

**THE IMPACT OF THE INTERNATIONAL MONETARY
FUND'S MACROECONOMIC POLICIES
ON THE AIDS PANDEMIC**

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Expansion of funding for HIV/AIDS, especially treatment, is under attack over concerns about cost effectiveness and financial constraints. The International Monetary Fund is deeply implicated in the history of the AIDS pandemic, the underlying weakness of health systems, and the ideology of constrained resources that underlies most attacks on AIDS funding. The IMF imposed structural violence on developing countries in the 1980s and 1990s through neoliberal and macroeconomic reforms that intensified individual and communal vulnerability to infection and dismantled already weak health systems. This same macroeconomic fundamentalism has recently been repackaged and renamed. IMF fundamentalist policies continue to prioritize low inflation, constricted government spending, robust foreign currency reserves, and prompt repayment of debt at the expense of investments in health and more expansionary, pro-growth and job-creation policies. Several recent surveys have concluded that the IMF reluctantly relaxed overly restrictive policy prescriptions in response to the global economic crisis, but this relaxation was temporary at best and only extended to countries previously acceding to IMF orthodoxy. AIDS activists are campaigning for billions of dollars to fulfill the promise of universal access. If IMF pressures persist, developing countries will continue to undermine the additionality of donor health financing by substituting donor for domestic financing, refusing to invest in recurrent costs for medicines and health workers, and neglecting needed investments in health infrastructure and health system strengthening.

Funding and programming for HIV/AIDS, especially for antiretroviral therapy, is under attack. Using arguments about resource constraints, cost-effectiveness,

prevention versus treatment, neglected conditions, and health systems distortions, academic, global health, and political analysts are lining up to argue that HIV/AIDS has been getting too much money, that the future of global health financing is bleak, and that HIV/AIDS programming will have to take a backseat to other underserved health priorities, including disease prevention, child and maternal health, and health system strengthening more broadly (1–21). More specifically, critics have been questioning the disproportionate footprint of Global Health Initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the U.S. PEPFAR (President’s Emergency Plan for AIDS Relief) program and their results-based focus on priority infectious diseases. The critics have argued against the de facto creation of an international entitlement to AIDS treatment (18), and are collectively, if unintentionally, providing ideological cover for the persistent underfunding of the Global Fund, the flat funding of PEPFAR, and the reprogramming of health aid in Europe (22, 23).

Given this onslaught on AIDS funding, it might seem off-point to critique the International Monetary Fund (IMF), which sits obliquely at the edge of these debates. However, the IMF is deeply implicated in the history of the AIDS pandemic, in the weakness of health systems, and in the ideology of restrained resources that underlies most of the current attacks on AIDS funding. The IMF imposed structural violence on developing countries in the 1980s and 1990s through neoliberal and macroeconomic reforms that intensified individual and communal vulnerability to infection and dismantled already weak health systems. Those same policies, now repackaged but fundamentally the same, continue to prioritize low inflation, constricted government spending, robust currency reserves, and prompt repayment of debt at the expense of needed investments in health and more expansionary, pro-growth and job-creation economic policies.

A SHORT HISTORY OF THE INTERNATIONAL MONETARY FUND’S DISASTROUS IMPACT ON HIV/AIDS AND HEALTH SYSTEMS

IMF-mediated neoliberal and macroeconomic policies have caused injury to developing country economies and to the well-being of their health systems. Although this is not the place to document the entire story of failed neocolonial “development,” it is appropriate to trace some of the key aspects of neoliberal and macroeconomic policies promoted by the IMF that have intensified the global health crisis in general and the AIDS pandemic in particular. These include: (a) maintaining colonial patterns of ownership; (b) consolidating control of a crushing debt burden; (c) deforming economies and trade toward exploitation of natural resources and production of low-cost exports and importation of high-cost finished goods; (d) liberalizing capital controls, currency exchanges, and financial markets, resulting in currency devaluations, market volatility, and net outflows of capital; and (e) enforcing structural adjustment

programs, including (i) fiscal austerity and reduced government spending, particularly in health and education, and (ii) privatization and marketization of public resources, goods, and services (24–34).

