Social Science & Medicine 174 (2017) 220–227

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The impact of IMF conditionality on government health expenditure: A cross-national analysis of 16 West African nations

Thomas Stubbs [a, b, *], Alexander Kentikelenis [c, d], David Stuckler [c], Martin McKee [e], Lawrence King [a]

[a] Department of Sociology, University of Cambridge, United Kingdom
[b] School of Social Sciences, University of Waikato, New Zealand
[c] Department of Sociology, University of Oxford, United Kingdom
[d] Department of Sociology, University of Amsterdam, Netherlands
[e] European Observatory on Health Systems and Policies, London School of Hygiene & Tropical Medicine, United Kingdom

ARTICLE INFO

Article history:
Received 4 February 2016
Received in revised form
2 November 2016
Accepted 11 December 2016
Available online 13 December 2016

Keywords:
Health systems
International Monetary Fund
West Africa
Health expenditures
Universal health coverage

ABSTRACT

How do International Monetary Fund (IMF) policy reforms—so-called 'conditionalities'—affect government health expenditures? We collected archival documents on IMF programmes 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, we find that IMF policy reforms reduce fiscal space for investment in health, limit staff expansion of doctors and nurses, and lead to budget execution challenges in health systems. Further, we use cross-national fixed effects models to evaluate the relationship between IMF-mandated policy reforms and government health spending, adjusting for confounding economic and demographic factors and for selection bias. Each additional binding IMF policy reform reduces government health expenditure per capita by 0.248 percent (95% CI −0.435 to −0.060). Overall, our findings suggest that IMF conditionality impedes progress toward the attainment of universal health coverage.

1. Introduction

Strengthening public healthcare systems is central to achieving Universal Health Coverage (UHC), a key objective of the United Nation's Sustainable Development Goals (UNGA, 2015; WHO, 2014). Yet, in low-income countries (LICs), especially those dependent on aid or subject to fluctuating commodity prices, it is unclear how progress can be sustained. Recent studies highlight the importance of funding UHC through increasing domestic tax revenues and employer contributions (O'Hare, 2015; Reeves et al., 2015). Success will also depend on the ability to overcome long-standing barriers to health system expansion, including legacies of conflict, state failure, and underinvestment in healthcare facilities and personnel (Benton and Dionne, 2015). Foreseeably, a multitude of global actors will contribute to shaping the design, implementation, and ultimate outcome of these endeavours (Chorev, 2012; Patel and Phillips, 2015).

Quite possibly the most important international institution setting the fiscal priorities of LICs is the International Monetary Fund (IMF). Established in 1944, a core function of the organization has been to provide financial assistance to countries in economic turmoil. In exchange for this support, countries agree to implement IMF-designed policy reform packages phased over a period of one or more years—so-called 'conditionalities'. Over the past two decades, the 59 countries classified by the IMF (2015b) as LICs have been exposed to conditionalities for 10.3 years on average, or one out of every two years. The IMF's extended presence in LICs has spurred a great deal of controversy. Critics stress inappropriate or dogmatic policy design (Babb and Kentikelenis, In press; Babb and Carruthers, 2008; Kentikelenis et al., 2016; Stiglitz, 2002), adverse effects on the economy (Dreher, 2006), and negative social consequences (Abouharb and Cingranelli, 2007; Babb, 2005; Oberdabernig, 2013).

In relation to health, the IMF has long been criticized for impeding the development of public health systems (Baker, 2010; Batniji, 2009; Benson, 2001; Benton and Dionne, 2015; Cornia et al., 1987; Goldsborough, 2007; Kentikelenis et al., 2015a,b; 2016; Ooms and Hammonds, 2009; Stuckler and Basu, 2009;

* Corresponding author. Office S13, 17 Mill Lane, Cambridge, Cambridgeshire CB2 1RX, United Kingdom.
E-mail address: ths27@cam.ac.uk (T. Stubbs).

http://dx.doi.org/10.1016/j.socscimed.2016.12.016
0277-9536/

Stuckler et al., 2008; 2011). For example, a recent qualitative analysis of IMF programmes in Guinea, Liberia, and Sierra Leone found that the organization contributed to the failure of health systems to develop, thereby exacerbating the Ebola crisis (Kentikelenis et al., 2015a). The IMF's policy advice was associated with fewer public health resources, difficulties in hiring and retaining health workers, and unsuccessful health sector reforms. The IMF responded by arguing that its programmes strengthen health systems (Clements et al., 2013; Gupta, 2010, 2015). Box 1 summarizes the debate between the IMF and its critics.

To revisit these controversies, we use original documents collected from the IMF's Archives to examine whether and how IMF-mandated policy reforms have impacted government health expenditures in West Africa. We also construct a novel dataset of IMF-mandated policy reforms to evaluate quantitatively the impact of IMF lending conditionalities on government health spending in the region.

