales (e.g. cholera in South America). HIV/AIDS has become the leading cause of death among adults (15–59 years) worldwide (WHO, 2003). In 2004, an estimated 40 million people across the globe were living with HIV (UNAIDS, 2004). Two-thirds of those affected live in sub-Saharan Africa, where in 2004, the prevalence rate for adults (15–49 years) was 7.4%. There is also growing concern for the interaction between HIV/AIDS and other infectious diseases, such as tuberculosis and malaria (WHO, 2004).

Developing countries are also secondarily burdened with considerable adult chronic disease. Chronic disease now accounts for >70% of the disease burden in middle-income countries and almost 50% in low-income countries (WHO, 2003). Risk factors for chronic diseases, such as the consumption of alcohol, tobacco and processed foods, are on the rise (WHO, 2002). This increase has been attributed to the global marketing of multinational corporations, trade and agricultural policies, urbanization and changes in living and working patterns. Smoking, the cause of considerable mortality, has been declining in industrialized countries, yet rising in poor countries (WHO, 2003). Smoking is not only a major risk factor for multiple chronic illnesses, but also for infectious diseases, such as tuberculosis (Yach, 2003). Developing countries, therefore, face not only the double burden of non-communicable and communicable diseases, but also interconnections between the two.

In addition to the vast unmet health needs, there is increasing evidence that important inequalities in health exist between the poor and the non-poor within countries. For example, in India, the poorest 20% of the population has more than double the mortality rates, malnutrition and fertility when compared with the richest 20% (Peters et al., 2002). The poor do not only suffer more from malnutrition and traditional ‘diseases of the poor’, but also have a greater prevalence of and risk for non-communicable diseases. Poor Indians have higher rates of hypertension and heart disease, as well as greater levels of use of alcohol and tobacco (Peters et al., 2002). In addition, other social inequalities, such as gender, also intersect with poverty. An immense task remains for

Table 1: Selected health indicators among low-, middle-, and high-income countries, 2001

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Income level</th>
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<tbody>
<tr>
<td>Life expectancy at birth (years)</td>
<td>Low</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>80</td>
</tr>
<tr>
<td>Incidence of tuberculosis (per 100 000)a</td>
<td>233</td>
</tr>
<tr>
<td>Prevalence of HIV among adults</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Data source: 2003 World Development Indicators, World Bank.
aData are for the year 2000.
devising public policies that will raise significant levels of population health, although reducing social inequalities.

HEALTHY PUBLIC POLICY IN DEVELOPING COUNTRIES

Addressing the unmet health needs in poor countries is challenging, requiring among other strategies, macro-level, broad-based interventions. Healthy public policies fall into this category, aiming to promote salutatory conditions by ensuring secure and sustainable livelihoods, lifestyles and environments (Milio, 2001). Government sectors at local and national levels (e.g. agriculture, trade, education and industry) should be accountable for the health consequences of their policy decisions (WHO, 1988). Healthy public policies have been promoted predominantly as a strategy for industrialized countries. This may be attributed to health promotion’s historical orientation as a uniquely Western approach, rooted in the Ottawa Charter and Canadian policy documents (Lalonde, 1974; Epp, 1986; WHO, 1986). It may also be attributed to the emergence of health promotion as a response to the ‘second epidemiologic revolution’, as the focus on prevention of communicable diseases shifted toward the increasing burden of non-communicable illnesses (Terris, 1992). Health promotion did not have the same appeal among developing countries that continued to face high mortality and infectious diseases. Moreover, the critique of health promotion as individual-centered and often victim-blaming approach was not particularly attractive in areas where poverty and poor living conditions remained widespread.