No story about the impact of globalization can start without appraising, first, the ownership portfolios of former colonial masters, where the spoils of plunder are amassed. Although local elites have been given managerial and occasional junior partner status, a significant portion of extractive resources and productive capacity of developing countries is owned by transnational corporations and global financial interests; and the benefits of that ownership are expropriated and exported to financial centers in the global North (35–37). Deprived of control over their natural resources and human capital, African countries have remained comparatively impoverished and simultaneously highly unequal. Resulting gradients of inequality are themselves incubators of disease (38).

Second, African countries in particular, but other developing countries as well, have been buried in debt starting in the late 1960s. Although much of that debt was at one point private—frequently, debt of private industry to commercial banks used in the capitalization of productive capacity—the debt increasingly became multilateral and bilateral, debt that was owed by developing country governments to individual governments and/or to the World Bank and IMF. After the oil shock of the 1970s, and as terms of trade worsened and the global economy suffered stagflation, developing countries needed to borrow more and more money at higher and higher interest rates to bolster their foreign currency reserves and public expenditures. Similarly, as the World Bank lent money to governments to build physical infrastructure appropriate to an export economy, and as First World governments bilaterally lent money to finance purchase of excess goods, military and nonmilitary, the developing world's debt burden became more and more bloated. Fundamentally, low-income countries, particularly in Africa, became chronically indebted as a result of an inherently imbalanced pattern of trade between the underpriced agricultural/extractive and pre-industrial economies of the South and the overpriced industrial and information-based economies of the North (39–42).

Paying off this mound of debt became particularly problematic because so little of it resulted in increased productive capacity, job creation, or wealth redistribution. Not only was loan money used to buy expensive Western consultants, questionable showcase infrastructure projects, and Western luxury imports, but a great deal of it was given to undemocratic and corrupt governments that were proxies for foreign business interests and pawns to Cold War great powers (37). Needless to say, these debts did not result in economic benefit to the poverty-stricken masses. As a consequence of the debt burden, many African countries spent more on debt repayment than on public health. The Jubilee Campaign and many other activist groups campaigned for cancellation of this debt (42), resulting eventually in partial debt relief from the IMF, World Bank, and other multilateral and bilateral creditors through the Highly Indebted Poor

Country Initiative and from the G-8 through the Multilateral Debt Relief Initiative. As of late 2009, nominal debt relief totaled \$124 billion for 35 low-income countries, at a cost of \$74 billion net present value to creditors (43).

Third, the general effect of international trade policy, orchestrated by the IMF, has been to dismantle rural subsistence, multisectoral economies in favor of import/export-oriented economies (36, 37). Thus, it has become increasingly difficult for rural populations to earn a living and to subsist off the agricultural product they produce (44). Instead, agricultural economies have been restructured toward a narrow range of export farm products (45). Young men, driven from the countryside, migrated to cities and to new industries that were also export-oriented and increasingly capital-intensive. This mass, single-sex migration simultaneously disrupted familial ties and deepened the rural poverty of women, thereby providing fertile ground for the commodification of sex and the explosion of sexually transmitted diseases, including HIV (25, 46, 47).

Fourth, the market fundamentalism of the IMF required liberalized capital, financial, and currency markets—facilitating legal and illegal capital flight and market speculation in currency and financial markets that have expanded exponentially over past decades, at the same time that proportional investments in productive capacity decreased (48, 49). This new focus on financial rather than productive investment has led repeatedly to speculative bubbles in currencies and financial exchanges, with a temporary influx of external capital, followed, almost inevitably, by currency and market crashes such as the one now occurring (50, 51).

