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## *Blocking Progress: The IMF and HIV/AIDS*

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In many low-income countries, HIV/AIDS activists and broader networks of public health and education advocates have been increasingly frustrated by the inability of their countries to spend more on the public health and education systems generally, and on the additional doctors, nurses and teachers projected to be needed to fight HIV/AIDS effectively or achieve other Millennium Development Goals (MDGs) by 2015. The Joint Learning Initiative on Human Resources for Health and Development, a global study of health workforces, found that to provide the essential health interventions required to achieve the MDGs will require Africa to increase its health workforce by at least 1m additional doctors, nurses, and midwives over the current level of 600,000 health care workers.<sup>1</sup> A similar study by the World Health Organization found that for essential health services to be provided, sub-Saharan Africa needs a total of 2.5m additional health care workers.<sup>2</sup>

Yet such spending increases are not at all possible under the current economic policy choices. Most health and education ministries only have the budgets granted by their finance ministries, and in turn, the finance ministries explain that budgets are in line with the fiscal and monetary policy targets agreed with the International Monetary Fund (IMF).

Most low-income countries are under pressure to stay 'on track' with their IMF programs, as its essential for also accessing World Bank money or aid from the other major multilateral or bilateral donors and creditors. By playing such a gatekeeper role to all other foreign aid, the IMF's 'signal effect' has given it tremendous power beyond the amount of money in its loans. The fundamental problem is that under current IMF policy choices and spending constraints, many countries will not be able to increase expenditures or public investment in line with what is projected to be needed to fight HIV/AIDS or achieve the MDGs.

A flashpoint of controversy in recent years has been over the IMF's use of ceilings or caps on the wages for all public sector employees in the budget as among its binding loan conditions. When enforced, the national wage bill ceilings consequently constrain the levels of wages available for each of the sector budgets, including for health personnel. Therefore, even when donors are willing to finance personnel costs, such as increased salaries or new health care worker posts, countries may be prevented from using such funds because of the IMF's spending limits on wages. As the wage ceilings have made planning for ambitious scaling-up of health personnel all but impossible, the IMF has become a lightning rod for unwanted attention. The same is true for education advocates seeking to hire more teachers.<sup>3</sup>

In 2004, the IMF wage bill ceiling collided with a bold UK initiative to fund Malawi's national Emergency Human Resources Plan, an important step that

broke with common donor practice by funding the recurrent expenses associated with increasing salaries of domestic health care workers and creating new posts. When the IMF objected, it was negotiated and finally agreed the wage ceiling could be lifted to accommodate the money spent on personnel if done slowly over six years. Recently, the IMF has attempted to placate critics with a July 2007 claim it will now back away from its widespread use of the wage ceilings, but may still use them as it deems necessary.<sup>4</sup>

Unfortunately, both the ingenuity shown by the UK to spend on wages and the 'flexibility' on wage ceilings by the IMF in the Malawi case are the exceptions and not the rule. Generally, aid donors are unwilling to commit funds for recurrent wages, and the IMF reinforces this by raising concerns about potential macroeconomic problems that could result from entering into long-term expenditure commitments without long-term donor commitments to finance them. Donors should, however, follow the UK's enlightened lead by planning for longer-term aid commitments and making resources explicitly available for personnel salaries.

#### WHAT DO FISCAL AND MONETARY POLICIES HAVE TO DO WITH GETTING MORE DOCTORS, NURSES AND TEACHERS HIRED?

Although the wage bill ceilings have been the focus of much attention and ire, and the unpredictability of future donor aid commitments is also a legitimate concern, both are merely symptoms of the deeper underlying problem of chronically insufficient national and sector budgets generally. Keeping wages constrained is just a subset of the larger IMF goal of reducing or keeping overall national public expenditure constrained. The two key policies used to achieve this goal are the fiscal policy (deficit-reduction targets) and monetary policy (inflation-reduction targets) in the macroeconomic framework of the IMF loan programs.

These two policies can directly impact the GDP growth rate for the whole economy (and thus the amount of taxes raised and public expenditure available) and how much foreign aid can be absorbed and spent in a year. HIV/AIDS, health and education advocates who are trying to get more doctors, nurses and teachers hired must understand how these two key fiscal and monetary policies will be essential to achieving their advocacy goals for increased public expenditure.

The main two problems are that the IMF's unnecessarily restrictive deficit-reduction and inflation-reduction targets are creating a monumental bottleneck that is preventing countries from: (1) being able to fully utilize all of the increasing levels of foreign aid that have become available in recent years; and, (2) being able to generate higher levels of expenditure domestically.

Regarding not fully using available donor aid, an April 2007 study of 29 sub-Saharan African countries by the IMF's Independent Evaluation Office found that over 70% of the donor aid increases given to the countries between

1999–2005 was redirected into building international currency reserves at the central bank or paying down domestic debt in order to meet the strict IMF monetary policies, while only 28% was actually allowed to be spent as intended by donors.<sup>5</sup> A recent study by the Washington, DC-based Center for Global Development also found that donor aid flows for global health were being undermined by IMF policies that are unnecessarily restrictive.<sup>6</sup>

Regarding not generating higher domestic expenditure, the IMF advises countries to raise short-term interest rates in order to lower inflation, but this can have the negative side-effect of slowing down GDP growth rates, employment and public spending. Therefore, there is a trade-off in which the IMF prefers to sacrifice higher GDP growth and spending in order to get lower inflation.

