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The Consequences of IMF Conditionality for Government Expenditure on Health

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Nisreen Moosa*
School of Commerce, University of South Australia, Adelaide, SA, Australia.

*Correspondence: nisreen.moosa@mymail.unisa.edu.au

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Abstract
The International Monetary Fund (IMF) was established in 1944 to supervise the international monetary system that collapsed in 1971. Since then, the Fund has reinvented itself as some sort of a “development agency,” providing loans with strings attached. Any country that wishes to obtain loans must follow the IMF-prescribed policies that reflect the neoliberal ideas of the Washington Consensus. As these policies are typically contractionary and involve austerity, the IMF has been accused of pursuing policies that exhibit a negative impact on health expenditure, with dire consequences for the population. Although the empirical evidence on this issue is mixed, it is well known that the IMF operations are more likely to exert a negative effect than a positive effect on government spending on health.

Keywords: IMF; Health Expenditure; Conditionality; Washington Consensus; Structural Adjustment.

1. INTRODUCTION

The International Monetary Fund (IMF) was established in 1944 as a constituent component of the Bretton Woods agreement to act as a supervisor of the international monetary system of fixed exchange rates. The Fund was entrusted with the task of helping (developed) countries suffering from balance of payments difficulties by providing loans and allowing currency devaluation only if the underlying country could demonstrate that it had a chronic deficit. Since the collapse of the Bretton Woods system in 1971, the Fund reinvented itself by acting as some sort of a development agency and an adviser on economic and financial stability. Its operations were extended to cover the developing world, which was at one time the jurisdiction of the World Bank. The operations of the IMF include the provision of loans, but these loans are not without strings attached—strings that come with the conditionality that involves measures of “reform.” The conditionality clauses invariably include austerity measures to depress aggregate demand, including the removal of subsidies and the imposition of higher taxes. These policies have frequently led to popular revolt and austerity protests, taking the form of large collective actions that include political demonstrations, general strikes, and riots triggered by grievances over the policies of economic liberalization urged by the IMF. The policies may involve the reduction of government subsidies and/or higher prices of basic staples such as food, water, and domestic gas. Typically, the demonstrators demand lower prices, restored government subsidies, and wage increases to compensate for higher prices, or jobs (for example, the 1977 “bread riots” in Egypt as the IMF policies caused a quadrupling of bread prices).

These so-called “reforms” have adverse consequences for the well-being of people, including public spending on health, which takes a direct hit as a result of fiscal tightening and the retrenchment of social services. The IMF has been criticized severely for the conditionality associated with its operations. For example, Stiglitz (2002) refers to Thailand’s “AIDS increase as a result of IMF-forced cutbacks in health expenditures,” which the Director of the External Relations Department of the IMF responded to by accusing Stiglitz of dishonesty, claiming instead that its policies have led to higher levels of health spending (Dawson, 2003). The debate has been bipolar, as the IMF, its staff, and few supporters claim that a positive effect can be observed running from the IMF-prescribed policies to health care. For example, a study by the Fund staff reveals that
the IMF’s policies have a positive and significant effect on public health spending in low-income countries (for example, Clements et al., 2013). The empirical evidence is mixed, but every study that involves IMF staff somehow detects positive effect running from IMF policies to public health expenditure.

The objective of this paper is to demonstrate that the nature of conditionality and the parameters that govern the operations of the IMF are more likely to be associated with a decline rather than a rise in health expenditure. The debate on this issue will be evaluated. Although the evidence is mixed, it will be argued that empirical research on this issue is motivated by the desire to support preconceived beliefs, and that self-preservation and ideology provide an explanation as to why studies involving IMF staff produce supportive evidence for the Fund’s operations.