Fifth, the debt and balance-of-payment crises in Africa, which consolidated debt within international financial institutions, set the stage for infamous structural adjustment programs of the 1980s and 1990s (33, 34) that have further deflated and destabilized African economies. These structural adjustments, imposed by the IMF as a condition of extending and refinancing African debt, invariably included two phases. The first phase required macroeconomic stabilization via (a) currency control deregulation, currency devaluation, and the build-up of foreign currency reserves, so that foreign debt could be paid and imports could be paid for; (b) price stabilization through reduced inflation (5% target) and higher interest rates, and a reduction in real wages and consumption; and (c) budgetary austerity including, typically, a mandatory 3 percent cap on deficit spending (32). Fiscal austerity measures often included overall budget ceilings, wage caps, and/or wage reductions in the public sector (32). These restrictions led to inadequate wages and appalling working conditions for health workers, which in turn contributed to a growing brain-drain problem (52–55). In addition, fiscal restraint reduced public investments in health infrastructure and health systems, leading to the tattered systems that we see today. Nonetheless, according to the IMF, restraining public spending had to be done, because of the higher value of not “crowding out” private investment that was presumed to be more productive (56).

Phase two of IMF reforms required trade liberalization—reduced tariffs and less subsidization of domestic industry, tax reform transferring tax burdens

from businesses to workers and consumers (for example, value added taxes); privatization/marketization of government services and assets; and liberalization of labor laws, including non-indexing of wages (32, 45). In addition, at the same time that the global powers were using structural adjustment programs to force reductions in social spending, including social spending on health and education, they were imposing cost-recovery policies on medical visits, charging for condoms, and retailing medicines (57). IMF “un”healthy user fees resulted in dramatically lower attendance in sexually transmitted disease clinics in Kenya and in reduced condom use in Zimbabwe (44).

The IMF also came up with special policies and ideological constructs to deal with fickle donor aid. Since donor aid was often volatile and unpredictable in the short term, the IMF warned countries against relying on aid in planning their public sector spending. In particular, it discounted the desirability of investing aid in recurrent costs that would have to be paid over the long haul (31). Instead, the IMF advocated an ideology of self-sufficiency or sustainability, wherein countries had to calculate their future public spending on the assumption that such spending would ultimately depend entirely on domestic resources (31).

PRE-CRISIS IMPACT OF INTERNATIONAL MONETARY FUND POLICY ON HEALTH SPENDING

There is now ample proof that IMF macroeconomic policies constrained spending on health and education, even in the pre-crisis era of increasing global resources for health. The IMF’s Independent Evaluation Office (IEO) examined IMF loan programs in 29 sub-Saharan African countries between 1999 and 2005 and found that 37 percent of all annual aid increases was diverted to building currency reserves and that another 37 percent was devoted to domestic debt repayment (58). That left only 27 percent of annual aid increases for actual spending on health, education, infrastructure, or other pro-development needs. So-called weak performers (inflation above 5% and foreign currency reserves less than 2 months of imports) spent even less, only 17 percent of new aid. Likewise, countries with less than two and a half months of reserves put 95 percent of increased aid into reserves, whereas countries with high reserves absorbed 100 percent. Finally, weak performers with more than 5 percent inflation put 85 percent of increased aid into debt reduction, in contrast to countries with inflation below 5 percent, which put only 21 percent into debt reduction. Accordingly, the “main drivers” in decisions to curtail the spending of aid were the IMF’s insistence on very low levels for inflation, its excessive concerns about the volatility of aid, and its desire for ever higher currency reserves to protect against “shocks” (58). The IEO also found that the IMF Poverty Reduction Growth Facilities limited domestic financing of aid shortfalls and required full saving of windfalls (58). In essence, the IMF continued to discount the availability of future aid flows, which reduced the amount of aid actually spent.

The Center for Global Development assessed IMF macroeconomic restraint policies and their impact on developing countries' health spending (59). It found that the IMF had not done enough to explore more expansionary, but still feasible options; that empirical evidence did not support pushing inflation to the 5 percent level in low-income countries; that the IMF should consider the supply-side benefits of additional spending on spare capacity utilization, investment, and future output growth; and that wage-bill ceilings had been overused.

