

Does the IMF Constrain Health Spending in Poor Countries?*

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The effect of International Monetary Fund (IMF) programs on health spending is controversial. Critics argue that the programs, which set out macroeconomic policies that a country has agreed with the IMF, unduly constrain health spending because they include policies (such as targets for the fiscal deficit and how it is financed) that unnecessarily restrict government spending. Critics also maintain that ceilings placed on total government wage payments in many IMF programs have unnecessarily disrupted much-needed expansions of the health workforce. The IMF responds that governments are responsible for choices on expenditure priorities and that the Fund does not set targets for spending or wages in particular sectors.

This brief reviews the findings of the Center for Global Development's Working Group on IMF Programs and Health Spending, convened in Fall 2006 to investigate these issues and make practical recommendations for improvements. The group focused on the interaction between IMF-supported macroeconomic policies and government health spending, drawing upon background analyses and detailed case studies of Mozambique, Rwanda, and Zambia. The group reached several broad conclusions:

- IMF-supported fiscal programs have often been too conservative or risk-averse. Despite some increased flexibility in recent years, they have often unduly narrowed the policy space by failing to investigate sufficiently more ambitious, but still potentially feasible, options for higher government spending and aid.
- The IMF Board and management have not made sufficiently clear what is expected of IMF staff in exploring the macroeconomic consequences of alternative aid scenarios. As a result, the IMF risks sending confused signals to donors and recipient governments.
- Wage bill ceilings have been overused in IMF programs and should be limited to the (probably rare) circumstances where a loss of control over payrolls threatens macroeconomic stability. IMF programs have not imposed specific constraints on hiring or wages in the health (or education) sector, but IMF efforts to protect these sectors from the effects of aggregate ceilings cannot be enforced in practice.
- A striking disconnect exists between macroeconomic and health sector policy-making. Key fiscal decisions are taken with little understanding of potential consequences for the health sector and health ministries typically cannot make an effective case for increased budgetary priority. Donors have often added to the fragmentation of budgetary processes. Addressing these capacity gaps will require considerable external support, but governments must take the lead.

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IMF influences on health spending are indirect but potentially significant

In its country work, the IMF has two main functions: (i) advising countries on the consequences and feasibility of macroeconomic policies such as the size of fiscal deficits and overall public spending; and (ii) providing signals to the international community, including donors, on whether a country's proposed strategy is sustainable. The IMF has no mandate at all on health sector issues. It is governments that make the decisions on what share of their resources to spend on health and on policies that will determine how effectively those resources are used.

In fact, those government decisions often do not match the political rhetoric given to the importance of health, especially for the poor. For example, in most African countries the share of total government spending devoted to health has not increased as much as promised by political leaders (who undertook in the 2001 Abuja declaration to increase the share of total government spending going to health to 15 percent). Within the health sector, planning and budget implementation need to improve to ensure resources reach frontline providers and that those providers have adequate incentives for effective delivery of services, including access by the poor. Higher spending on health is critical, since most health systems are funded at levels well below what is necessary to deliver a basic package of health interventions, but the right policies are needed to ensure that more money translates into better health. These are issues on which the IMF has little to say, given its role as a macroeconomic risk advisor; in particular, it does not have the mandate or competence to say how much additional resources health systems can use effectively.

However, IMF activities often have important indirect effects on the health sector, especially in countries that enter into specific agreements ("programs") with the IMF on their macroeconomic policies. Most countries that are highly dependent on donor support have had many IMF programs, which are a frequent requirement for access to many other types of financing (such as debt relief). Although IMF programs do not set conditions directly on the health sector, many health interventions are especially sensitive to fiscal policies, such as the overall level of public spending. Even temporary interruptions to funding can be devastating for health because of the importance of ensuring continuity in services and drug supply for HIV/AIDS, tuberculosis and other major diseases. In countries with weak budgetary processes, the burden of short-term expenditure cuts has often fallen disproportionately on health spending. For example, health got much less than its originally budgeted share in Zambia during the 1990s, when severe financing difficulties led to the introduction of monthly cash budgets. In addition, the nature of much health spending—such as the large share spent on wages and the complexity of training and

recruitment—makes good forward-looking budgetary planning, based on predictable resource levels, crucial.