2. CONDITIONALITY, STRUCTURAL ADJUSTMENT, AND HEALTH SPENDING

The term “conditionality” refers to a set of “reforms” that borrowing countries must implement in order to obtain IMF loans, including reduction in public spending, currency devaluation (presumably to encourage exports), and changes to monetary policy (Toye, 1994). In the mid-1980s, new and highly intrusive measures were introduced under the umbrella of the so-called “structural adjustment policies” (Woods, 2006), including privatization of state-owned enterprises and the liberalization of trade and finance (Summers and Pritchett, 1993; Toye, 1994). In this sense, the IMF has been acting for the benefit of multinationals and against the people of the countries it is supposed to help. In a sense, the IMF has been the conduit for the implementation of the neoliberal ideas envisaged by the Washington Consensus in countries around the world. Nooruddin and Simmons (2009) think that it is not a surprise that the increase in openness in the developing world corresponds closely with the increasing importance of the Washington Consensus. Moreover, they describe the consensus as follows: “the set of policies that often constituted the conditions countries were to follow to receive aid, an important component of which was lowering barriers to import competition.”

This proposition is supported by Williamson (1990) who refers to a consensus (read the Washington Consensus) between governments and international financial agencies on general philosophy and the number of adjustment policies to be taken. Williamson suggests that the consensus is based on the three premises that policies should be market-friendly, outward-oriented, and macroeconomically stable. A typical policy package comprises 10 policy prescriptions including (i) fiscal discipline, (ii) reduction of general subsidies to finance human resources and infrastructure, (iii) tax reform, (iv) financial liberalization, (v) unified and competitive exchange rates, (vi) trade liberalization, (vii) abolishing barriers to foreign direct investment, (viii) privatization, (ix) deregulation, and (x) property rights. A country that does not meet the conditionality clauses will be deprived of IMF loans, which will in turn limit its access to development aid and international capital markets.

The IMF proposes three channels through which its programs are linked to strengthening of health systems. The first is that IMF-prescribed policies enhance economic growth and boost the tax revenues, thereby allowing governments to invest in public health (Clements et al., 2013; Crivelli and Gupta, 2016). Second, social spending floors shelter sensitive expenditures from austerity measures (Gupta, 2010; Gupta et al., 2000; IMF, 2015). Third, the implementation of the IMF’s policy advice is conducive to foreign aid and investment (Clements et al., 2013; IEO, 2007). In contrast, the critics contend that adequate investment in health is hampered by pressure to meet rigid fiscal deficit targets and because funds are diverted away from the health sector to repay debt or boost reserves (Kentikelenis, 2015; Kentikelenis et al., 2015a, 2015b, 2016; Ooms and Schrecker, 2005; Stuckler and Basu, 2009; Stuckler et al., 2008, 2011). If, as the evidence indicates, the IMF-prescribed policies depress economic growth, the resources available to fund healthcare shrink (Barro and Lee, 2005; Dreher, 2006; Przeworski and Vreeland, 2000). Furthermore, these policies are not conducive to the attraction of health aid (Stubbs et al., 2016).

The IMF policies have both direct and indirect consequences for health expenditure, which can be construed to be positive and negative, depending on who is expressing the underlying view. The first of the positive direct effects, as mentioned earlier, is that the IMF operations are subject to conditions designed to protect social expenditures from the adverse consequences of adjustment policies (Gupta et al., 2000). In response, Kentikelenis et al. (2015b) argue that spending targets are frequently expressed as shares of gross domestic product (GDP), and as the IMF policies cause economic contraction, total expenditure declines.
Furthermore, the extent to which these conditions are implemented and the importance the Fund provides to monitor them have been questioned (Goldsborough, 2007; Kentikelenis et al., 2014; Oxfam, 1995).

