Debt and Health

People living in poor countries around the world suffer from a scandalous and dangerous shortage of healthcare. Life expectancy for many is less than 50 years – in some less than 40 – while life expectancy in many rich countries is around 80 years.

Meanwhile, the rich world claims billions of dollars in debt payments from these countries, often for loans that should not have been given in the first place, putting the realisation of decent health services still further out of reach.

The ongoing debt crisis has a severe impact on the provision of – and access to – healthcare in poor countries. Studies in countries such as Kenya and the Philippines have shown that an increase in public health expenditure saves lives. But it is impossible for developing country governments to invest in decent public health services when they have to use up valuable resources to service their debts. In addition, conditions they have to satisfy to qualify for international debt relief often force further cuts in government spending on healthcare. These conditions also weaken the role of the state in providing healthcare by pushing privatisation and deregulation of the private sector, which can make it harder for poor countries to monitor and ensure the most effective healthcare provision. Healthy people are the basis of a productive economy. Debt relief can provide crucial funding for public healthcare that enables poor people to escape the downward spiral of poverty and disease.

The debt crisis has its origins in the 1970s and 1980s, when rich governments, banks and companies made huge loans to governments in developing countries. Many of these loans served their own political or commercial ends and were often made to weak or corrupt regimes. Even where reasonable loans were made, rocketing interest rates and plummeting commodity prices contributed to the ballooning debt burden. Whilst

Jubilee Debt Campaign's Debt and... briefings, produced with different partners, explore the impact of debt on people’s lives. They argue that ‘unpayable’ debts, which a country cannot afford whilst meeting basic human needs, and ‘illegitimate’ debts, which arose from unfair or irresponsible lending, should be cancelled.

A hospital ward in Malawi. Debt cancellation has allowed Malawi to make long overdue investments in public services like health.

“There will never be sustainable human development if the debt is not cancelled... Our people are dying because of debt, because we do not have the money for hospitals and drugs.”
Jack Jones Zulu, Jubilee Zambia
Triple challenge remains for Zambia

Life expectancy in Zambia is 42 years. Three quarters of the 11.5 million population live below the $1 per day poverty line and do not have reasonable access to safe drinking water. Almost half the population is undernourished and 17% of people have AIDS. Exacerbating this situation is a failing public healthcare system, with only 1 doctor for every 6,300 Zambians. All of this was made much worse by damaging conditions attached to loans from the International Monetary Fund, which forced Zambia to impose fees for healthcare, cut health staff and reduce the salaries of those who remained.

In 2005 a breakthrough came for the Zambian people when $2.4 billion of debt relief was finally granted. This enabled the Zambian government to scrap rural health fees in 2006. Because of debt relief, the Zambian government now has the means to prevent many illnesses and vastly improve the wellbeing of its poorest citizens.

However, Zambia still faces challenges. For example, the debt relief obtained in 2005 is being threatened by ‘vulture funds’ – private funds that buy up poor countries’ debt at a severely reduced price and then claim for the full amount, plus interest and penalties. Zambia has lost one such claim already, and is shelling out some $15 million to a vulture fund. This is threatening Zambia’s ability to pay for rural healthcare costs. There must be international action to prevent such exploitation of debt relief by vulture funds.

Zambia also faces a significant shortage of healthcare workers, as many of the trained and qualified people that are underpaid and overworked leave for other countries in the region such as South Africa and Botswana, or move beyond the continent. The wealthier countries to which these skilled people migrate should at least reimburse Zambia for the cost of training them.

there have been major steps forward in cancelling debt in response to campaigner pressure, the rich world has still not taken full responsibility for these debts and the ensuing debt crisis. The result is that debt still drains impoverished countries of resources that should be spent on healthcare and other vital public services.

In critical condition?

The health systems of many developing countries are in crisis. A shortage of staff, medicines, equipment, clinics, outposts, and hospitals – above all a shortage of funds – is leaving millions of people without the basic medical services that could save their lives.

UNICEF estimates that almost 10 million children under the age of five die each year from preventable diseases, whilst 1,400 women die in pregnancy or childbirth every day.

The debt crisis plays a role in fuelling this health crisis. Many of the least developed countries spend more servicing external debts than on their total health budget. As resources are diverted to paying off rich world creditors, less money is available for healthcare and other essential services. For instance, the chart on the back page shows government spending on health compared to government spending on debt. Countries like the Philippines, Peru, and Ecuador are not even eligible for multilateral debt relief.

The international financial institutions have long encouraged countries to prioritise debt payments over paying for services. As the debt crisis became more severe from the 1970s and 1980s onwards, the International Monetary Fund (IMF) began telling impoverished countries to cut back on public spending in order to keep servicing debts: many were encouraged to start charging user fees for health services – which simply meant that the poorest people gave up using them – and these policies continue today in many countries.

Eventually, the rich world did acknowledge the need for some limited debt cancellation. But the strings attached to debt relief and new loans limit countries’ investment in crucial health systems. Over many years, poor and indebted countries were told to cut back public spending in order to get any debt relief. In particular, they were often told to freeze public wage bills – which meant stopping pay increases and recruitment of already underpaid and overworked doctors, nurses and other health staff. The international financial institutions are so convinced of the need to cut public spending that they often insist on this even when other donors are willing to make more funding available.

