



Structural adjustment and public spending on health: Evidence from IMF programs in low-income countries



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ARTICLE INFO

Article history:

Available online 24 December 2014

Keywords:

IMF
Low-income countries
Health expenditures
Structural adjustment

ABSTRACT

The relationship between health policy in low-income countries (LICs) and structural adjustment programs devised by the International Monetary Fund (IMF) has been the subject of intense controversy over past decades. While the influence of the IMF on health policy can operate through various pathways, one main link is via public spending on health. 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. Critics have pointed to adverse effects of Fund programs on health spending or to systematic underfunding that does not allow LICs to address health needs. We examine the effects of Fund programs on government expenditures on health in low-income countries using data for the period 1985–2009. We find that Fund programs are associated with higher health expenditures only in Sub-Saharan African LICs, which historically spent less than any other region. This relationship turns negative in LICs in other regions. We outline the implications of these findings for health policy in a development context.

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1. Introduction

The International Monetary Fund (IMF or Fund) was established in 1944 with a mandate to safeguard global financial stability, which includes serving as countries' lender of last resort. In exchange for low-cost financing, borrowing nations – often in a dire economic condition – agree on a list of policy reforms. Thus, the IMF has come to influence a wide range of policy areas, including public health. Critics of the Fund have argued that these mandated reforms have damaged health and health systems in borrowing countries. For example, Stiglitz (2002) pointed to Thailand's 'AIDS increase as a result of IMF-forced cutbacks in health expenditures' (p. 20). The Fund promptly responded, accusing Stiglitz of dishonesty and citing rises in health spending (Dawson, 2003).

Despite the often polemical nature of such debates (Goldsborough, 2006), past inquiries into how the IMF affects public health spending have produced mixed results. Analysts connected to the IMF have found a positive impact, and those unconnected have found a negative or mixed impact (see Table 1). A recent study by Fund staff analyzing 'the most comprehensive

[social spending] dataset assembled thus far' covering the period 1985–2009 provides a useful point of departure, finding that the IMF's programs have a positive and significant effect on public health spending in low-income countries (LICs) (Clements et al., 2013). We reanalyze this dataset, finding no statistically significant relationship in LICs. However, when we split the sample into a relatively poorer Sub-Saharan African sample and a relatively richer non-Sub-Saharan African sample we find a positive relationship in the former and a more robust negative relationship in the latter.

This article is structured as follows. Section 2 presents the channels linking Fund programs with government health spending, and summarizes existing evidence on this relationship. Section 3 provides a description of our data and addresses methodological issues related to the analysis. Sections 4 and 5 present our findings and report on robustness checks. In the final section, we place our results in the context of progress in meeting health needs, consider the policy implications of our findings, and offer some ways forward for future analyses.

2. Structural adjustment, health spending and the IMF

For most of its seventy-year history, the IMF has been associated with 'conditionality', understood as a set of reforms that borrowing countries must implement in order to obtain access to IMF

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financing. Initially, such reforms entailed reductions in public spending, exchange rate devaluations, and changes to monetary policy (Toye, 1994). From the mid-1980s onwards, however, the IMF began including new and intrusive conditions, that came to be known as ‘structural adjustment’ policies (Woods, 2006). As a consequence, borrowing countries must implement reforms on wide-ranging policies, such as privatization of state-owned enterprises and liberalization of trade and finance (Summers and Pritchett, 1993; Toye, 1994).

What have the effects of these programs been for health policy and public health expenditures? We posit that the IMF influence on such spending operates through direct and indirect pathways.

Direct pathways concern specific conditions in Fund programs that could plausibly affect health expenditures. First, starting in the mid-1990s, the IMF began to introduce conditions designed to protect social expenditures in light of adjustment (Gupta et al., 2000). However, spending targets are often expressed as shares of GDP, which – in the context of economic contraction – would translate into less total expenditure if the pre-crisis share is maintained. The extent to which these conditions are implemented and the importance that the Fund attached to monitoring them have also been questioned (Kentikelenis et al., 2014b; Goldsborough, 2007; Oxfam, 1995), but – to our knowledge – no systematic comparative data are available on this issue. Furthermore, for LICs that developed a medium-term expenditure framework in the context of their Fund programs, spending targets can become spending ceilings, as countries needed to factor into the target donor financing for health, thereby crowding out public spending (Ooms and Schrecker, 2005).