It is also claimed that the IMF policies frequently go beyond spending conditionality to foster a more active reshaping of the health sector, including the enhancement of the role of the private sector in healthcare provision (Benson, 2001; Gupta et al., 2000; Loewenson, 1995; Turshen, 1999), the introduction of cost-sharing for the use of health services (IEO, 2003; Pitt, 1993; Sen and Koivusalo, 1998), and decentralizing health services (Kentikelenis et al., 2014). Kentikelenis et al. (2015b) argue that while it is possible that public revenue generated from patients or hospital privatization may be reinvested in the health system (thus raising spending), the proceeds may be diverted to other areas of spending. The enhancement of the role of the private sector can hardly be a substitute for public health expenditure as private health care is beyond the means of the vast majority of people, particularly in low-income countries. Even in rich countries such as the United States, people die either because they do not have a private health cover or because they are denied a specific form of treatment for one reason or another. This is probably the reason why we frequently hear the terms “medical refugees” and “dental refugees” in reference to Americans seeking treatment in Mexico. The same criticism applies to the introduction of cost-sharing for the use of health services and the decentralization of health services.

Furthermore, it is claimed (on behalf of the IMF) that public health expenditure is subject to the “resource effect” arising from the low interest credit provided under its programs. The additional resources, as the argument goes, could be used to boost expenditure to meet health priorities. However, it is unlikely that this effect will materialize because the extra resources will be used to repay external debt (Gould, 2003). In addition, it is argued, on behalf of the Fund, that the IMF operations give the underlying country a “stamp of approval,” which boosts aid flows (Clements et al., 2013). Although there is some evidence for the link between foreign aid and Fund programs (Bird and Rowlands, 2007), it is not necessarily the case that those funds will be directed to health (Rowden, 2009b; Stuckler et al., 2011) or that they will be channeled through the government (Lu et al., 2010; Sridhar and Woods, 2010).

The indirect effects of the IMF-prescribed policies are the unintended consequences of structural adjustment. To start with, the Fund’s conservative projections, which form the basis of conditionality, frequently leave little space for fiscal maneuverability (de Renzio, 2005; Goldsborough, 2007; Kentikelenis et al., 2014; Rowden, 2009b). The IMF operations invariably involve the imposition of limits on the wage bill of the public sector, which can drive public health expenditure downwards, given that much of public health spending in low-income countries goes toward the payment of the salaries of doctors and nurses (Van der Gaag and Barham, 1998). Furthermore, currency devaluation and the removal of subsidies are bound to make medicine and medical technology more expensive and hence less available to the vast majority of people (Musgrove, 1987; Van der Gaag and Barham, 1998). The IMF policies typically involve the privatization of public assets, including hospitals. Even if the proceeds are reinvested in the health sector (which is not necessarily the case), this will only be a short-run phenomenon that will benefit private healthcare providers. It does not make sense to sell a public hospital and then use the proceeds to subsidize the cost of private health care—in any case, the IMF hates anything called “subsidies.”

Although the IMF always claims that its programs strengthen health systems (Clements et al., 2013; Gupta, 2010, 2015), it has long been criticized for impeding the development of public health systems (Baker, 2010; Benson, 2001; Goldsborough, 2007; Kentikelenis et al., 2015a, 2015b; 2016; Stuckler and Basu, 2009; Stuckler et al., 2008, 2011). For example, a recent qualitative analysis of IMF programs in Guinea, Liberia, and Sierra Leone found that the IMF contributed to the failure of health systems to develop, thereby exacerbating the Ebola crisis (Kentikelenis et al., 2015a). The recent experience shows that the IMF’s policy advice is associated with fewer public health resources, difficulties in hiring and retaining health workers, and unsuccessful health sector reforms. Van der Hoeven and Stewart (1993) suggest that “neither the IMF nor the World Bank recognized the need to take any special actions to protect the poor.”

