C1 | AUSTERITY RERUN

The austerity decades (2010–2025)

Since 2010, governments around the world have been cutting public expenditure. By late 2021, austerity cuts are expected in 154 countries, and as many as 159 countries in 2022. The trend is expected to continue at least until 2025, with an average of 139 countries each year. Austerity is projected to affect 5.6 billion persons in 2021 or about 75% of the global population, rising to 6.6 billion or 85% of the world population in 2022. By 2025, 6.3 billion people or 78% of the total population may still be living under austerity. However, as we present later in this chapter, it does not need to be this way. There are policy alternatives.

Analysis of government public expenditure projections, based on data for 189 countries in the October 2020 World Economic Outlook database (International Monetary Fund 2020), shows that two major global crises led to periods of fiscal expansion, limited to one or two years, followed by long periods of socially painful austerity. This happened in 2008–2009, at the beginning of the global financial and economic crisis, and then in 2020 during the first waves of the COVID-19 pandemic. After these short periods of fiscal expansion, governments – advised by the International Monetary Fund (IMF), the G20,[1] and others – rapidly scaled back much-needed public support with adverse consequences for the majority of the population.

The high levels of expenditures needed to cope with the COVID-19 pandemic and the resulting socioeconomic crises have left governments with growing fiscal deficits and debt. However, rather than continuing to explore financing options to provide desperately needed support for people and the economy, since 2021 governments are entering into another period of fiscal austerity. Figure C1.1 shows the number of countries contracting public expenditure, calculated as a percentage of gross domestic product (GDP), from 2008 to 2025 (Ortiz and Cummins 2021). Contrary to public perception, austerity is not limited to European countries, but is more prevalent in developing countries.[2]

The post-pandemic shock appears to be much more intense than the one that followed the global financial and economic crisis. The average expenditure contraction in 2021 is projected at 3.3% of GDP, which is nearly double the size of the previous crisis, and 1.7% of GDP in 2022. Even more worrisome is the commonplace use of excessive budget contraction, defined as spending less than the (already low) pre-pandemic levels. When looking at real changes, more than 40 governments are forecasted to have budgets that are, on average, 12% smaller in 2021–2022 than in 2018–2019, including countries with high

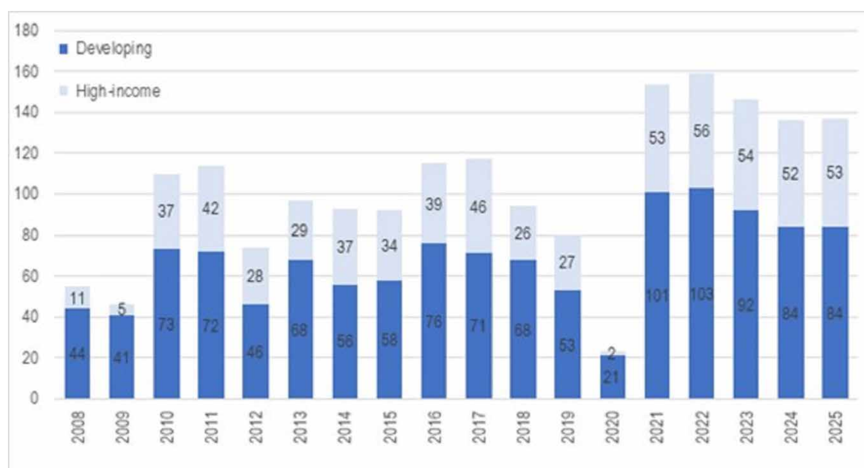

Figure C1.1 Number of developing and high-income countries contracting public expenditure, expressed as a percentage of GDP, 2008–2025.
Source: Ortiz and Cummins (2021), based on IMF (2020).

developmental needs such as Ecuador, Equatorial Guinea, Kiribati, Liberia, Libya, Republic of Congo, South Sudan, Yemen, Zambia, and Zimbabwe.

The fiscal choices made by most governments over the decade of 2008 to 2019 were alarming. Nearly $10 trillion were allocated to the financial sector, and $2.4 trillion was used for fiscal stimulus plans, while just $0.24 trillion was provided in official development assistance (ODA) to developing countries. Another $0.75 trillion – more than triple the amount of ODA – was assigned to the IMF to support/influence developing countries (IMF 2010c; Ortiz and Cummins 2019). While trillions were given to bail out the financial sector, the costs of adjustment were thrust upon populations in many countries in 2010–2019.