Second, policies often move beyond spending conditionality to foster a more active reshaping of the health sector. These include enhancing the role of the private sector in healthcare provision (Benson, 2001; Gupta et al., 2000; Loewenson, 1995; Turshen, 1999), introducing cost-sharing for the use of health services (IEO, 2003; Pitt, 1993; Sen and Koivusalo, 1998), and decentralizing health services (Kentikelenis et al., 2014b). 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, and devolution of responsibilities may occur without concurrent devolution of resources.

Finally, the Fund can be linked to public health expenditure via a ‘resource effect’ of the low interest credit provided under its programs. These additional resources could be used to boost expenditure to meet health priorities, although in some instances they are used to repay external debt (Gould, 2003). In addition, the Fund has argued that the presence of programs give countries a ‘stamp of approval’ that can catalyze aid flows (Clements et al., 2013), thus boosting total health expenditures through donor financing. While there is some quantitative 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, 2009; Stuckler et al., 2010) or that they will be channeled through the government (Lu et al., 2010; Sridhar and Woods, 2010).

While these implications for health expenditures are the most easily traceable, *indirect* pathways – unintended consequences of other policy reforms – may be equally important. A first common condition concerns the budget deficit. The Fund’s conservative projections, which form the basis of conditionality, often leave little fiscal breathing space for countries (Kentikelenis et al., 2014b; de Renzio, 2005; Goldsborough, 2007; Rowden, 2009). In the context of overall budgetary retrenchment, health spending can suffer as a result of the attempts of national authorities to meet bailout conditions. Another often-used condition concerns limits on the public sector wage bill. Given that in LICs much of public health spending is directed to salaries of doctors and nurses, general wage limits can drive these expenditures downwards (Van der Gaag and Barham, 1998). Fund policies can also increase prices for medicine and medical technology via currency devaluations that raise the costs of imported drugs and hospital equipment (Musgrove, 1987; Van der Gaag and Barham, 1998).

In addition, Fund-supported policies can have differential effects

Table 1
Empirical evidence on the relationship between structural adjustment and health expenditures.

	Span	Countries	Sample composition	Lender	Method	Dependent Variable: health expenditures as ...	Results: adjustment programs associated with ...	IFI authors
van der Hoeven and Stewart (1993)	1981–1990	18	Latin America	IFIs	Descriptive statistics	Share of GDP, and share of government spending	Decline in spending	No
Thiesen (1994)	1970–1988	31	Africa	IFIs	Descriptive statistics	Share of government spending	Decline in spending	No
Van der Gaag and Barham (1998)	1970–1993	95	Middle- and low-income	IFIs	Descriptive statistics	Per capita	Increase in spending	Yes
Gupta et al. (2000)	1985–1997	65	IMF borrowers	IMF	Descriptive statistics	Share of GDP	Increase in spending except in transition countries	Yes
IEO (2003)	1985–2000	146	All developing	IMF	ARIMA model	Share of GDP, share of total government spending, and per capita	Increase in spending	Yes
Nooruddin and Simmons (2006)	1980–2000	92	High-, middle- & low-income	IMF	OLS regression	Share of government spending	Decline in spending in democracies; increase in non-democracies	No
Huber et al. (2008)	1970–2000	18	Latin America	IMF	Prais-Winsten regression	Share of GDP	Increase in spending	No
Clements et al. (2013)	1985–2009	59	Low-income	IMF	System GMM and OLS regression	Share of GDP, and share of government spending	Increase in spending	Yes
Current study	1985–2009	63	Low-income	IMF	OLS regression	Share of GDP, share of total and discretionary government spending, and per capita	Decrease in spending in non-Sub-Saharan African LICs; increase in spending in Sub-Saharan African LICs	No

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