3. THE DEBATE

The debate between the IMF and its critics with respect to health care can be viewed clearly in an interview with two fund officials, followed by a criticism from Rowden (2009a), a reply from the IMF, and then another
reply from Rowden. There is also the exchange between Stubbs et al. (2017b) and Gupta (2017) who wrote in response to Stubbs et al. (2017a). The IMF defended its position with respect to issues related to health and social policy in an interview conducted by Glenn Gottseelig (2009) with Sanjeev Gupta (Deputy Director of the IMF’s Fiscal Affairs Department) and Catherine Pattillo (Advisor in the Strategy, Policy and Review Department). In this interview, the IMF officials were asked directly whether or not governments with IMF-supported programs are pressed to reduce social spending to meet prescribed economic targets. Gupta responded by declaring that “IMF-supported programs have been very flexible by accommodating larger fiscal deficits and higher inflation, and by continuing to protect priority social expenditures” and that “the programs have placed considerable emphasis on strengthening social protection for the most vulnerable.” He attributed constraints on health expenditure to “administrative capacity constraints,” rather than excessively tight macroeconomic policies—specifically, he mentioned “poor national coordination,” “shortcomings in the health care system,” and “absorptive capacity.” If these factors mean anything at all, they are bound to be affected by tight policies designed primarily to meet debt repayment and boost creditworthiness, albeit at the expense of starving people.

When asked if IMF-supported policies require countries to cut spending on social programs so that inflation can be contained, Pattillo answered in the negative, arguing that “in a number of crisis-affected countries, programs were also flexible in adapting high inflation targets as food and fuel prices increased.” Gupta then rejected the proposition that social spending in general, and health spending in particular, have declined in countries with IMF-supported programs, arguing that “the IMF’s Independent Evaluation Office did not find any evidence of a decline in social spending in IMF-supported programs.” He referred to the IMF studies showing that social spending—including health and education spending—has increased by 0.6% of GDP relative to preprogram levels and that spending increases have been higher for education, at 0.35% of GDP compared to health at 0.25%. These numbers conceal the unpleasant truth that these programs are contractionary, and when GDP shrinks, the level of health expenditure per capita declines in turn. Then a big question mark must be put on the word “independent” in the name of a body that is a constituent part of the IMF.

Another issue that was raised in the interview was whether or not the IMF’s policies deter countries from using available donor aid for health spending and whether or not the IMF’s position on aid intended for the health sector is diverted to repay domestic debt or boost reserves. Gupta responded by suggesting that “IMF-supported programs play an important role in mobilizing donor support around country-owned poverty reduction strategies” and referred to an IMF study concluding that social spending (including spending on health and education) in 51 countries was generally unaffected by aid flows during the period 1990-2004. It is not surprising at all that studies conducted by the IMF produce results that tell us what a wonderful job the IMF has been performing.

When confronted with the proposition that IMF programs typically involve public sector wage-bill ceilings, which are bound to have a negative impact on health expenditure, Gupta responded by saying that “IMF program conditionality has never included any wage-bill ceilings, or hiring freezes for that matter, specifically on the health sector.” However, he added that “a new policy on wage ceilings was put into effect in July 2007” under which “ceilings can be used only in exceptional circumstances where they are crucial for macroeconomic stability, and should be of limited duration, periodically reassessed, and sufficiently flexible to accommodate spending of scaled-up aid in priority social sectors.” For the designers and implementers of the IMF programs, all circumstances are exceptional and macroeconomic “stability,” which is achieved by economic contraction, is always the primary objective. Moreover, even if wage-bill ceilings do not exist, governments adopting austerity measures are bound to impose these ceilings.