The IMF's advice underwent a major change in 2010, supported by the Organization for Economic Cooperation and Development (OECD) and the G20, that influenced policies in many countries. Two IMF Board papers called for large-scale fiscal adjustment "when the recovery is securely underway" and for structural reforms in public finance to be initiated immediately "even in countries where the recovery is not yet securely underway" (IMF 2010a; 2010b). Reforms of universal pension and health entitlements were called for, accompanied by minimal safety nets for the poorest, also known as rationalizing and narrow-targeting welfare, often using the euphemism "strengthened safety nets" (IMF 2010a, 15–32). On the composition of fiscal adjustment, it was advised that most of it could come from: (a) unwinding the previously adopted fiscal stimulus packages; (b) reforming pension and health entitlements to reduce the long-term financial obligations of the state by way of avoiding "a rise in spending as a share of GDP" (IMF 2010a, 16); (c) containing other spending, by means

such as eliminating subsidies; and (d) increasing tax revenues, often focused on regressive consumption taxes or value-added tax (VAT). The Fund's austerity agenda soon became mainstream policy advice in a number of international organizations and a majority of countries, thrusting the costs of adjustment on populations (see Chapter D4).

A review of 779 IMF country reports between February 2010 and August 2019 showed that six main policies were considered to consolidate budgets, and two measures to boost revenues (Ortiz et al. 2015; Ortiz and Cummins 2019). These measures are also being advised at country level after 2020:

1. **Wage bill cuts or caps** in 130 countries, reducing or freezing the salaries and number of public sector workers who provide essential services to the population, including education, health, and social workers. These cuts or caps adversely impact public service delivery.
2. **Reducing subsidies** (fuel, food, agriculture) in another 130 countries, despite periods of high food and energy prices. When basic subsidies are withdrawn, food and transport costs increase and can become unaffordable for households. Higher energy prices also tend to contract employment-generating economic activities.
3. **Rationalizing and narrow-targeting welfare ("safety nets")** in 107 countries, often by revising eligibility criteria and targeting the poorest, rather than appealing to options consistent with the Sustainable Development Goals (SDG) agenda, such as financing universal social protection systems. In most developing countries, the middle classes have low incomes, and targeting the poor while excluding them increases their vulnerability.
4. **Pension and social security reforms** in 105 countries, cutting benefits and eroding public systems. Reforms include raising contribution rates, increasing eligibility periods, prolonging the retirement age and/or lowering benefits, and structural reforms moving towards private systems, despite the failure of pension privatization in earlier decades (Box C1.1). As a result, future pensioners will receive lower benefits.
5. **Labor flexibilization reforms** in 89 countries, such as revising minimum wages downward, limiting salary adjustments, decentralizing collective bargaining, and increasing the ability of enterprises to fire employees. In a context of economic slow-down, such measures encourage labor market "precarization" and depress workers' incomes (see Chapter C2).
6. **Reforming healthcare systems** in 56 countries, including raising fees and co-payments for patients as well as introducing cost-saving measures in public healthcare centers. These measures risk excluding populations from receiving critical assistance at a time when it is needed most.
7. **Increasing consumption taxes or VAT** on basic goods and services in 138 countries to increase revenues. This regressive policy generates inequality and may further contract economic activity.

8. **Privatizations** in 59 countries and strengthening public–private partnerships (PPPs) in 60 countries. Privatization proceeds produce short-term budget gains but long-term losses given the lack of future revenues. Additional privatization risks include layoffs, tariff increases, and unaffordable and/or low-quality basic goods and services (see Chapter B3). PPPs are promoted as a solution for countries under fiscal constraints, however PPPs have a much larger cost to the public budget. Citizens end up paying more than if services were publicly provided, as private companies add profits, and have much larger transaction costs as well as higher costs; private operators tend to charge higher prices to users.