Serious health and education advocates today have no choice but to wade into the murky world of abstract debates about the degree of restrictiveness of the IMF's fiscal and monetary targets, how they impact the size of national budgets in poor countries, and possible alternatives.

No one wants policies that are too 'loose' or lead to large budget deficits or high inflation rates, or policies that are too 'tight' or unnecessarily restrictive, as these can constrain optimally higher GDP growth rates and public spending levels. In between these two extremes are what economists call 'the gray area', or a range of still feasible alternative options that could allow for differing degrees of public expenditure and restraint. The IMF does not like to talk about the existence of this range of alternatives.

Examples of possible 'gray area' alternatives were highlighted in an Oxfam International report that took IMF deficit-reduction targets for a set of countries and suggested hypothetical projections for how much more public spending countries could have engaged in had they been allowed to pay down their deficits more slowly. The outcomes were striking, in some cases enabling a doubling of health and education sector budgets.<sup>7</sup>

Each option within this 'gray area' range of feasible alternatives has its own short-term and long-term costs and benefits, all of which could be discussed, assessed and debated by key public stakeholders, such as health and education ministry staff, relevant legislative committees and civil society. However, in most low-income countries, such inclusive discussions of ranges of alternative policy scenarios have not been the case. Usually the IMF meets periodically with central bank and finance ministry officials from borrowing countries behind closed doors, where it insists on extremely restrictive policies. The problem is that the IMF insists its preference is the *only* option, and officials tend to go along with this.

## 25 YEARS OF RESTRICTIVE SPENDING POLICIES

The IMF's position has become the dominant orthodoxy in development economics, but this was not always the case. In the early 1980s, former US President Ronald Reagan and UK Prime Minister Margaret Thatcher

transformed the IMF and World Bank by eliminating the Keynesian economists, who believed in a key role for the state in modulating economic policies, and replaced these staff with the neoliberal economists who favored free trade and free markets over state intervention. At the IMF in particular, a subset of neoliberal economists called ‘monetarists’ rose in ascendancy, who believed that inflation is always unacceptable and that budget deficits should not be allowed. At this time, such extremely restrictive fiscal and monetary policies were viewed as just one very conservative option along a range of other feasible possible policies, but as years went by, the IMF’s position has gained dominance and is today widely believed to be the only option available to countries.

For over 25 years, leading think-tanks, university departments, textbook publishers and corporate media have contributed to the perception that extremely restrictive fiscal and monetary policies are not only ‘sound’ and ‘prudent’, but also that they are the *only* option. (The dominance of these ideas has remained true despite the apparent hypocrisy of rich countries, who still freely adopt more expansionary monetary policies or countercyclical fiscal policies when needed, but who do not allow developing countries to do so.)

Key tenets of the monetarism that informs IMF policies include that fiscal deficits must be paid down to very low levels very quickly and that inflation rates must be driven down into at least the 5% to 7% range in order to constitute ‘macroeconomic stability’. However, this definition of stability is contradicted by much other published research in the peer-reviewed economics literature, which shows that moderately higher budget deficits and inflation rates do not necessarily constitute ‘instability’.

Public health and education advocates should know and use this information – that the IMF does not have the last word. They must step up investment in macroeconomic literacy trainings for civil society, key legislative committee members, health and education ministry staff and the media.

In borrowing countries, such training is essential for enabling advocates to more forcefully engage with their finance ministries about what is being agreed to with the IMF. Advocates must create public spaces where the options for alternative, more expansionary spending policies can be publicly discussed, debated and assessed, and in a transparent and accountable way that can be done *before* the finance ministries sign on to future IMF loan programs.

#### IF YOU’RE GOING TO SCALE-UP, YOU’LL NEED THE FISCAL AND MONETARY POLICIES TO MATCH

Global advocacy networks are increasingly pressuring the IMF to change. An example of this mounting pressure was expressed in an October 2007 global NGO sign-on letter to Dominique Strauss-Khan, the incoming IMF Managing Director, in which 125 organizations called on him to change these unnecessarily restrictive policies that undermine developing countries’ ability to increase health and education spending.<sup>8</sup>

Because the richest countries dominate politics on the IMF Executive Board, health and education advocates in the rich countries are also calling on their governments to use their influence at the IMF to make formalized policy changes and instruct staff to allow for looser fiscal and monetary policies.

Critics of the monetarist policies introduced by Reagan and Thatcher had fought against them in the 1980s and 1990s, and lost both times. But today, the global imperative to fight HIV/AIDS effectively and meet the MDGs presents a new factor in the equation. The current policy incoherence of trying to both scale-up spending with one hand while letting the IMF restrict spending with the other is becoming increasingly untenable for growing numbers of advocates who are demanding results.

The same over-zealous spending restraint that has been a hallmark of the monetarists for 25 years may also end up being their Achilles heel in today's changing world, which is eager to see scaled-up public spending. In this sense, the persistent political demands of emerging global social movements for health and education may end up signaling the beginning of the end for the reign of the monetarists at the IMF. If they keep pushing, these movements can help open the way for use of the more expansionary fiscal and monetary policies likely to be needed to enable a significant scaling-up of public investments in health, education and other national development goals in low-income countries.

#### NOTES

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