The IMF responded to the IEO and Center for Global Development critiques with a series of papers that explored the spending and absorption of foreign aid. The Fund challenged the IEO critique by using a different cohort of countries, over a different time period, and over a more extended period of time (60). It also defended policies allegedly designed to maintain macroeconomic stability and smooth the aid volatility by building reserves and reducing debt so that resources might be spent more prudently in the future (61, 62). However, it did not respond to more fundamental critiques about an overly restrictive set of fiscal and monetary targets or to earlier critiques about flexibilities for increasing official development assistance for AIDS (63–65). Likewise, the IMF could not mount an effective challenge to a peer-reviewed study that correlated increasing rates of tuberculosis and TB deaths to the presence of IMF economic reform programs in post-communist Eastern European and former Soviet countries (66–68).

Following the sharp escalation of food and fuel prices in 2007–8 and the risks of imported inflation for developing countries' inflation rates, currency reserves, and fiscal deficits, the IMF's policy advice embodied its typical litany of fiscal, monetary, and trade policy recommendations (69). According to a December 2008 report, "The central gist of the policy advice is to pass the higher prices onward from the state to the consumer in order to ease the external imbalance and budget deficit, tightening monetary policy in order to abate inflation levels, and employing exchange rate depreciation as a 'shock-absorber'" (70). For the IMF, the risk of lower credibility if inflation targets are missed outweighed predictable output losses arising from higher interest rates. Likewise, the IMF's policy advice on fiscal deficits was to reduce universal fuel subsidies, reduce taxes, and limit public sector wage increases (70).

POST-CRISIS POLICIES: NEW PACKAGE, SAME SUBSTANCE

The current global financial and recessionary crisis could have been an occasion to dramatically revise and dampen the structural imperatives of global finance and to reorder macroeconomic policies that have for so long disadvantaged most low- and middle-income countries and have created gradients of inequality that fuel the AIDS pandemic. After all, through no fault of their own, 39 of the poorest countries in the world face a \$216 billion balance-of-payment shortfall in 2009. Fiscal stimulus required another \$41 billion. More broadly, there is an

estimated \$1 to 2 trillion shortfall in external financing in developing countries at the same time that growth rates have fallen from 8.7 percent in 2007 to 1.6 percent in 2009 (71). Instead, despite this crisis, the IMF, an institution that claims no history, continues to assert that old critiques are stale, that it has changed its stripes to be more pro-poor, and that it will be the post-crisis savior of developing country economies. In particular, it claims that it has amended its financing facilities, that it has wholeheartedly adopted anti-cyclical policies for its client countries, that it has reduced conditionality, and that it is preserving fiscal space for pro-poor safety nets.

One might hope that the deepening global recession would have caused the IMF to rethink its policies, especially in Africa, so that Africa, too, might be able to pursue more expansionary fiscal policies to offset precipitous declines in export earnings and aggregate demand and to address additional demands for social spending. However, an early 2009 report from the IMF on the impact of the financial crisis on Africa continued to prioritize macroeconomic fundamentalism (71). Although a few countries with low debt and no financing constraints might be permitted to undertake fiscal easing, the IMF said that most countries must “preserve hard-won gains in economic fundamentals” by avoiding excessive borrowing that crowds out the private sector or fiscal measures that might exacerbate the loss of foreign exchange reserves. Indeed, the IMF suggested that “to support growth and create fiscal space, all countries would be well-advised to persevere with structural fiscal reforms.” The IMF paper also prioritized efforts to prevent inflation, but discouraged capital controls, arguing that they were unlikely to be effective. A subsequent IMF update focusing on sub-Saharan Africa repeated these policy prescriptions, but added additional ones favoring a medium-term return to government spending focused on infrastructure and human capital investments, rather than government spending, for example, on health (72).

Admittedly, the IMF has put new wrappings on its old policies (73–75). What was historically called structural adjustment facility, then enhanced structural adjustment facility, and more recently, poverty reduction and growth facility (PRGF), has now been renamed the Extended Credit Facility (EFC). The EFC changes none of the substantive policies of the PRGF, and instead reproduces the same loan terms and maturities, albeit with slightly expanded credit limits (76, 77). There is a new Stand-by Credit Facility (SCF) for low-income countries that mirrors the structure of the balance-of-payment support previously extended to IMF-compliant middle-income countries. Although the SCF has reduced formal conditionality, it is only available to countries that have already adopted IMF monetary, fiscal, and reserve-balance conditionality (76, 77). In other words, countries that have “voluntarily” locked themselves in the IMF stability cage—accepting ex-ante conditionality—get to borrow without an outside jailer imposing additional, but now unnecessary, terms.