Box C1.1: The failure of pension privatization reforms

From 1981 to 2014, 30 countries privatized fully or partially their public mandatory pensions. Fourteen countries were in Latin America, another 14 countries in Eastern Europe and the former Soviet Union, and two in Africa. It must be noted that this is a very small number of countries (only 30 of 192 countries in the world). Most of the privatizations were supported by the World Bank, IMF, OECD, US Agency for International Development (USAID), and Asian or Inter-American Development Banks, against the advice of the International Labor Organization (ILO). As of 2018, 18 countries have reversed pension privatization fully or partially: Venezuela (2000), Ecuador (2002), Nicaragua (2005), Bulgaria (2007), Argentina (2008), Slovakia (2008), Estonia, Latvia and Lithuania (2009), Bolivia (2009), Hungary (2010), Croatia and Macedonia (2011), Poland (2011), the Russian Federation (2012), Kazakhstan (2013), the Czech Republic (2016), and Romania (2017). The reasons why governments reversed pension privatizations are:

- Coverage rates stagnated or decreased
- Pension benefits deteriorated significantly
- Poverty, gender, and income inequality increased
- Expensive: high transition costs created large fiscal pressures
- High administrative costs
- Financial market and demographic risks transferred to individuals
- Weak governance: capture of regulation and supervision functions
- Social dialogue deteriorated
- Concentration of the private insurance industry
- Limited effect on capital markets in developing countries
- Ultimately, the financial sector benefitted from people's pension savings

Sources: ILO 2017; Ortiz et al. 2018.

Austerity had a detrimental impact on populations. Inequalities grew, and millions were pushed into poverty, with women particularly affected (UN-WOMEN 2015). In some European countries, citizens challenged these policies and courts declared austerity cuts unlawful and unconstitutional, such as Portugal (2013), Latvia (2010), and Romania (2010), and benefits had to be restored (ILO 2014a and 2017, OHCHR 2013). However, as shown in Figure C1.1, the majority of affected countries were developing countries where no legal action was taken. The United Nations (UN) (2016a and 2019) and the Center for Social and Economic Rights (CESR) (2018) argue that, according to standards of international law, both states and international financial institutions (IFIs) may be held responsible for complicity in the imposition of economic reforms that violate human rights.

The health impacts of austerity

We organize the mechanisms linking austerity with health into (1) direct effects, (2) indirect effects, and (3) effects on social determinants.

1. Direct effects

Austerity led to reductions in public health spending, impacting the volume and quality of healthcare services (Reeves et al. 2014; Stubbs and Kentikelenis 2018). Empirical studies assessing the effect of declining health spending found a significant and detrimental relationship with infant mortality, under-five mortality, and several other health outcomes (Thomson et al. 2017). In Eurozone countries, where austerity was either unilaterally implemented or imposed by IFIs, government spending cuts translated into shrinking numbers of healthcare personnel, hospital bed reductions and closures of facilities, reduced opening hours, and increased waiting times for medical procedures, all of which worsened healthcare access (Kentikelenis et al. 2014; UN 2016b). The introduction or increase of user fees and co-payments for medicines in several countries (e.g., Czech Republic, France, Italy, Netherlands, and Romania), and more stringent eligibility criteria for subsidized health services (e.g., Greece), meant vulnerable populations such as migrants were unable to access necessary care (Maresso et al. 2015). One study estimated that between 2010 and 2012, amid a new round of austerity, unmet medical needs increased across the European Union by 1.23% points each year (Reeves et al. 2015).

In developing countries, it was typically the IMF that advised governments to undertake austerity either as part of its regular surveillance missions or when countries sign up to its structural adjustment programs to borrow money. While the IMF claims to protect social spending in these programs, independent research has challenged the veracity of these claims (e.g., Kentikelenis et al. 2016; Stubbs and Kentikelenis 2018). For example, a study of West African countries found that, on average, each binding IMF policy reform reduced government health expenditure per capita by 0.25% (Stubbs et al. 2017), primarily driven by

budget deficit targets that reduced investment in health and limited expansion of doctors and nurses. These measures lowered the accessibility and affordability of healthcare and increased neonatal mortality (Forster et al. 2019b).

Adjustment measures also sought to enhance the role of the private sector and non-governmental organizations (NGOs) in healthcare provision. When coupled with rollbacks in expenditures, government health provision was outsourced to NGOs, often less equipped to provide comprehensive health services of sufficient quality (Kentikelenis and Shriwise 2016; Pfeiffer and Chapman 2019). Sometimes this was linked to health system decentralization – transference of fiscal and operational responsibilities to the sub-national level. In principle, decentralization can make health systems more responsive to local needs; but in practice it contributed to inadequate health system coordination and budget execution problems, since local authorities lacked technical capacities or diverted funds to alternative uses (Stubbs et al. 2017). It also impaired responses to nationwide disease outbreak, as occurred during the West African Ebola epidemic (Kentikelenis et al. 2015).