A big problem facing both the IMF and its critics is that our knowledge is limited about some key economic relationships that determine how macroeconomic policies will influence growth and poverty outcomes. For example, we often do not know how public spending (in the health sector and elsewhere) will affect future economic capacity and competitiveness in a particular country. Also, it is hard to predict how private investment might respond to lower fiscal deficits. So humility is required when pronouncing on the appropriate macro framework. In practice, policy choices must be made under considerable uncertainty and must balance the costs of different types of potential mistakes—such as threats to macroeconomic stability versus foregone expenditure opportunities. How these risks are balanced should be different than a decade ago because the macroeconomic situation—in Africa and elsewhere—is significantly better. Furthermore, even if all these economic relationships were well understood, many fiscal policy decisions—especially for the health sector—involve fundamental social choices that should be left to national political processes. The IMF job is to help countries explore the consequences of feasible policy options to clarify the tradeoffs involved.

So a key question is whether the IMF has unduly narrowed the range of feasible policy options that should be left to domestic political processes.

What has happened to government health spending? Moderate increases but still well short of supporting an effective basic health system

After declining in the mid-1990s, average government health spending has risen moderately, both as a share of GDP and as a share of total government spending, since the late 1990s. These recent increases were only sufficient to restore average health spending to its previous shares (i.e., an average of about 2½ percent of GDP and 7½ percent of total government spending in 2003). However, the data in many countries is poor and these numbers do not capture the recent substantial increase in donor-financed spending on specific disease-based initiatives, especially HIV/AIDS, much of which is channeled outside the government budget. For example, total spending by Zambia's Ministry of Health in 2005, including donor financing for health going through the national budget, was US\$141 million. In contrast, the total amount budgeted for Zambia under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program in FY 2005 was US\$130 million (although not all has yet been disbursed).

Measured in dollars per head, average government health spending in the group of countries eligible for the IMF Poverty Reduction and Growth Facility (PRGF) rose from \$10 in 1998 to \$15 in 2005 (at market exchange rates). Most countries, though, still spend much less than the levels estimated as the minimum necessary for effective delivery of a basic public health system (e.g., around \$40 per person, in current prices).

Fiscal content of IMF programs: Too little exploration of more ambitious but still feasible spending options, despite some recent moderate flexibility

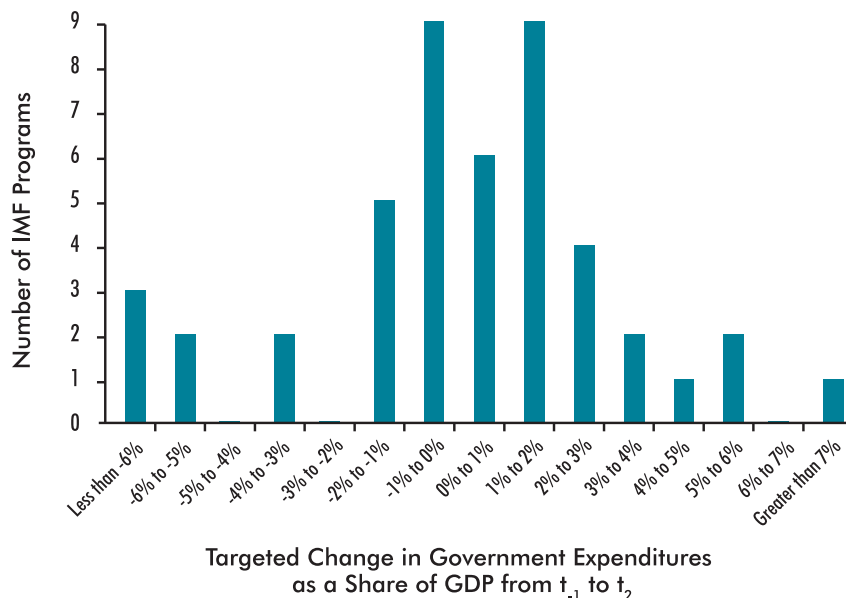
Fiscal policies in IMF programs have not taken sufficiently into account the significant improvement in macroeconomic conditions (reflected in, for example, lower debt, lower inflation and higher external reserves) in most low-income countries, including in Africa. Consequently, the programs have often been too conservative or risk averse for present conditions. In particular, the IMF has not done enough to explore more expansionary, but still feasible, options for higher public spending.