The IMF claims that its programs have been flexible in accommodating larger fiscal deficits and higher inflation during the current crisis and that it continues

to protect priority social expenditures (78). And, there is some truth to the claim that the IMF has temporarily reduced inflation and fiscal deficit targets, given double external shocks arising from the food/oil price crisis and the more recent financial meltdown. Likewise, the IMF has promised to scale up concessional loans to developing countries by \$10 billion, 2009–11, and by \$17 billion through 2014, and it has agreed to suspend interest charged through the end of 2011. Finally, in August 2009 the IMF allocated special drawing rights, totaling nearly \$20 billion, to low-income countries (78).

Most critics note, however, that in doing so the IMF simply bowed to the inevitable (77)—developing countries simply could not accommodate the multiple impacts of rising food and oil prices (food up 45% from the end of 2006); reduced remittances (down 10% in 2009), static foreign aid, and fractional foreign investment (down 25%); increased costs of borrowing on international markets; and faltering terms of trade, reflected in plummeting commodity prices and export earnings (down 12% in 2009) (79). Good-performing countries that nonetheless struggled to undertake counter-cyclical spending were able to do so mainly because of so-called past gains—reduced public debt and accumulated official foreign currency reserves, both resulting from previously delayed social spending. However, countries with more vulnerable debt positions and weaker reserves were required to adopt more cautious and even more temporary expansive fiscal policies. Likewise, the IMF’s alleged anti-cyclical policy space was programmed to be of very short duration (77). In nearly every country where it has bowed to the reality of macroeconomic “imbalances,” it urged a quick return to pre-crisis macroeconomic policies as early as 2010–11: “As the recovery gains strength . . . countries should be prepared to realign policies toward medium-term stability” (78). “Once economic activity rebounds, stimulus measures will need to be unwound, deficits restrained, and debt reduced to sustainable levels” (80).

In terms of conditionality, the IMF notes that it has suspended use of structural performance criteria, that specific, structural conditions are now monitored through structural benchmarks (81), and that the number of structural conditions has been declining from nine per grant to six per grant since the early 2000s. Following protracted critique, the IMF has reduced its formal wage-bill ceilings so that none of the 37 Fund-supported programs in low-income countries contain a wage-bill ceiling as a performance criterion, and only three have indicative, non-binding targets (81).

Despite the IMF’s pious declarations of change, critics have issued successive reports challenging ongoing evidence of macroeconomic fundamentalism. The Center for Economic and Policy Research (CEPR) has issued the most recent and comprehensive critique, wherein it evaluates the IMF’s macroeconomic policy prescriptions for 41 countries that have entered into agreements with the Fund since 2008. The CEPR paper found that 31 of the 41 countries had been compelled to implement pro-cyclical fiscal and/or monetary policies, though such policies were relaxed in some countries as the crisis intensified (82).

Nonetheless, the IMF again defended its post-crisis policies for low-income countries (81, 83, 84), whereafter the CEPR issued a comprehensive rebuttal (85). Another CEPR study focused on Eastern Europe, documenting the disastrous effects of IMF pro-cyclical, contractionary policies on Hungary, Latvia, and Ukraine (86). Similarly, a smaller study by the Centre for Economic Governance and AIDS in Africa and Results found that macroeconomic policies advanced by the IMF (very low inflation, low fiscal deficits, high foreign currency reserves, and limited access to domestic credit) restricted options for increasing health spending and alleviating health workforce shortages in Kenya, Tanzania, and Zambia (87). In the spring of 2009, the Global Campaign for Education surveyed the impact of post-2007 IMF standby arrangements on 16 low-income countries (88). Its findings confirmed the conclusions of an earlier Third World Network analysis of nine loans, which showed that the IMF continued its fundamentals of tightening fiscal and monetary policies, including the establishment of rigorous inflation targets (89). Finally, a 2009 study by Eurodad (European Network on Debt & Development) examined 10 post-2008 crisis loans and found that they had granted extremely limited fiscal and monetary flexibility, and then only on a very short-term basis (90). Five programs pushed for wage-bill freezes or cuts; five had to reduce their deficits; five had to pass through food and fuel price increases; and all had to make spending cuts. None had the flexibility to defer debt payments.