2. Methods

2.1. Data sources and study design

We collected 484 documents—primarily loan agreements and staff reports—from the IMF Archives in Washington DC and online pertaining to the 16 West African countries (UN Statistics Division classification): Benin, Burkina Faso, Cabo Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo. When requesting a loan from the IMF, countries send a letter to its management setting out the loan specifics (e.g. amount and duration), main objectives, and associated conditionality. These documents—drafted by country policymakers in collaboration with IMF staff—are known as Letters of Intent with attached Memoranda of Economic and Financial Policies, and are reviewed and updated in regular intervals. For example, a programme that is reviewed five times over its duration is linked to six Letters of Intent and Memoranda of Economic and Financial Policies: one for the original approval and then one for each review. The IMF also produces its own staff report to accompany each Letter of Intent, which contains information on macroeconomic developments, policy discussions, programme monitoring, as well as a concluding staff appraisal. We use these documents in a mixed methods research strategy. In doing so, we seek to avoid the risks of presenting selective evidence that can be associated with qualitative research, while yielding nuanced accounts that supplement statistical associations and illuminate causal pathways.

First, to map potential mechanisms of how IMF policies impact government health spending, we searched our archival material for information related to health systems and social protection policies. Our search terms included 'health', 'medic*', 'pharm*', 'pro-poor', 'social', 'poverty', 'labor', and other related keywords. To ensure that outliers were not captured, we only report pathways for which evidence was identified in three or more countries. While these mechanisms provide expositional clarity, they should not be viewed as wholly representative of the countries considered. That is, not all pathways apply to all countries under study (or during all IMF programmes), and it is possible that additional pathways exist that we were unable to capture. To our knowledge, this study is among the first to systematically deploy the IMF's own primary documents to identify specific IMF policy reforms related to health.

Second, we utilised these records to develop a new measure of exposure to IMF influence, which we then employed to quantify the association between IMF programmes and government health expenditures. We extracted all IMF loan conditions applicable to West African countries between 1995 and 2014, and disaggregated them into those which are binding and non-binding. During conditionality extraction and classification, we replicated coding to ensure inter-coder reliability and minimize measurement error.

In our quantitative analysis, we focus on binding conditions because they directly determine scheduled disbursements of loans, whereas non-binding conditions serve as markers for broader progress assessment (IMF, 2001b)—that is, non-implementation does not automatically suspend the loan—and may thus introduce noise to the analysis if included. Web Appendix 1 provides further details on the categories of conditions.

Our measure advances on previous research, which has relied on dummy variables or numbers of years of exposure to characterise IMF influence and has therefore overlooked heterogeneity in conditionality across programmes (Murray and King, 2008). While the IMF has its own conditionality database, known as Monitoring of Fund Arrangements (MONA), this database has been criticized by researchers and the IMF's own Independent Evaluation Office (Arpac et al., 2008; IEO, 2007a; Mercer-Blackman and Unigovskaya, 2004). First, the data is collected *ad hoc* from IMF desk economists, rather than being sourced directly from the loan agreements (Mercer-Blackman and Unigovskaya, 2004). Second, the data is presented in a way that precludes use in academic research: a large number of conditions are duplicates (thereby necessitating extensive and error-prone data cleaning), a break in reporting exists in 2002, and some reported conditions lack crucial information like the intended date of implementation. Third, underreporting and misclassification of conditions is ubiquitous (IEO, 2007a; Mercer-Blackman and Unigovskaya, 2004).

Fig. 1 summarizes the conditions applicable in all IMF loans for each country in Africa between 1995 and 2014, recorded from our own research. As shown, West Africa stands out as having the highest number of conditions across the continent, totalling 8344 (4886 binding and 3458 non-binding) across the 16 countries.

Box 1
How do IMF programmes affect health systems?

The IMF proposes three channels through which its programmes are linked to strengthening of health systems. First, IMF-supported reforms improve economic growth or raise tax revenues, thereby expanding fiscal space to allow governments to invest in public health (Clements et al., 2013; Crivelli and Gupta, 2016). Second, the inclusion of social spending floors in IMF programmes shelters sensitive expenditures from austerity measures (Gupta et al., 2000; Gupta, 2010; IMF, 2015a). Third, implementation of the IMF's policy advice catalyses foreign aid (including for health) and foreign investment (Clements et al., 2013; IEO, 2007b).

In contrast, critics argue that governments are unable to adequately invest in health because of pressure to meet rigid fiscal deficit targets set by the IMF, and that the organization diverts additional revenues and aid earmarked for the health sector to repay debt or increase reserves (Kentikelenis 2015; Kentikelenis et al., 2015a,b, 2016; Ooms and Schrecker, 2005; Stuckler and Basu, 2009; Stuckler et al., 2008; 2011). Additional evidence suggests that IMF-supported programmes decrease economic growth (Barro and Lee, 2005; Dreher, 2006; Przeworski and Vreeland, 2000), thereby shrinking available resources to fund health systems, and that the organization's programmes do not catalyse health aid (Stubbs et al., 2016).