The problem is not that the IMF is pursuing a “one size fits all” approach, imposing the same squeezes on deficits and

spending in all countries. In fact, IMF programs vary considerably in the size of targeted changes in fiscal deficits and public spending (see Chart 1). Moreover, reflecting better macroeconomic starting conditions, recent programs target, on average, small *increases* in fiscal deficits and overall spending, compared with the cuts targeted in earlier programs. For example, programs negotiated during 2003-2006 started out with an average fiscal deficit (after grants) of about 3 percent of GDP and average total government spending of about 23 percent of GDP. These programs targeted expansions in the first year of about $\frac{1}{2}$ -1 percent of GDP. In contrast, programs negotiated during 2000-2002 started out with an average deficit of over 5 percent and targeted reductions of about 1 percent in the first year and much larger reductions in subsequent years, mainly on the spending side.

Despite this shift toward moderate fiscal expansion, both a recent study of IMF programs in Africa by the IMF Independent Evaluation Office (IEO) and the detailed country case studies for the Working Group found that the IMF has tended to favor additional domestic debt reduction or external reserve increases over additional public spending. The IEO study found that, across all programs in Africa, each additional dollar of expected aid was associated with a targeted fiscal expansion (i.e.,

Chart 1. IMF Program Targets for Changes in Government Spending for PRGF Programs



additional spending) of only 27 cents. Only when external reserves were quite high (above 2½ months of imports) and domestic macroeconomic conditions highly stable—represented in the IEO study by inflation under 5 percent—did programs aim to channel the bulk of additional aid to higher spending.

While the IMF is right to take account of the level of reserves and domestic macroeconomic conditions when designing fiscal policies and how aid will be used, the degree to which these factors influenced the fiscal strategy seems too conservative. A wider range of paths for the fiscal deficit and spending is now possible, following debt relief and with the prospect of higher aid, but there was often little analysis—at least in publicly available IMF documents—of the rationale underlying the specific path chosen for the fiscal deficit and overall government spending. For example, the 2004 Mozambique program, starting from a position where domestic financing of the deficit was already zero and domestic debt was only 5 percent of GDP, targeted further domestic debt reduction. The goal was to reduce domestic interest rates and thereby encourage (“crowd in” as economists refer to it) higher private investment. But empirical evidence across low-income countries indicates that such effects can vary substantially and cannot just be assumed. More generally, IMF staff point to the frequent lack of sector-specific analysis—from the World Bank or elsewhere—on the likely effects of additional spending, including for health, as a major obstacle to exploring broader fiscal options. While this lack of information is an undoubted problem, it implies that the IMF should either be more humble in its pronouncements about the appropriate fiscal strategy or be more pro-active in encouraging collective solutions. In Rwanda, for example, a 2003 donor-sponsored effort to explore alternative expenditure options was a missed opportunity to broaden the debate over fiscal strategy.

The Working Group also investigated how IMF programs responded when aid was higher or lower than expected. Many programs required that higher-than-expected aid be saved and that expenditures be cut if aid fell short of projections. Such an asymmetric approach gives little weight to the costs of temporary disruptions to spending which, as noted, can be especially high for health. The approach is no longer justified in the majority of low-income countries so a change in the way IMF programs are designed, to allow a greater cushioning of expenditures from short-term shocks, is needed. The case studies suggest that the IMF is moving in this direction, albeit gradually. Of course, cushioning against shocks in bad times is only possible if reserves are built up in good times, but this does not mean that all increases in aid have to be treated as temporary and saved.

The IMF and aid projections: Unclear expectations create a risk of confused signals

With some commendable recent exceptions, the IMF has not explored in any depth the macroeconomic consequences of scenarios for scaling up aid. In some earlier programs in the case study countries, IMF aid projections were oriented around goals of reducing aid dependency (e.g., Mozambique) or avoiding borrowing even on concessional terms (e.g., Rwanda), without any convincing macroeconomic arguments for the approach taken. The IMF programs did eventually adapt when substantially higher aid was forthcoming, but it is not possible to say whether the initial negative signals discouraged any aid.