2. Indirect effects

Privatization of state-owned enterprise and natural resources – in addition to interventions in health systems described above – resulted in losses to reliable public revenue sources used as fiscal foundations for effective health systems (King et al. 2009); and where state-owned enterprises provided health coverage to employees, these benefits were withdrawn and former employees lost access to healthcare (Stuckler, King, and McKee 2009). While regressive consumption taxes were introduced or increased to raise budget revenues and counterbalance shortfalls, these measures did not increase overall tax revenues; they merely altered the tax structure: more revenues from consumption taxes, less from trade taxes (Reinsberg, Stubbs, and Kentikelenis 2020). By shedding qualified civil servants, austerity prescriptions also undermined the administrative ability of governments to deliver effective services (Reinsberg et al. 2019a), such as public health and pandemic preparedness and response. Moreover, privatizations and public sector layoffs and wage cuts increased corruption, as civil servants tried to supplement diminishing incomes (Reinsberg, Kentikelenis, and Stubbs 2019; Reinsberg et al. 2020).

3. Effects on social determinants

Austerity measures had a profound impact on a complex web of macro-level factors that affect population health. First, they are linked to an erosion of labor rights, dwindling incomes, increases in unemployment, higher poverty head-counts and poverty gaps, and greater income inequality (Kentikelenis et al. 2014; Reinsberg et al. 2019b; Rickard and Caraway 2019; Stubbs et al. 2021b). In the past decade, public sector salary freezes and restrictions on hiring were introduced in Cyprus, Greece, Ireland, Portugal, and Tunisia, amongst others.

These layoffs led to declines in unionization (since unions are more prevalent in the public sector), expansions in the informal sector, and increased poverty and inequality (Forster et al. 2019a; Martin and Brady 2007). In the United Kingdom, there was a mass rise in referrals to food banks, especially in local authorities that suffered the greatest cuts in spending on local services and welfare benefits (Loopstra et al. 2015). Lack of gainful employment is linked to alcoholism and suicide (Stuckler, King, and McKee 2009), and is a root cause of health problems over the life course.

Second, austerity measures affect educational outcomes, impacting social mobility opportunities and people's knowledge about healthcare. Resources for an effective education sector – infrastructure and a well-trained workforce – were cut in some countries during austerity rounds, eroding the quality of educational provision. A study of developing countries between 1990 to 2014 found the education sector was not protected from austerity and documented IMF reforms that explicitly targeted reductions to teachers' payroll and employment cuts (Stubbs et al. 2020).

Third, austerity increased rights abuses by weakening governments' abilities to enforce civil rights (Stubbs and Kentikelenis 2017). The protection of civil rights requires government expenditures for properly trained and adequately compensated judges, police, and military and for institutions to monitor the activities of enforcement entities. One study showed austerity is linked to deteriorating levels of respect for women's rights because it undermines government ability and willingness to protect such rights (Detraz and Peksen 2016). Hardships caused by austerity also resulted in increased social unrest, in some instances leading to violent repression by the ruling government. Studies demonstrate a significant rise of world protests since governments adopted austerity policies in 2010 (Ortiz et al. 2013; 2021) (Box C1.2). Other research shows that austerity increases incidents of conflict (Hartzell et al. 2010; Casper 2017), resulting in injuries and casualties, destruction of health facilities, and collapse of health systems.

Fourth, austerity eroded social cohesion and trust, a vital requirement for governments to mount a successful pandemic response (Kentikelenis 2017). These psychosocial effects are linked to a range of negative health outcomes. For example, privatizations and labor flexibilization increased stress, resulting in adverse mental health consequences and increases in alcoholism and suicide (Antonakakis and Collins 2015; Stuckler, King, and McKee 2009). Further, austerity and the resulting distrust in governments fueled the rise of the radical right (Evans and McBride 2017).