The tide, however, is turning. The New Public Health extends past individual lifestyle strategies, adopting broader social and political strategies, including a range of interconnecting factors such as investments in housing and quality education, sustainable environment, urban development and food security (Baum, 2002). Also health promotion has been increasingly reaching poorer countries. The regional editor of Africa for this journal stated (p. 87) ‘...while Africa made her entry into the world of health promotion belatedly, a firm foundation for further development is now in place’ (Nyamwaya, 2003). Conferences in Adelaide and Jakarta have put global health on the health promotion agenda; responsibilities for global health should be shared at national and international levels (WHO, 1988; Kickbusch and de Leeuw, 1999). The global increase in risk factors for chronic illnesses described earlier calls for urgent attention and has been flagged by some Southern researchers. A recent editorial in The Lancet describes the need for healthy public policy in Nigeria: ‘Developing healthy public policy is particularly pertinent in Nigeria where the recent drive for increased foreign investment by the Government has resulted in the commissioning in the past 2 years of a massive cigarette factory by British American Tobacco and a giant brewery by Heineken’ (Anyaa, 2005). We should continue to move toward filling research voids at the policy level, particularly with respect to macro-economic issues (Labonté, 1999), which will be the focus of the remainder of this paper.

MACRO-ECONOMIC POLICIES

Developing countries struggle between increasing their economic wealth while concomitantly alleviating poverty and reducing social and health deprivations. Governments in poor countries face serious challenges in developing appropriate public policies that serve the best interests of their citizens. Limited resources, particularly during times of macro-economic instability, have spurred many countries to seek financial support from International Financial Institutions (IFIs), such as the International Monetary Fund (IMF) and the World Bank. This type of support often increases the leverage that these external agencies have over national policy making and has important implications for the health of populations (Okuonzi and Macrae, 1995). By the 1990s, the World Bank had become a major player in the field of international health, both as donor and as policy advisor—a role crystallized by their influential 1993 World Bank report, Investing in Health, which set the stage for their approach to health policy (World Bank, 1993). The World Bank and other IFIs contributed to the rise of neoliberalism during the 1980s to mid-1990s (Thérien, 2002) and the promotion of market principles in health and social sectors (Laurell, 1991). Understanding these institutions and their programs is critical to understanding macro-economic policy in the global South. What follows is a brief overview of the major
macroeconomic aid programs to developing countries during the past 30 years (see also Table 2) and the links between the major programs and population health. This overview is divided into two sections. First, structural adjustment programs (SAPS) prominent during the 1980s and early 1990s are reviewed. Secondly, current initiatives in debt reduction and poverty alleviation are discussed.

**Structural adjustment programs**

Following the second oil crisis, many developing countries faced problems in the 1980s related to their balance of payments, stemming from a reduction in trade and capital (Stewart, 1989). To address the flailing economies and skyrocketing inflation rates, many countries required external support. In order to qualify for loans, several countries attempted SAPs, a package of economic policy interventions designed by the IMF and the World Bank. These policies aimed to solve structural macro-economic imbalances by first stabilizing the economy and then restoring short-to-medium growth through a variety of interventions including monetary, fiscal, institutional and regulatory actions. SAPs were designed to lead to liberalization, privatization and retrenchment of the state, thereby reducing inefficiencies and stimulating economic growth (Loxely, 1998).

SAPs can broadly be categorized into three different ‘generations’ (Cornia et al., 1992). The first generation of SAPs sets fiscal and monetary objectives, void of any social considerations, including the protection of vulnerable groups. Over time, this ‘first’ generation of SAPs was subsequently replaced by a ‘second’ generation that expanded to other sectors, including health, and education, and eventually ‘third’ generation policies, which mandated the integration of specific social and health objectives, such as the creation of protective mechanisms and social safety nets. Although IFIs modified the content of SAPs toward the inclusion of health and social considerations, the extent and success of these modifications are not clear. Critics argued that social considerations were implemented too late after adjustment, often used merely as a political strategy to appease communities in order to sustain SAPs and prevent popular uprisings (Schoepf et al., 2000).