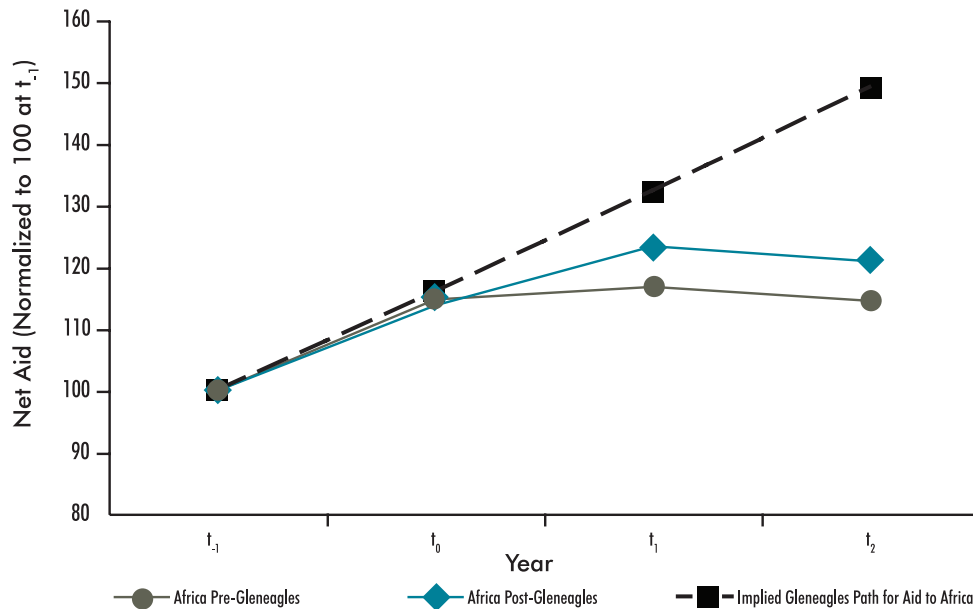
The IMF approach seems to be slowly changing: in the last couple of years, in-depth analyses of alternative scenarios for “scaling up” aid have been undertaken in several countries (e.g., Ethiopia, Madagascar, Zambia and, very recently, Mozambique and Rwanda). However, what is expected of IMF staff by the IMF Board and management is still not clear, and much seems to depend on the initiative of individual mission chiefs. The Working Group was told that it is now the policy of the IMF African Department to undertake such an analysis whenever it is requested by the authorities and sufficient information on likely expenditure plans is available. At the time of the report, however, that revised approach had not been reflected in any general policy statement by the IMF.

This lack of clarity has two consequences. First, the IMF has not done as much as it could to help countries (and donors) explore the macroeconomic consequences of higher aid. Second, it risks sending confused signals to donors. If only conservative scenarios are presented, does this mean the IMF thinks more resources cannot usefully be absorbed from a macroeconomic perspective or only that the IMF does not think more resources will be forthcoming?

In fact, projections of aid to Africa in IMF programs remain conservative—reflecting skepticism by IMF staff, which may well be justified, on donors’ resolve to deliver on their commitments to double aid by 2010 (see Chart 2). Of the 27 IMF programs and reviews in sub-Saharan Africa that were completed in the 18 months after the Gleneagles Summit, projections in only two were as optimistic as the Gleneagles commitments.

Targets for inflation

Most recent IMF programs with low-income countries have targeted inflation at very low levels (i.e., 5 percent or lower),

Chart 2. IMF Net Aid Projections to Africa***Notes:**

* Weighted by initial levels of aid

largely reflecting the fact that inflation was already low or membership in currency unions linked to the Euro or dollar. Available empirical evidence does not justify pushing inflation down to these levels in low-income countries. The IMF should not be unduly risk-averse by ruling out more expansionary aid-financed fiscal options just because they may put some upward pressure on prices.

However, a large monetary expansion is not the answer to the growth problems of low-income countries. Such an expansion would be unlikely to yield sustained higher growth, because expectations of higher inflation would adapt quickly.