How austerity created the conditions for inequitable pandemic outcomes

The health effects of the pandemic vary by public policy responses between countries which imposed austerity and those which opted to maintain public spending and social protection programs. As McKee and Stuckler (2020)

Box C1.2: Anti-austerity protests

In recent years, the world has been shaken by protests. From the Arab Spring to the "Indignados" (outraged), from Occupy to food riots, there have been periods in history when people rebelled about the way things were, demanding change, such as in 1848, 1917, or 1968; today we are experiencing another period of rising outrage and discontent.

An analysis of 2,809 protests occurring between 2006 and 2020 in 101 countries covering over 93% of world population shows there was a major increase in protests beginning in 2010 with the adoption of austerity measures in all world regions. Not only is the number of protests increasing but also the number of protesters. Crowd estimates suggest that 52 events had one million or more protesters; some of those may well be the largest protests in history (e.g., 250 million in India in 2020 and 17 million in Egypt in 2013). The main grievances are:

- Anti-austerity and economic justice: About 1,500 protests (below).
- Failure of political representation and political systems. Over 1,500 protests on lack of real democracy; corporate influence; corruption; failure to receive justice from the legal system; transparency and accountability; surveillance of citizens; and anti-war/military.
- Civil rights: Over 1,360 protests on issues such as ethnic/indigenous/racial rights; women's rights; right to freedom of assembly/speech/press; religious issues; rights of lesbian/gay/bisexual/transgendered people (LGBT); immigrants' rights; and prisoners' rights. It must be noted that a small number of protests focus on denying rights to specific groups (e.g., radical right anti-immigrants, anti-gay).

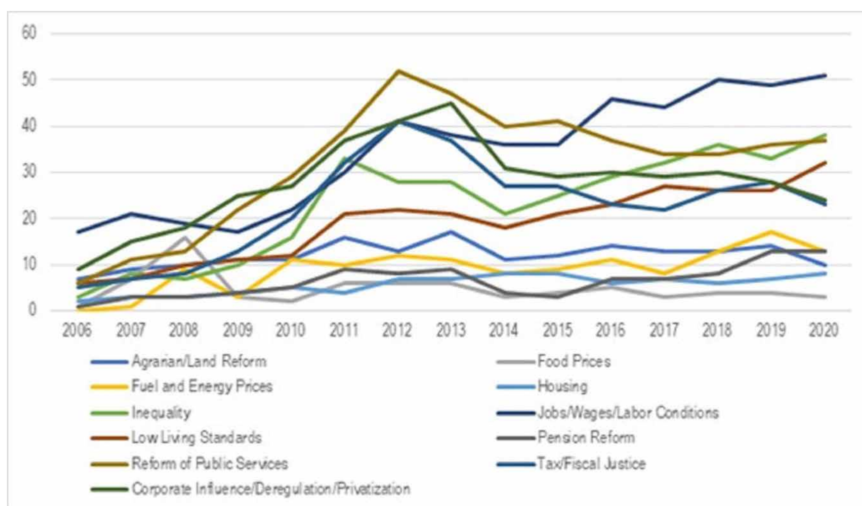

Figure C1.2 Anti-austerity protests in 101 countries, 2006–2020 (in number of protests/year).
Source: Ortiz et al. forthcoming.

- Global justice: About 900 protests were against the IMF and other IFIs, for environmental justice and the global commons, and against imperialism, free trade, and the G20.

Regarding anti-austerity protests, the most prevalent cause is the reform of public services. Citizens march against full and partial privatization, rationalization of services, cost-recovery measures, and other reforms that reduce the quality and quantity of public services in areas such as health, education, and water, among others (e.g., Australia, Chile, Egypt, France, Russia, Turkey). Low living standards and inequalities are issues raised in most protests (e.g., Angola, Iran, Lebanon, Philippines, Tunisia, United States). Related protests are workers' demand for jobs and decent wages (e.g., Argentina, Bangladesh, China, India, Indonesia, Jordan, Mexico, South Africa, South Korea), against budget cuts (e.g., Canada, Greece, Ireland, Italy, Sudan, Spain, United Kingdom), pension reforms (e.g., Chile, France, Greece, Latvia, Portugal, Ukraine), protesting evictions and demanding affordable housing (e.g., Ireland, Spain, United Kingdom, United States), the removal of subsidies (Ecuador, Kyrgyzstan, Mozambique, Nigeria, Peru, Uganda), and rising prices of goods and services (e.g., Brazil, Burkina Faso, Egypt, Ethiopia, Haiti, India, Nicaragua, Niger, Romania, South Africa, Tunisia).