Fact:

Sub-Saharan Africa has 25% of the world’s disease burden, but only 1.3% of the trained health workforce; altogether it paid out more than $23 billion in debt payments in 2005.
Maria, 7, is happy after a successful operation in Ecuador. Many more such operations could be funded through debt cancellation.

Rich country donors also often prefer to give to so-called ‘vertical’ funds, tackling a specific disease for example. This can do some good, and is certainly more eye-catching politically, but it can also mean money being diverted to tackle one particular medical problem, rather than the health needs of the population as a whole. What poor communities need most is a comprehensive health system, which addresses the range of health problems they face. This is where debt cancellation can be so effective, as unlike other kinds of finance – the resources made available can be used directly for core budget support, such as paying doctors’ and nurses’ salaries.

Unhealthy staff levels

Health systems rely absolutely on having well-trained, well-supported and motivated staff. But the siphoning off of resources to service debts, and the conditions attached to debt relief, mean that, in severely indebted developing countries, a tiny number of healthcare workers are expected to work in extremely challenging conditions, mostly without enough pay to support themselves. Meanwhile, more affluent neighbouring countries and, in particular, donor countries that claim to want to support health systems, lure health staff abroad to work for higher salaries. Of the 489 graduates of the Ghana Medical School between 1986 and 1995, 61% have left Ghana: more than half of those who left came to the UK, and one third to the US. During this period, donors were taking more than just doctors: Ghana was also paying out around $350 million a year on debt service.

“Sick people are not going to produce anything.”
Alfredo Palacio, President of Ecuador 2005-2007

Global health watchdogs agree that there should be a minimum of one doctor to every 26,000 people, and half the population has no access to healthcare. The Philippines’ constitution prioritises its external debt payments of $12 billion a year over other expenditure.

Ecuador fights back

Ecuador’s total external debt was $16.9 billion in 2004. The country paid an astonishing $3.7 billion in external debt payments that year, and public spending on debt service was more than six times as much as public spending on healthcare. Even though 16% of the population lives on less than 1$ per day, Ecuador is not eligible for the international debt relief scheme. The World Bank considers Ecuador’s debt to be ‘sustainable’, because its debt to GDP ratio in 2006 was relatively low. However, the debt servicing to government revenue ratio, which according to UN standards should not be higher than 13%, was at a very high 38% in 2006. This shows the true burden of Ecuador’s external debt and why the country cannot pay for poverty reduction programmes.

When Ecuador laid a new oil pipe in 2003, the IMF demanded that 80% of the revenues go to repaying external debt; the other 20% was to go to an external oil fund to be used if oil prices dropped or if they had other major pressures on their government spending. Instead, the country decided to allocate 10% of new oil proceeds to funding healthcare and education. In 2005 the IMF and World Bank cancelled a loan to Ecuador because too much of their oil revenues were funding public education and healthcare initiatives, and not enough was going to paying back creditors in rich countries. In response, Ecuador expelled the World Bank representative.

The newly elected President Rafael Correa is taking a tough stance on external debt, launching a massive investigation to identify which debts are illegitimate and should not be repaid by the country, for example if they were lent for projects that have been useless or have had a negative social and environmental impact. Freed up funds have already enabled some 600 new health workers to be employed in order to immediately improve the quality of health services for those members of the population who are most in need.
Burundi, Chad, Malawi, Mozambique, Niger, Sierra Leone, and Tanzania all had less than 4 physicians for every 100,000 people in 2004.

Hope for recovery?

Once countries get debt cancellation, it does make a difference. A study of the impact of debt relief on 10 African countries showed that their health budgets increased overall by 70% in just four years. Debt cancellation has, for instance, paid for:

- the abolition of user fees for healthcare in rural Zambia, and the recruitment of 800 new healthcare staff;
- a free childhood immunisation programme in Mozambique;
- staff for rural clinics, and implementation of HIV and AIDS and anti-malarial programmes in Benin;
- paying for healthcare staff in Honduras.

A prescription

Jubilee Debt Campaign, Health Unlimited and Oxfam are calling for urgent debt cancellation, to help deal with developing countries’ health crises. In particular, we urge that:

- Rich countries, institutions and commercial creditors must cancel all illegitimate and unpayable debts being claimed from all poor countries, not just those countries eligible for the international debt relief scheme known as the Heavily Indebted Poor Countries (HIPC) initiative.
- Creditors should recognise debtor governments’ accountability to their own citizens, and not impose economic policies on poor countries through conditions on debt relief or loans. This includes conditions limiting public spending or specifying how healthcare should be delivered.
- Southern governments must abide by the demands of their citizens that funds from debt cancellation be used to improve essential public services, including comprehensive primary healthcare, and the governments must be open and accountable to their people over the use and monitoring of these funds.


Produced by Jubilee Debt Campaign in association with:

Health Unlimited

Oxfam

Expected health spending compared

Source: UNDP Human Development Report 2004

Take action:

You can make a difference by urging the UK government to do its part to end the debt crisis and support the provision of healthcare for all. Visit these websites for the latest information and campaign actions:

www.jubileedebtcampaign.org.uk
www.healthunlimited.org
www.oxfam.org.uk

About us:

Jubilee Debt Campaign is part of an international movement working to alleviate extreme poverty through the cancellation of unjust and unpayable poor country debts. It is a UK coalition of about 200 national organisations and local groups, supported by thousands of individuals.

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