IMF program negotiations: Too narrow a circle weakens political support

The narrow circle of national discussions on IMF programs had two adverse consequences. First, an overly narrow debate aggravated the lack of integration between sector-level policies (i.e., choices on the level and composition of expenditures and what was needed to improve their effectiveness) and the overall macroeconomic framework. Second, it weakened political support for chosen policies. In the case studies, it was striking how some decisions

affecting the health sector were incorrectly attributed, including by some government officials, to the IMF program. This “blame the IMF” attribution of policy choices is unhealthy because it undermines what should be a robust domestic debate about priorities.

The IMF alone cannot broaden the dialogue—that ultimately depends on the government—but it could do more to discuss and publish the rationale for its proposals and to encourage more analysis and discussion of various options. A shift toward greater emphasis on providing inputs into a broader policy dialogue would require important changes in the IMF way of doing business. This should include downplaying the Fund’s role as a negotiator of short-term macroeconomic conditions in countries that have already established a reasonable degree of macroeconomic stability.

Wage bill ceilings have been overused in IMF programs and should be restricted to very specific circumstances

Conditions related to the wage bill have been included in many IMF programs with low-income countries. For example, 17 out of the 42 countries with PRGF-supported

programs during 2003-2005 included a ceiling that limited total government spending on wages, although the number of cases has begun to decline. The ceilings were only used in Africa and in a few Central American/Caribbean countries. The Working Group concluded that such ceilings have been overused. They were useful as a temporary device when a loss of control over payrolls threatened macroeconomic stability (e.g., Zambia 2003-2004), but such situations will probably be rare. In practice, ceilings were used in many other situations, including efforts to influence long-term resource allocation choices (i.e., how much to spend on wages compared to other categories of spending) that the IMF is not well-suited to pronounce upon.

IMF programs have not imposed specific constraints on hiring or wages in the health sector. Indeed, programs with ceilings on the overall government wage bill usually tried to allow for new hiring in priority social sectors, including health, under the overall ceiling. However, there was often no way to enforce such protection or even to monitor in a timely manner what actually happened. Consequently, if space under the ceilings was used up by hiring in sectors with more political influence, employment in health could be constrained.

Although IMF conditions on the wage bill should be greatly reduced, governments will still face huge long-term challenges in their efforts to address their large health workforce needs within likely resource availability. Evidence from the case studies suggests that countries often have no clear strategy to match incentives to the most urgent needs for the supply and distribution of skilled staff. In some cases where long-term human resource plans have been developed (e.g., Zambia), the targeted staff increases are large but have not been integrated with medium-term expenditure planning. Consequently, they provide only limited guidance to priority-setting in annual budget discussions.

Strengthened national budgetary and planning processes are needed to reduce the disconnect between fiscal and health sector policies

While the main focus of the Working Group was on identifying changes in the IMF approach that can improve the framework for choices on health spending, the IMF role—for good or ill—will always be an indirect and secondary one. Some critical changes can only be made by national governments, ideally supported by donors. The group's investigation highlighted a striking disconnect between overall fiscal and budgetary policies and health sector issues.

Fixing this disconnect will require actions by many stakeholders, not just the IMF. First, a huge analytical and information gap exists: macro-policy decisions are often made with little

understanding of the likely effects for the health sector, including the potential costs in disease burdens and lives lost. Similarly, discussions on health policy are often not guided by a clear idea of overall budget constraints. In Mozambique and Zambia, for example, a frequent complaint was that, in setting annual budgets, budgetary policymakers often lacked a clear idea of what additional health interventions (let alone outcomes) would be achieved with additional funding. Consequently, allocation decisions relied on somewhat arbitrary rules of thumb. Second, national planning and budgeting capacities—including those of ministries of health—are seldom strong enough to make meaningful choices on tradeoffs. Addressing these analytical and capacity gaps will require additional external technical support. In the IMF, the issue is usually discussed in terms of stronger IMF-World Bank collaboration, but it is much broader than that because the relevant external expertise often lies with bilateral donors or other multilateral institutions. Strengthened frameworks are needed for identifying who does what and by when in order to help governments, with feedback on accountability. Third, donors have contributed to the segmentation of budgetary processes. In particular, extensive off-budget activities weaken national priority-setting.

Lessons

The Group's main recommendations are directed at the IMF, but the report also has important messages for national governments, development partners, and civil society.