Sources: Ortiz et al. 2013 and 2021 (forthcoming).

articulate, "an outbreak that requires social distancing and quarantine is likely to develop very differently in a setting in which there is a workforce with access to universal health coverage and social protection, than in one in which employment is casual and people must choose whether to go to work when ill or starve" (640).

Years of austerity have starved health systems and social protection programs of resources, creating a context in which many countries were wholly unprepared for the COVID-19 pandemic (see Chapter B3). This has exacerbated pre-existing inequalities, as vulnerable populations face the dual challenge of retrenched public services – on which they are more reliant – and economic crises. Within advanced countries, inequalities in COVID-19 prevalence and mortality rates have been documented between more and less affluent neighborhoods, and higher and lower socioeconomic groups. For example, COVID-19 infection is seven times higher in the most deprived areas of Spain's Catalonia region compared to the least deprived; in England and Wales, black, Asian, and minority ethnic groups account for 34.5% of critically ill COVID-19 patients despite only 14% of the

population from such backgrounds; and in Chicago COVID-19 mortality rates for black residents was 34.8 per 100,000, compared to 8.2 for white residents (Bambra et al. 2020).

Developing countries have also been deeply affected by the pandemic, where the funding gap for COVID-19 responses remains vast (Stubbs et al. 2021a). In the face of reductions in tourism, capital inflows, and remittances, an estimated 150 million additional people will have fallen into extreme poverty in 2021 (World Bank 2020). The weak state of public health systems – overburdened, underfunded, and understaffed from the previous decade of austerity – has left countries prone to healthcare failures and total breakdown in healthcare services, with catastrophic effects for poorer populations. For example, in debt-distressed Ecuador, fiscal austerity measures endorsed by the IMF led to a fall of 64% in public investment in the health sector in the last two years, including expenditures vital for a pandemic response, such as construction of hospitals and purchase of medical equipment, and 3,680 public health workers were laid off in 2019 (Badillo and Fischer 2020). The country's handling of the COVID-19 crisis has been especially poor; and it is the country's marginalized populations – Indigenous peoples, women, elderly, informal workers, and households of the lowest-income quintiles – that have been disproportionately affected by the pandemic, as they are more dependent on public services (Corkery et al. 2020).

Despite health systems being strained to the breaking point during the pandemic, in the world's poorest countries investment in public health has been – and continues to be – limited because governments are prioritizing debt repayments to private creditors over providing basic care for the population (Jubilee Debt Campaign 2020).

The threat of austerity 2020 onwards

In 2020, there was an initial respite from austerity as the pandemic forced governments into emergency health expenditures to build intensive care units, procure ventilators, drugs, masks, and COVID-19 tests, as well as temporary socioeconomic expenditures – e.g., social protection, income/food support, subsidies to utilities and care services, furlough schemes, support to enterprises, loan guarantees, tax deferrals – to facilitate compliance with lockdowns and economic recovery.

The unexpected expenditures to cope with the pandemic have resulted in significantly increased debt and fiscal deficits. Figure C1.1 above demonstrates how the post-pandemic shock appears to be even more premature and severe than the one that followed the global financial crisis. Current projections indicate that 154 countries will be contracting expenditure by an average 3.3% of GDP in 2021, which will increase to 159 countries in 2022, and the trend continues at least up to 2025. The incidence and depth of fiscal austerity varies across regions. Europe and Central Asia have the highest proportion of countries contracting expenditure in 2021 (46 out of 49 countries, or 94%). All other

regions are close behind, ranging between 73% and 80% of countries affected. This includes the Middle East and North Africa (16 out of 20 countries or 80%), sub-Saharan Africa (37 out of 47 countries, or 79%), Latin American and the Caribbean (25 out of 33 countries, or 76%), South Asia (6 out of 8 countries, or 75%), and East Asia and the Pacific (22 out of 30 countries, or 73%) (Ortiz and Cummins 2021). A new general allocation of $650 billion Special Drawing Rights (SDRs) by the IMF in 2021 was welcome, but new lending may still come with strings attached, requiring governments to implement austerity policies. At a time when many countries are experiencing third and fourth waves of COVID-19 surges, vaccine rollouts are extremely uneven, lockdowns are resurfacing, economic recessions are being prolonged, job losses are growing, and record poverty numbers continue being shattered. Prioritizing fiscal adjustment is simply irrational.