In response to this interview, Rowden (2009a) raised several points as to why the IMF is likely to reduce spending on health, which triggered a response and a response to the response. In particular, he asserts that “the IMF is not a development organization per se, but acts to ensure that sovereign debt payments are made on time to external lenders and that creditworthiness is maintained,” which means that “its short-term priority for borrowers to generate increased exports and earn foreign exchange which may be used to repay creditors.” He suggested that “by looking to the IMF for its assessment of the adequacy or ‘soundness’ of a recipient country’s macroeconomic policies before giving out foreign aid each year, bilateral and multilateral aid donors have wrongly afforded tremendous leverage and power to the IMF.” The “soundness” of macroeconomic policy typically means keeping inflation in check, which is inconsistent with currency devaluation that leads to imported inflation.
The IMF is an ideologically driven organization, adopting the neoliberal ideas of *laissez faire* and the Washington Consensus. Rowden (2009a) refers to the IMF’s “ideological disposition that prioritizes short-term financial sector variables in macroeconomic policy to the subordination or neglect of real sector variables, such as long-term developmental goals, industrialization, higher employment or increased public investment,” arguing that “such a position is associated with the school of monetarism within neoclassical economics.” It is these types of policies that induce a long-term trend of low-growth, low-employment and low-public investment that has been characterized by chronically insufficient health budgets and dilapidated health infrastructure.

Typically, the IMF-imposed macroeconomic targets include an annual inflation rate at or below 5-7% per year and to keep budget deficits below 3% of GDP. The restrictiveness of these policies, according to Rowden (2009a), “undermines the ability of domestic industries to generate higher levels of productive capacity, employment, and GDP output—and thus, tax revenues—that otherwise could be the case under more expansionary fiscal and monetary policy options.” As a result, the government is deprived of higher levels of tax revenue for recurrent expenditures and for long-term public investment as a percent of GDP. A report published by the General Accountability Office (2001) on IMF loans suggests that “policies that are overly concerned with macroeconomic stability may turn out to be too austere, lowering economic growth from its optimal level and impeding progress on poverty reduction.” Similarly, Pollin and Zhu (2006) contend that “there is no justification for inflation-targeting policies as they are currently being practiced throughout the middle- and low-income countries.” The Center for Global Development (2007) found that “the empirical evidence does not justify pushing inflation to these levels in low-income countries.” On November 14, 2007, the House Financial Services Committee of the U.S. Congress sent a letter to the Managing Director of the IMF, expressing concern about “the IMF’s adherence to overly-rigid macroeconomic targets,” suggesting that “it is particularly troubling to us that the IMF’s policy positions do not reflect any consensus view among economists on appropriate inflation targets” (Financial Services Committee, 2007). It is true that high inflation can be damaging for investment and growth, but how high is high? Controlling inflation should be looked upon in terms of costs and benefits. Rowden (2009a) refers to the “empirically unjustifiable tight fiscal and monetary targets in non-transparent meetings with central bank and finance officials behind closed doors.”

Gupta and Pattillo replied to Rowden (2009a) by identifying three principal criticisms that require a response: (i) IMF policies keep budget deficit targets below 3% of GDP; (ii) the IMF has very little empirical evidence to justify pushing inflation down to the 5-7% level, and (iii) the IMF’s policies for borrowing countries are primarily designed for achieving short-term priorities, which could be in conflict with longer-term successful economic development strategies or health goals. On the first point they respond by citing some IMF reports claiming that “the evidence does not support the view that IMF-supported programs adopt a one-size-fits-all approach to fiscal adjustment” and that “there was no evidence that IMF-supported programs were overly tight.” As far as point (ii) is concerned, they pick selective evidence to claim that 5% is the beginning of the inflation-related death zone, without mentioning what costs are involved. For point (iii) they claim that the statement is false because “Fund-supported programs are framed in the context of a medium-term macroeconomic framework that incorporates longer-term development objectives.” Ironically, they claim that “the objective of IMF-supported programs is to promote high and sustained growth, which will improve the well-being of the poor and create fiscal space for increasing priority spending, including on health.” Tell that to the people of Egypt who revolted violently against the IMF programs in 1977.

Rowden (2009a) replies by referring to biased sampling covering the period 1993-2001 (well after deficit targets had already been dramatically lowered under the original IMF stabilization loans of the 1980s) and suggests that the results would be different if the sample went back to 1980. Furthermore, he suggests that Gupta and Pattillo do not address a central concern—the fall in public investment as a percent of GDP, neither do they explain how and under what conditions the targets may be raised. Furthermore, Rowden notes that Gupta and Pattillo do not address the concerns raised in a number of studies, including Government Accountability Office (2001), Pollin and Zhu (2006), Center for Global Development (2007), and the letter to IMF from the Financial Services Committee (2007).