Shortly following the implementation of first-generation SAPs, UNICEF noted deterioration of children’s nutrition and health (Cornia et al., 1987). Concerned that SAPs were a contributing factor, these authors called for ‘adjustment with a human face’ by urging social considerations, and supportive policies be incorporated into SAPs. UNICEF was critical in putting health on the agenda of SAPs and effectively launched what would be one of the most controversial and debated issues in public health: were SAPs anti-health policies?

Public health activists and researchers responded to a call to protect the health of communities, particularly poor and vulnerable populations such as children. An extensive literature examining the linkages between SAPs and population health emerged and the debate that ensued was often quite ideological in nature (Breman and Shelton, 2001). SAPs came under fire as it was alleged that these policies negatively affected population health through two avenues: dismantling public health-care systems and the deterioration of socio-economic conditions. Results of these studies, however, varied considerably in terms of results and interpretations. However, the most alarming

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**Table 2: Macro-economic aid policies**

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
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<tbody>
<tr>
<td>SAP</td>
<td>Loans offered by IFIs (especially the World Bank and IMF) during the 1980s and early 1990s to developing countries with specific conditions attached</td>
</tr>
<tr>
<td>HIPC</td>
<td>Introduced by the IMF and World Bank in 1996 to relieve a portion of debt among the poorest countries within a comprehensive framework for poverty reduction</td>
</tr>
<tr>
<td>PRSPs</td>
<td>Introduced by the IMF and World Bank in 1999 as operational documents outlining a country’s development priorities and objectives of and strategies for poverty reduction. PRSPs are required for receiving concessionary loans and debt relief among highly indebted countries (see below)</td>
</tr>
<tr>
<td>HIPC II</td>
<td>Enhanced HIPC introduced in 1999. To qualify for debt relief, the country must produce a PRSP by the decision point (a debt-sustaining analysis is conducted by the IMF and World Bank, which is used to decide on a country’s eligibility) and make progress on implementing the PRSP by the completion point (demonstrated a satisfactory track record)</td>
</tr>
<tr>
<td>MDRI</td>
<td>Proposed by the G8 in 2005 for the IMF, World Bank and African Development Fund to cancel 100% of debt among HIPC countries reaching completion point</td>
</tr>
</tbody>
</table>
picture emerged from Africa, where studies pointed toward overwhelming negative effects on health outcomes (Breman and Shelton, 2001). Moreover, the intended outcomes of economic stability and growth had not been achieved in Africa and the pressure of the HIV/AIDS epidemic on health-care systems was enormous (Poku, 2002). This underscored the need for more flexible interventions that consider the variability across contexts instead of simply applying a single blueprint.

Debt relief and the poverty reduction strategy papers

By the 1990s, not only had SAPs been heavily criticized by the international community, there was increasing concern about the unmanageable debt owed by these countries and the intensity of their debt servicing, that is, interest owed annually (George, 1992; Hertz, 2004). For example, Ethiopia—one of the world’s poorest countries—was using a whopping 45% of its export earnings on debt payments (Poku, 2002). To address these concerns, the IMF and the World Bank adopted a more flexible approach to debt relief and poverty reduction (Thérien, 2002). These institutions initiated the Highly Indebted Poor Countries (HIPCs) initiative in 1996, which aimed to reduce the external debt of the poorest countries within a broader poverty alleviation framework (Gupta et al., 2002). After a ‘laborious and disappointing start’ (Thérien, 2002), HIPC gained momentum. In 1999, an enhanced HIPC initiative (HIPC II) was expanded in order to ‘provide faster, deeper and broader debt relief and strengthen the links between debt relief, poverty reduction and social policies’ (IMF, 2006a). Debt relief and a greater focus on poverty reduction have been deemed necessary to achieving the Millennium Development Goals (Commission on Macroeconomics and Health, 2001). In addition, in June 2005, the G8 proposed the Multilateral Debt Relief Initiative in which the IMF, World Bank and the African Development Fund should cancel 100% of the external debt owed by the HIPC countries that reached the completion point of HIPC II (IMF, 2006b). As of September 2006, 29 countries were approved for debt relief packages and 11 more countries are eligible (IMF, 2006a).