Other analyses of IMF staff reports for 80 primarily developing countries show that 72 countries are projected to begin a process of fiscal consolidation in 2021 in order to free-up resources to stabilize debt levels and meet debt service (Eurodad 2020; Oxfam 2020). The austerity cuts in these 80 developing countries will place an increasing burden on vulnerable populations. Revenues will be increased through regressive consumption taxes for two-thirds of countries for which data is available, and over half the countries will be left below pre-pandemic government expenditure levels. Fourteen countries, including Tunisia which had just 13 doctors per 10,000 people when COVID-19 struck, are expected to freeze or cut public sector wages and jobs, which could mean lower quality of healthcare and fewer nurses, doctors, and community workers in countries already short of healthcare staff (Oxfam 2020), with such cuts in the past often leading to skilled health worker outmigration.

For its part, the World Bank continues to support private sector solutions by focusing on PPPs, despite that these have resulted in adverse global health outcomes (Eurodad 2018) (Box C1.3). Studies estimate that it earmarked 60% of the $14bn of the Fast-Track COVID-19 Facility through its private sector arm, rather than using it to strengthen public health systems (Dimakou et al. 2020).

Box C1.3: The failure of hospital PPPs: the cases of Lesotho and Sweden

Lesotho's Queen Mamohato Memorial Hospital: This PPP contract was signed in 2008 to build a national hospital to replace an old one and upgrade the network of urban clinics. The World Bank assured that the PPP would bring vast improvements at the same annual cost as the old hospital and was promoted as a flagship model for Africa's health systems. However, a 2014 report by Oxfam and the Lesotho Consumer Protection Association denounced that the real cost of the PPP was 51% of the total health budget

of Lesotho, or over three times the cost of running the old hospital. A 2017 UNICEF-World Bank public expenditure review showed that the annual cost had only minimally declined and still consumed more than one-third of the total health budget. According to Lesotho's Deputy Prime Minister Monyane Moleleki, "the Queen Mamohato Memorial Hospital is bleeding government coffers" (People's Health Movement et al. 2017, 88).

Sweden's Nya Karolinska Solna (NKS) Hospital: This PPP contract was signed in 2010 to build and manage the new NKS hospital, which was planned to open in 2015. The European Commission advised to opt for a PPP model based on certainties around efficient delivery on time, cost-savings and value for money. However, at the end of 2018, the hospital was significantly delayed and faced massive cost overruns, which led to a public investigation. Today, the NKS holds the renowned status of being the most expensive hospital in the world (for a fuller discussion of the politics leading to PPPs, see *Global Health Watch 5* Chapter B5).

Sources: Ortiz and Cummins 2019; EURODAD 2018; Romero 2015; PSI 2015.

No more austerity: financing alternatives for health and social protection

Austerity measures are being used as a Trojan horse to reduce government intervention, under the assumption that universal public health and other development policies are not affordable or that government expenditure cuts are inevitable. This is simply not true. There are alternatives, even in the poorest countries. There is a wide variety of options to expand fiscal space and generate financing resources, supported in policy statements of the UN and IFIs (see for instance, ILO, UNICEF, and UNWOMEN in Ortiz et al. 2017).

1. **Increasing tax revenues:** This is the principal channel for generating resources, achieved by altering different types of tax rates – e.g., on consumption, corporate profits, financial activities, property, imports/exports, natural resources – or by strengthening the efficiency of tax collection methods and compliance. Many countries are increasing taxes for social investments, not only on consumption, which is generally regressive and counter to social progress, but also on other areas. For example, Bolivia, Mongolia, and Zambia are financing universal pensions, child benefits, and other schemes from mining and gas taxes; Ghana, Liberia, and the Maldives introduced taxes on tourism to support social programs; and Brazil introduced a tax on financial transactions to expand social protection coverage. Wealth taxes are also being proposed in many countries to cope with the COVID-19 pandemic; even

the IMF supports that high earners and companies that prospered in the coronavirus crisis should pay additional tax to show solidarity with those who were hit hardest by the pandemic.[3]