The issue of renewed debt has special salience, given the debt crisis of 30 years ago that delivered developing country economies into the tight embrace of the IMF and World Bank. In March 2009, the IMF reported that the debt-to-GDP (gross domestic product) ratios of 28 low-income countries exceeded 60 percent, twice the IMF threshold for “weak performers”; Yuefen Li of the United Nations Conference on Trade and Development (UNCTAD) cited concerns in at least 49 least-developed countries (91); and Jubilee issued a report warning about the renewed debt crisis in developing countries (92).

Although the IMF likes to tout the increased concessionality of its loans, the fact remains that they are loans—sovereign debts that will have to be repaid with interest by future generations, who once again become trapped in the unbreakable cycle of revolving credit loans and repayments. Gail Hurley of Eurodad argues that “it is profoundly unjust that poor countries will in essence pay for the mistakes of the rich via new rounds of debt” (93). Of course, the IMF has no intention of granting a moratorium on external debt payments, as supported by Eurodad (94) and UNCTAD (95), and has limited means for providing true grants instead of concessionary loans. Repaying these loans, including interest, and increasing foreign currency reserves will once again require fiscal restraint and stringent inflation safeguards. These constraints, in turn, not only will restrict government investments in AIDS and other health programming, they will also prevent needed investments in growing developing country economies, creating jobs, and raising government revenues to expand fiscal space.

CONCLUSION

The International Monetary Fund frequently claims that it has modified its macroeconomic policies in response to past criticisms of its overly restrictive inflation, deficit, and currency reserve targets and their demonstrated adverse effects on health spending. A review of the most recent evidence, however, shows that the IMF continues to prioritize what it calls “macroeconomic stability” over all other development and health concerns. Assumptions that Dominique Strauss-Kahn, the new French socialist managing director of the IMF, would change IMF policy mandates, or that the IMF has turned in new directions because of food, fuel, and recessionary shocks imported into developing countries, have proven illusory at best. Short-term accommodation to the inevitability of external shocks does not constitute even a modest reform to the IMF’s macroeconomic fundamentalism. To the contrary, the Fund continues its historical commitment to tight monetary, fiscal, and reserve policies, at the same time that it continues to prioritize its role as a gatekeeper to external financing through its signaling effect (96–98).

Global health activists are pursuing new channels of domestic and donor resources for health so that Millennium Development and other health goals might be reached. AIDS activists, in particular, are campaigning for the tens of billions of dollars needed to fulfill the promise of Universal Access, now postponed from 2010 to 2015, and perhaps derailed entirely. If the IMF’s hydraulic pressures constraining increased fiscal expenditures persist, then developing countries will continue to undermine expansion of donor health financing via substitution (decreasing domestic health funding as donor funding increases) (99), by refusing to invest in recurrent costs for medicines and health workers, and by neglecting needed investments in health infrastructure and health system strengthening. The Health 8, the High-Level Taskforce on Innovative Financing for Health Systems, the International Health Partnership plus associated initiatives, multi-lateral and bilateral donors, and health activists—all must demand immediate and profound changes to the IMF’s lock-down fiscal and monetary policies that adversely affect health sector spending. Members of the IMF Executive Board must be instructed by their governments to change overly restrictive IMF policy prescriptions and to widely publicize those changes to line officials and to developing country ministries of finance.

The time for false assurances of pseudo-reform has ended—it is a time for action, a time to dismantle the AIDS-enhancing edifices of IMF-engendered macroeconomic and market fundamentalism.

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