Another exchange was initiated by Stuckler et al. (2011) who suggest that “IMF macro-economic policies, which specifically advise governments to divert aid to reserves to cope with aid volatility and keep government spending low, could be causing the displacement of health aid.” They attempt to determine
whether aid displacement was greater when countries undertook a new borrowing program from the IMF between 1996 and 2006 and conclude that “health system spending grew at about half the speed when countries were exposed to the IMF than when they were not.” Glassman (2011) comes to the rescue of the IMF by describing as a “controversial conclusion” (of Stuckler et al.) that IMF policies could be causing the displacement of health aid and showing her dislike to the fact that this article was picked up by The Guardian (2011). In particular, she argues on the basis of econometric grounds by suggesting that “the paper fails to document the econometric strategy used to reach their conclusion” and that “comparisons of health spending in countries with and without programs are subject to statistical biases in different directions, which are again influenced by the same factors that affected a country’s decision to enter an IMF-supported program in the first place.”

In a comment on Glassman’s defence of the IMF, Rowden attributes the observation that various studies have inconsistently found differences or no differences between IMF program and non-IMF program countries to “the ideological biases that underpin them,” arguing that “many current finance ministry and central bank officials who have gone to school in the last 20-30 years have largely been taught one thing—and one thing only—that the only ‘prudent’ and ‘sound’ option for fiscal and monetary policies is the very conservative one favoured by the Reagan and Thatcher governments steeped in the school of monetarism within neoclassical economics.” According to this line of thinking, all other viable options have subsequently been dismissed as “imprudent” and “unsound.” Rowden concludes that “it should not matter if a country has an IMF program or not, as its fiscal and monetary policies are likely subject to the same sharp right-wing turn taken in the economics profession 30 years ago, from which it has yet to recover.” This means that IMF-like policies may be implemented, on ideological grounds, without the IMF demanding that.

In another comment on Glassman’s piece, a commentator (who was unimpressed by Glassman lecturing everyone on the difference between causation and correlation) likens the IMF’s role of a lender of last resort to the behavior of colonial powers in the 17th-19th centuries. During that period, whenever a country in Latin America, the Middle East, North Africa, and Southeast Asia defaulted on its debt, the creditors (almost always the British, French or Dutch) would typically invade the country, take over their public finances, and devote them to paying down the debt, regardless of the consequences for public health (and everything else, for that matter). When or if the debt was paid off, the creditors would either set up a permanent colonial administration, or a loyal, dependent client state.

4. THE EMPIRICAL EVIDENCE

Few studies examine empirically the relation between structural adjustment and health expenditure. Some of these studies are based on descriptive statistics only, including van der Hoeven and Stewart (1993), Thiesen (1994), van der Gaag and Barham (1998), and Gupta et al. (1998, 2000). Two of these studies found increasing expenditure on health, using as the dependent variable either the share of GDP or the share of total government expenditure. By using a sample of 118 developing and transition countries, Gupta et al. (1998) find that since the mid-1980s real per capita spending on education and health has increased, on average, in developing countries but decreased in the transition economies. They observe comparable increases in countries that had IMF-supported adjustment programs during the same period despite the fiscal consolidation often required by those programs.