2. **For social protection, expanding social security coverage and contributory revenues:** Increasing coverage and therefore collection of social insurance contributions is a reliable way to finance social protection, freeing fiscal space for other social expenditures. Social protection benefits linked to employment-based contributions also encourage formalization of the informal economy. A remarkable example can be found in Uruguay's Monotax.[4] Argentina, Brazil, Tunisia, and many other countries have demonstrated the possibility of broadening both coverage and contributions by formalizing and protecting workers in the informal economy.
3. **Borrowing or restructuring existing debt:** This involves active exploration of domestic and foreign borrowing options at low cost, including concessional, following careful assessment of debt sustainability. For example, South Africa issued municipal bonds to finance basic services and urban infrastructure. For countries under high debt distress, restructuring existing debt may be possible and justifiable if the legitimacy of the debt is questionable and/or the opportunity cost in terms of worsening deprivations of the population is high. In recent years, more than 60 countries have successfully renegotiated debts, and more than 20 have defaulted/repudiated public debt, such as Ecuador, Iceland, and Iraq, directing debt servicing savings to social programs.
4. **Eliminating illicit financial flows:** Estimated at more than ten times the size of all ODA received, a titanic number of resources illegally escapes developing countries each year. To date, little progress has been achieved, but policymakers should devote greater attention to cracking down on money laundering, bribery, tax evasion, trade mispricing and other financial crimes that are both illegal and deprive governments of revenues needed for social and economic development.
5. **Reallocating public expenditures:** This is the most orthodox approach, which includes assessing ongoing budget allocations through Public Expenditure Reviews (PERs) and other types of thematic budget analyses, replacing high-cost, low-impact investments with those with larger socioeconomic impacts, eliminating spending inefficiencies, and/or tackling corruption. For example, Egypt created an Economic Justice Unit in the Ministry of Finance to review expenditure priorities, while Costa Rica and Thailand shifted military spending to finance universal health services.
6. **Using fiscal and central bank foreign exchange reserves:** This includes drawing down fiscal savings and other state revenues stored in special funds, such as sovereign wealth funds, and/or using excess foreign exchange reserves in the central bank for domestic and regional development. Chile, Norway, and Venezuela, among others, are tapping into fiscal reserves for social investments.

7. **Lobbying for aid and transfers:** This requires either engaging with different donor governments or international organizations to ramp up North–South or South–South transfers. Despite being much smaller than traditional volumes of ODA, bilateral and regional South–South transfers can also support social investments and warrant attention.
8. **Adopting a more accommodating macroeconomic framework:** This entails allowing for higher budget deficit paths and/or higher levels of inflation without jeopardizing macroeconomic stability. A significant number of developing countries have used deficit spending and more accommodative macroeconomic frameworks during the global recession to attend to pressing demands at a time of low growth and to support socioeconomic recovery.

Many governments around the world have been applying these options for decades, showing a wide variety of revenue choices as well as creativity to address critical investment gaps. Each country is unique, and all options should be carefully examined, including the potential risks and trade-offs, and considered in national social dialogue. National tripartite dialogue, with government, employers, and workers as well as civil society, academics, Parliaments, United Nations agencies, and others, is fundamental to generate political will to exploit all possible fiscal space options in a country and to adopt the optimal mix of public policies for inclusive growth and social justice. Given the importance of public investments for human rights and inclusive development, it is imperative that governments explore all possible alternatives to expand fiscal space to finance national investments in decent work, improved health, and the fuller realization of human rights.

Notes

1 "G20" refers to the Group of 20 wealthier nations in the world: Argentina, Australia, Brazil, Canada, China, France, Germany, India, Indonesia, Italy, Japan, Republic of Korea, Mexico, Russia, Saudi Arabia, South Africa, Turkey, the United Kingdom, the United States, and the European Union. See https://www.dfat.gov.au/trade/organisations/g20.

2 The categorization of countries by income levels is based on World Bank fiscal year 2021 and does not imply endorsement; it is used to indicate that austerity is not solely a matter for higher income countries.

3 See "IMF Proposes 'Solidarity' Tax on Pandemic Winners and Wealthy," *Financial Times*, April 7, 2021. https://www.ft.com/content/5dad2390-8a32-4908-8c96-6d23cd037c38.

4 Monotax is a simplified tax collection/payment scheme for Uruguayan small contributors. People covered by the Monotax regime are entitled to the same social security benefits as salaried workers (ILO 2014b).

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