SIX RECOMMENDATIONS FOR THE IMF

The IMF needs to adapt its approach in low-income countries to its expected role and be crystal clear about what that role is. The recommendations assume that the IMF will remain as a key macroeconomic policy and risk advisor in these countries, although an alternative division of labor, involving a reduced role for the IMF, is clearly possible. To implement the six specific changes summarized below and discussed in more detail in the main report will require action by the IMF Board and Management. Alternatively, the Board could make clear that the IMF role in post-stabilization low-income countries will be more limited and scale back its involvement and policy pronouncements accordingly.

1. The IMF should help countries explore a broader range of feasible options for the fiscal deficit and public spending. This requires less emphasis on negotiating short-term program conditionality and a greater focus on helping countries strengthen their understanding of the consequences of different options.
2. The IMF Board and Management should adopt and make public clearer guidelines on what is expected of IMF staff

in analyzing the consequences of alternative aid paths and on what should drive IMF signals about aid levels

3. While it is not the IMF's job to decide what aid levels should be, it should do more to promote fuller and more timely information about expectations for aid in its programs
4. Wage bill ceilings should be dropped from IMF programs except in cases where a loss of budgetary control over payrolls threatens macroeconomic stability.
5. IMF programs should give greater emphasis to short-term expenditure smoothing, especially when macroeconomic instability is no longer a significant threat.
6. The IMF should be more transparent and pro-active in discussing the rationale for its policy advice and the assumptions underlying its programs.

LESSONS FOR OTHER STAKEHOLDERS

Many of the lessons for other stakeholders focus on the need to build better connections between the health sector and overall budgetary processes.

- *National priority-setting processes need to be sharpened. In particular, the capacity of ministries of health to undertake*

budgetary planning should be strengthened, with external support, to enable them to produce concrete operational plans that will make a good case for additional budgetary resources. The role of Parliaments in the priority-setting process also needs to be enhanced.

- *Donors should avoid adding to the fragmentation of budgetary processes and the national dialogue over policy priorities. They should improve the predictability of their aid and make longer-term commitments in order to promote more effective planning and implementation of health spending.*
- *Bilateral donors, the World Bank, and other multilateral institutions should be more proactive in providing timely sector-specific analysis, including on the likely benefits of additional spending. In the health sector, they should be more pro-active in giving empirically-based advice on how to translate increased resources into more effective interventions. This should include more concrete advice on how to reform wage structures and incentive systems for countries' health sectors.*
- *Civil society organizations involved in budgetary and health advocacy issues should give greater attention to monitoring and influencing the setting and implementation of annual budgets.*

Further Reading

- de Renzio, Paolo, and David Goldsbrough. 2007. "IMF Programs and Health Spending: Case Study of Mozambique." Background Paper to the Working Group on IMF Programs and Health Expenditures. Overseas Development Institute, London, Oxford University, Oxford, and the Center for Global Development, Washington, D.C.
- Goldsbrough, David and Caesar Cheelo. 2007. "IMF Programs and Health Spending: Case Study of Zambia." Background Paper to the Working Group on IMF Programs and Health Expenditures. Center for Global Development, Washington, D.C. and University of Zambia, Lusaka.
- Goldsbrough, David and Ben Elberger. 2007. "What Have IMF Programs With Low-Income Countries Assumed About Aid Flows?" Working Paper 116 and Background Paper to the Working Group on IMF Programs and Health Expenditures. Center for Global Development, Washington, D.C.
- Goldsbrough, David, Ehui Adovor, and Ben Elberger. 2007. What Has Happened to Health Spending and Fiscal Flexibility in Low-income Countries with IMF Programs? Background Paper to the Working Group on IMF Programs and Health Expenditures. Center for Global Development, Washington, D.C.
- Goldsbrough, Tom Leeming, and Karin Christiansen. 2007. "IMF Programs and Health Spending: Case Study of Rwanda." Background Paper to the Working Group on IMF Programs and Health Expenditures. Overseas Development Institute, London and the Center for Global Development, Washington, D.C.
- Lewis, Maureen. 2005. "Addressing the Challenge of HIV/AIDS: Macroeconomic, Fiscal, and Institutional Issues." Working Paper 58. Center for Global Development, Washington, D.C.

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