Other studies employ formal econometric modeling, including the use of ARIMA models, OLS, the generalized method of moments, and Prais-Winsten regression (Clements et al., 2013; Huber et al., 2008; IEO, 2003; Kentikelenis et al., 2015b; Nooruddin and Simmons, 2006; Stubbs et al., 2017a). Four of these studies found an unambiguous result of increase in health expenditure, while two show mixed results of increase for some countries and decrease in others. Interestingly, among the 10 studies employing summary statistics or formal modeling, the four that show unambiguous increase in health expenditure involve staff of the IMF or other international financial institutions. The IMF has claimed that its programs enhance government spending for health, and that a number of innovations have been introduced to enable borrowing countries to protect health spending from broader austerity measures (Kentikelenis et al., 2015b). This is the risk of combining preconceived ideas or the urge to provide supportive evidence for a claim by using (dodgy) econometrics. Let us examine some of these studies.
Kentikelenis et al. (2015b) investigate the effects of Fund programs on government health expenditures in low-income countries using data for the period 1985-2009. They find that Fund programs are associated with higher health expenditure only in Sub-Saharan African countries, which historically spent less than any other region. This relation turns negative in other low-income countries. They argue that examining the link between IMF programs and public health spending provides partial accounts of how health outcomes are affected because different economic and structural adjustment policies can impact population health in various ways.

A study conducted by the Independent Evaluation Office of the IMF (IEO, 2003) addresses the following question: What is the impact of the presence of an IMF-supported program on the level of social spending (other factors being held constant) relative to a situation without a program? The study attempts to determine what happens to public sector social spending under IMF-supported programs using a broad sample of 146 countries in the 1985-2000 period. Four different indicators were used for each type of spending: as a share of GDP, as a share of total government spending, and as an index of real spending at domestic prices and in U.S. dollars per capita. The empirical results reveal that, on average, the presence of an IMF-supported program does not reduce social spending and that the presence of a program is associated with increased public spending in health and education measured as either a share of GDP, total spending, or in real terms compared with a situation without a program. However, they find the positive effects attributable to the program to be short-lived—for these effects to be durable, they would have to be followed by further policy actions in these sectors beyond the program period.

Nooruddin and Simmons (2006) argue that a central component of the IMF’s programs is reducing government budget deficits. Hence, they wonder how domestic political considerations shape the distribution of cuts made by governments participating in IMF programs. Their central finding is that the role played by domestic politics shrinks as a result of participation in IMF programs. Although democracies allocate larger shares of their budgets to public services in the absence of IMF programs, the difference between democracies and non-democracies disappears under IMF programs.

Huber et al. (2008) declare at the very beginning that they expect the presence of an IMF agreement to be associated with lower levels of both social security/welfare and health/education expenditures. They use a dummy variable to indicate obligations to the IMF in a given year—the variable takes the value of 1 for each year a country has repurchase obligations with the IMF and 0 for each year it does not, cumulative since 1970. The coefficient on this variable turns out to be significantly positive, implying a higher level of health expenditure in association with IMF programs. However, it is not clear why they obtain negative association with social security and welfare spending. This in itself reduces the ability of people to pay for private health care.

Clements et al. (2013) find that education and health spending has increased during IMF-supported programs at a faster pace than in developing countries as a whole. The analysis is based on the most comprehensive data set assembled thus far for this purpose, with data covering 1985-2009 for 140 countries. Controlling for other determinants of education and health spending (including macroeconomic conditions), the results confirm that IMF-supported programs have a positive and significant effect on social spending in low-income countries. Over a 5-year period with IMF-supported programs, spending on health increased by about 1% of GDP. IMF-supported programs are in addition associated with increases in the share of government spending allocated to education and health.

Stubbs et al. (2017a) argue that the most important international institution setting the fiscal priorities of low-income countries is the IMF. They collect archival documents on IMF programs from 1995 to 2014 to identify the pathways and impact of conditionality on government health spending in 16 West African countries. Based on a qualitative analysis of the data, they find that IMF-prescribed policies reduce the potential for investment in health, put a limit on the numbers of doctors and nurses, and lead to budget execution challenges in health systems. Furthermore, they use cross-national fixed-effect models while adjusting for confounding economic and demographic factors and for selection bias. Their results reveal that IMF conditionality impedes progress toward the attainment of universal health coverage.

