Debate on the International Monetary Fund

AN EVALUATION OF THE INTERNATIONAL MONETARY FUND'S CLAIMS ABOUT PUBLIC HEALTH

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The International Monetary Fund's recent claims concerning its impact on public health are evaluated against available data. First, the IMF claims that health spending either does not change or increases with IMF-supported programs, but there is substantial evidence to the contrary. Second, the IMF claims to have relaxed strict spending requirements in response to the 2008–9 financial crisis, but there is no evidence supporting this claim, and some limited evidence from the Center for Economic Policy Research contradicting it. Third, the IMF states that wage ceilings on public health are no longer part of its explicit conditionalities to poor countries, as governments can choose how to achieve public spending targets; but in practice, ministers are left with few viable alternatives than to reduce health budgets to achieve specific IMF-mandated targets, so the result effectively preserves former policy. Fourth, the IMF's claim that it has increased aid to poor countries also seems to be contradicted by its policies of diverting aid to reserves, as well as evidence that a very small fraction of the Fund's new lending in response to the financial crisis has reached poor countries. Finally, the IMF's claim that it follows public health standards in tobacco control contrasts with its existing policies, which fail to follow the guidelines recommended by the World Bank and World Health Organization. The authors recommend that the IMF (1) become more transparent in its policies, practices, and data to allow improved independent evaluations of its impact on public health (including Health Impact Assessment) and (2) review considerable public health evidence indicating a negative association between its current policies and public health outcomes.

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We welcome the fact that the International Monetary Fund (IMF) has been willing to respond to our reviews of evidence on how its programs have affected population health (published in the *Debates on International Agencies* series in an earlier issue of the Journal, Vol. 39, No. 4). Considering that the IMF has been involved in collecting debts and restructuring the economies of low- and middle-income countries in about 7 of every 10 years over the past two decades, making the Fund one of the biggest macro-determinants of health budgets in these countries, it is extremely important to evaluate rigorously its effects on health and health care. Unfortunately, the IMF's response (see Gupta's article in this issue, p. 323) is somewhat selective, drawing extensively on IMF-sponsored studies that have not been published in peer-reviewed journals. It also fails to address some of the key points made in our articles, instead setting up straw men, as well as introducing a number of inaccuracies. We address here the several points in the IMF's response.

First, the IMF claims that health spending either does not change or increases with IMF-supported programs, yet there is substantial evidence to the contrary. The Fund cites three unpublished IMF-sponsored analyses: one by the IMF Independent Evaluation Office, reporting no effect of IMF programs on social and health spending (1); a second, incorrectly cited, Center for Global Development report (2), which as we noted did not identify an effect of IMF operations on health spending (although it did suggest that Fund programs reduced the ability of health systems to respond to changing circumstances); and a third IMF analysis suggesting that the Fund's Poverty Reduction and Growth Facility (PGRF) program had increased spending on health by 0.25 percent of gross domestic product (GDP) by the time the country exited the program. In the first two cases, the IMF neglects the problem of inadequate specification of exposure. In countries where spending data are measured with high degrees of error, it may not be possible to identify an effect of the Fund, should one actually exist, causing what is termed in statistics a type II error. In the third case, the IMF cites the wrong variable and commits interpretative errors. It reports increased spending as a fraction of GDP, overlooking the fact that, when GDP is declining (the norm when countries borrow from the IMF), spending as a fraction of GDP may increase even while overall spending declines. What matters for health is not its priority in the changing economy (health/GDP) but overall levels of spending (health spending per capita), two different variables. Furthermore, in real terms, health spending will decline unless its yearly growth exceeds the IMF inflation targets. No change in health spending, as the Fund's second citation reports, equates to an effective decline in health resources. Finally, the reported growth of health spending of 0.25 percent of GDP before and after IMF programs (which last, on average, more than a decade) is about half the mean total health spending growth in countries below US$5,000 GDP per capita (about 0.60% of GDP over the same time span; public health spending growth was, on average, –0.016% of GDP per year in countries starting an IMF program since 1990, after removing

statistical outliers where the data are implausible, such as those showing year-to-year doubling of real health budgets) (3). Thus the IMF's own findings are consistent with the evidence that its programs have been associated with effective cuts or slowdowns in the growth of the health sector.

Second, the IMF claims that it has relaxed its historically strict spending requirements in response to the 2008–9 financial crisis. Unfortunately, IMF policies are not in the public domain, precluding verification of its claims. There do seem to be signs that the Fund has accommodated annual fiscal deficits of about 3 percent in response to the crisis, but this is very low compared with the double-digit budget deficits experienced by non-IMF countries. A report by the independent Center for Economic Policy Research (4) found that in 31 of 41 countries accepting IMF loans, social spending budgets were being cut or allowed to decline in relation to inflation, with implementation of "negative" stimulus to the economy to increase interest rates and cut budgets, while non-IMF countries have been increasing public spending in response to the crisis. The limited evidence on IMF policies that is in the public domain shows that, in the medium term (three to four years) time horizon, current Fund programs call for reductions or real declines in spending, as reported by the Center for Economic Policy Research (4).