In 1999, the IMF and the World Bank introduced Poverty Reduction Strategy Papers (PRSPs). PRSPs are operational documents outlining a country’s development priorities and objectives of and strategies for poverty reduction (World Bank, 2001). Unlike first-generation SAPs, PRSPs should be designed with explicit social objectives integrated with macro-economic goals. Moreover, PRSPs should be country driven and nationally owned, developed with participation of civil society (World Bank, 2001). The implementation of the PRSP is a condition for countries seeking concessional loans and to qualify for debt relief under the HIPC II initiative.

The influence of PRSPs on population health is not yet clear. The 2001 WHO Commission on Macro-economics and Health endorsed the new PRSP process, but others have raised concerns. The most alarming criticism is that PRSPs are just a mere regurgitation of SAPs (Bond and Dor, 2003; Verheul and Rowson, 2005). Assessments of 23 PRSPs found limited concerns about health, particularly for the poor (Laterveer et al., 2003). A review of 21 PRSPs by the WHO in 2004 found that health was approached from a narrow perspective. ‘The overwhelming emphasis is on public health sector interventions to reach health goals... and—beyond water and sanitation—very few examples of other sectors which include health activities or goals’ (p. 12). Another review of 10 countries implementing PRSPs found that the composition of teams included members of ministries such as finance, economic and planning, but excluded health and other social sectors (WHO, 2001). This review also suggested that the process was dominated by the IMF and World Bank members.

TOWARD HEALTHY MACRO-ECONOMIC POLICY IN POOR COUNTRIES

Thus far, health promotion proponents have been relatively silent on issues related to macro-economic issues in the global South. Health promotion advocates did not heavily weigh into the intense SAP health debate. One indicator of this, albeit a rough indication, is presented in Table 3. Articles on SAPs and health were published in journals from multiple disciplines, including medicine, economics, health services, social science and international development, but this trend did not extend to health promotion journals.
Despite increasing acknowledgement that macro-economic policies must also have a social basis, there is a tendency for an ‘adding on social policy approach’, which simply continues the trend of devising market-based macro-economic policies with social ‘afterthoughts’ instead of moving toward a ‘transformational approach’ mainstreaming social policy into macro-economic policies (Elson and Cagatay, 2000). Given that the early assessments of PRSPs have identified limitations that are also cornerstones of health promotion and the new public health—social participation, intersectoral action, a social determinants approach to health—health promotion proponents could contribute by ensuring that these new forms of macro-economic policy interventions do not simply reproduce patterns of (neoliberal) economics-dominated development policy. The healthy public policy approach spearheaded by health promotion advocates provides a promising avenue to guiding future macro-economic policy in developing countries. Driving public policies toward favorable health outcomes, particularly for the poor, requires participation from a wide range of researchers and must go beyond influencing national policy building.

ACKNOWLEDGEMENTS

This paper benefited from the comments of three anonymous referees. The author is also grateful for the encouragement and advice provided on earlier drafts by Slim Haddad, Louise Potvin and Lise Gauvin and participants in the Université de Montréal’s, Séminaire de vendredi, Équipe FCAR, Promotion en Santé.

REFERENCES


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Table 3: Number of articles on SAPs and health published in peer-reviewed journals

<table>
<thead>
<tr>
<th>Journal focus</th>
<th>Number of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>International development</td>
<td>9</td>
</tr>
<tr>
<td>Medicine/epidemiology</td>
<td>14</td>
</tr>
<tr>
<td>Health systems and services</td>
<td>5</td>
</tr>
<tr>
<td>Health and social sciences</td>
<td>11</td>
</tr>
<tr>
<td>Health promotion</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
</tr>
</tbody>
</table>

*On the basis of Breman and Shelton’s (Breman and Shelton, 2001) literature review, additional searches found no articles in health promotion journals.*
research and policy. *Social Science and Medicine, 36*, 109–117.