In his response to Stubbs et al. (2017a), who tried to draw a causal link between IMF programs and government health expenditure, Gupta (2017) raises several broad methodological issues: drawing causal inferences from qualitative methods, addressing endogeneity when the counterfactual is almost never observed.
in reality, and interpreting findings from qualitative and quantitative methods. Specifically, Gupta raises the following questions: (i) is the qualitative method adopted by the article suitable for drawing causal inferences?, (ii) are all potential pathways covered by the qualitative method adequately and transparently?, (iii) are endogeneity issues addressed adequately?; (iv) are the findings from qualitative and quantitative methods interpreted accurately?, and (v) are the findings of the article consistent with those of the literature? Thus, he declares the following: (i) the qualitative method is based on a systematic search of document archive, the nature of the description in these documents suggests that the findings from the qualitative methods are mostly selective and anecdotal; (ii) there are other important pathways that the qualitative methods may have failed to identify with the list of key words used in the document search; (iii) addressing the endogeneity problem, otherwise the wrong conclusion may be drawn; (iv) the interpretation of the findings from the quantitative analysis appears to be incomplete and may lead to misunderstanding; and (v) it is important for the article to cast its findings in terms of the relevant literature that has studied the impact of IMF programs on public health spending in developing countries. He concludes that “while the proposed new methodology by the authors represents an improvement, the results derived from it are inaccurate and misleading.” Stubbs et al. (2017b) reply meticulously to Gupta and conclude that that structural adjustment programs should be judged by their effects on the human condition. They argue that “in an era of global uncertainty and important challenges to international organizations, the IMF could best address criticism by reforming its practices, thereby living up to its own standards on social protection, rather than continuing to deny evidence.”

It seems, therefore, that the evidence on whether the IMF-sponsored programs have a positive or negative impact on health expenditure is mixed. However, it is quite evident that somehow, the studies conducted by the IMF’s staff or supporters show unequivocally that the IMF has performed a wonderful job in promoting health expenditure, which is counterintuitive, to say the least. These results are engineered for the purpose of self-preservation. Let us not forget that the IMF should have been abolished in 1971, when the original purpose for its establishment was no longer there.

5. CONCLUSION

The problem with the empirical studies of the relation between health expenditure and IMF-prescribed policies is that they depend on regression equations that contain a large number of explanatory variables representing empirical models that have no corresponding theoretical models. This methodology, predominantly based on cross-sectional and panel data, produces results that are highly sensitive to the selected set of explanatory variables, model specification, and variable measurement. It is this problem that prompted Edward Leamer’s article “Let us Take the Con out of Econometrics” (Leamer, 1983). The Leamer critique revolves around the proposition that a regression model with a large number of potential explanatory variables can be used to prove almost anything and produce results (after extensive data mining) that support prior beliefs. For example, Moosa (2012, 2017) demonstrates that the same data set can be used to show that either of the two theories of capital structure is superior to the other, simply by changing the set of explanatory variables.

With respect to the issue under consideration in this paper, the proponents of either of the two views (that is IMF operations are good or bad for health expenditure) have produced contrasting evidence. Unfortunately, empirical work in economics and finance has been all about proving prior beliefs, which can be easily performed by playing around with model specification, variable definitions and measurement, and estimation methods. This is why a trend has emerged recently to deal with the sensitivity of the results with respect to variations in the model. However, if we combine the empirical results with common sense, intuition, and what happens on the ground, we will reach the conclusion that the IMF operations depress health expenditure. After all, the IMF is not a development agency—it is out there to allow multinationals to acquire public assets without paying considerably in the countries where it operates and to make sure that those countries pay their debt. The last thing the IMF cares about is the health and well-being of the people in those countries. After all, and as Rowden (2009b) puts it, the IMF follows the “deadly ideas of neoliberalism,” thus undermining public health.
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