Third, the IMF states that wage ceilings are no longer part of its conditionality in PRGF programs. This contradicts numerous independent assessments and is highly misleading (2, 5–7). For example, the Center for Global Development report notes: "Wage bill ceilings have been overused and should be restricted to very specific circumstances. Conditionality related to the wage bill was included in almost half of recent IMF programs with low-income countries. For example, 17 out of the 42 countries with PRGF-supported programs during 2003–2005 included some form of ceiling on the wage bill; all were in Africa or the Central America/Caribbean region. Such ceilings have been especially common in Africa" (2, p. xiv). While the IMF can argue that these cuts need not necessarily fall on the health sector, as governments can choose how to achieve the Fund targets, in practice there are few politically feasible alternatives, especially given the weak status of health ministers within governments. Hence, while the IMF may technically be correct in stating that it does not explicitly limit health spending as a conditionality, the final result is the same as if it did. Furthermore, when the IMF sets extremely low inflation targets, it must be aware that this leaves countries with little choice but to cut public wage bills, a major component of social spending. In Latvia, the IMF's structural adjustment targets have corresponded to about 60 percent cuts to public sector wages, resulting in massive layoffs, while the salaries of health workers remaining in post have been reduced markedly; this is in addition to the already drastic cuts in the health budget of about 30 percent resulting from IMF involvement (8). Health ministers in Iceland (Ögmundur Jónasson) and Latvia (Ivars Eglitis) have resigned rather than carry out the radical IMF-sponsored budget cuts that would undermine their health systems.

The situation is probably much worse in low-income countries such as Burkina Faso, which, unlike Iceland and Latvia, have very little bargaining power with the IMF (9).

Fourth, in a situation where aid flows have increased above IMF projections, the Fund acknowledges that it has diverted aid to reserves. As pointed out by Ooms and Hammonds (10), this diversion of health aid to reserves reflects the IMF's considerable concerns about the sustainability of aid flows, reflecting its reliance on overly conservative long-term projections of levels of external aid. The consequence is that opportunities are foregone to maximize the public health impact of aid resources, especially when there are implementable programs that could address immediate health problems and would accelerate progress to the achievement of the Millennium Development Goals.

Fifth, we are pleased that the G20 boost to the IMF's financial resources has resulted in the Fund's extending flexible credit to a few countries (the Fund's Flexible Credit Line with no strings attached, similar to what Keynes originally envisaged for all IMF members). Unfortunately, these loans are available only to those countries that have already met strict policy conditions (putting pressure on countries to guess what the Fund's criteria will be) and have relatively high interest rates. Thus, this credit has been extended only to middle-income countries such as Colombia, Poland, and Mexico, countries with close ties to the United States (9). One recent estimate by Ngaire Woods, presented to the European Parliament, is that more than 80 percent of the IMF's new lending has gone to Europe, mainly Eastern Europe, where European banks are threatened, and less than 2 percent of loans have gone to African countries (11, 12). This is in contrast to the stated G20 recovery plan: "We recognise that the current crisis has a disproportionate impact on the vulnerable in the poorest countries and recognise our collective responsibility to mitigate the social impact of the crisis to minimise long-lasting damage to global potential" (13). The mismatch between the IMF's stated intentions and its actions makes it essential to evaluate the extent to which the Fund meets its stated objectives. Transparent and accountable processes, such as Health Impact Assessment, as called for by Cave and Birley (14), should be a component of every loan package.

Sixth, the IMF suggests that it supports demand-side policies consistent with World Health Organization (WHO) tobacco control policies but only mentions its support for taxation, one of many elements of a comprehensive tobacco policy. This suggests that the IMF has simply failed to consider the adverse effects of tobacco industry privatization. Furthermore, the Fund's exclusive focus on demand is actually inconsistent with WHO policies, which recognize the importance of both demand- and supply-side measures as part of a comprehensive evidence-based response (15). Specifically, the WHO recently established an expert advisory group to examine the influence of the tobacco industry on tobacco control policy (16), and its Framework Convention on Tobacco Control includes an article (Article 5.3) that specifically seeks to reduce the inappropriate influence

of the tobacco industry on policy (15)—which, as we noted, is a key issue where previous domestic monopolies are privatized, so that, where it has been studied, privatization has been associated with reductions in tobacco prices and weakening of tax policies due to political influence by the newly privatized tobacco companies. Thus, if the IMF does advise taxing tobacco at a relatively high rate, it seems that countries have ignored this or have been unable to implement it. The most serious omission, however, is the Fund's failure to mention the good-practice guidelines on tobacco industry privatization that were drawn up for IMF and World Bank staff in June 2005 (17). These guidelines make clear the dangers of tobacco industry privatization and outline issues that IMF staff should consider in policy discussions and privatization conditionality—issues that it appears the IMF has failed to acknowledge or act upon.

Thus far, the IMF has responded to critiques of its impacts by denying the evidence (18). In one recent case, the IMF referred to peer-reviewed research in a premier international research journal as "phony science" (19), rather than engaging with the findings. And it responded to evidence about its programs from the independent Center for Economic Policy Research by claiming "reality is quite the opposite" (20), instead of addressing the research data. The IMF also has not taken up recommendations by its own, inappropriately named, Independent Evaluation Office (including former IMF staff and economists who are currently or previously networked to the Fund) (21).

We challenge the IMF to publish evidence that (*a*) strict spending requirements have been relaxed—including for low-income countries; (*b*) inflation targets will not lead to real cuts in social spending or restrict countries from increasing resources for health; (*c*) aid will not be diverted to reserves; (*d*) flexible credit will be made available to the poorest countries; and (*e*) where the Fund supports tobacco industry privatization, this will be conditional on an effective and comprehensive package of policies to reduce smoking. Until there are clear policies promoting these objectives, or evidence of their attainment, we must conclude—based on the available evidence—that the IMF is failing to meet these goals.

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