

Expenditure ceilings, multilateral financial institutions, and the health of poor populations

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"Grace in the Positive"

In December, 2001, 29-year-old Graça Nevas approached the Médecins Sans Frontières (MSF) team in Mozambique. Ms Nevas, one of the few Mozambican people openly living with AIDS, felt that she was going to die soon and wanted a documentary to be made about her final weeks or months. "I want to thank the people that supported me and convinced me not to commit suicide", she said, "and I want my children to know that I have fought until the end to be there for them. But most of all, I want the people of Mozambique to know that AIDS is real."

MSF had just received a green light from the Mozambican ministry of health to set up and run an antiretroviral treatment pilot project in one of the public-health centres in Maputo, Mozambique's capital. "Graça no Positivo" (Grace in the Positive), the documentary,¹ became a story about the feasibility and the positive effect of antiretroviral treatment in one of the world's poorest countries. When the documentary was released in December, 2002, many things had changed in Mozambique. Notably, funding from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) and the Clinton Foundation was expected to make antiretroviral treatment available throughout the country by 2008. However, the International Monetary Fund (IMF) and World Bank had warned the government of Mozambique that this plan might be too ambitious. The background to such warnings reveals the dark underside of the industrialised world's grand rhetoric about improving the health of the poor.

The trouble with medium-term expenditure frameworks

Mozambique is one of 32 countries in southern Africa that are eligible for assistance under the heavily indebted poor countries (HIPC) initiative, the centrepiece of the industrialised world's efforts to reduce a burden of external debt that has long interfered with many countries' ability to meet basic needs.² To receive debt relief, countries must prepare a poverty reduction strategy paper (PRSP) for approval by the IMF and World Bank, which then periodically assess implementation. Apart from the HIPC process, PRSPs and their assessments by the World Bank and IMF are becoming increasingly important as national aid agencies allocate development assistance. Most strategy papers include a multiyear budget projection called a medium term expenditure framework (MTEF), which includes spending targets for various sectors of government activity.

In some countries, health-spending targets identified in the MTEF have functioned, at least temporarily, as health-spending ceilings: the requirements of the IMF appear to mean that countries must include the value of all new donor funding received for initiatives such as scaling-up delivery of antiretroviral treatment. In a news item published in *The Lancet*, the reporter pointed out: "if a sector receives any new funds that were not initially budgeted for, it forfeits a similar amount from the government coffers."³ Such expenditure ceilings create an obvious disincentive for external funders to offer financing that is desperately needed for such interventions. One of us (GO) was warned by health ministry officials about this problem in 2002 while serving on the Mozambican Country Coordination Mechanism, a group set up to elaborate proposals for submission to the Global Fund. Only direct intervention by a member of former US president Clinton's entourage eventually resolved the issue.

In Uganda, the finance ministry initially sought to prevent the health ministry from increasing its budget to reflect the value of a grant received from the Global Fund;⁴ only after many months of negotiations did the finance ministry relent.⁵ According to a document prepared for the January, 2004, WHO High Level Forum on meeting the health Millennium Development Goals (MDGs), the Ugandan health ministry has stated that reconciling health expenditure requirements with "macroeconomic stability . . . is the single most important issue that has to be solved if there is a serious intention to achieve significant progress toward the MDGs".⁶ An April, 2003, IMF report commented that "similar issues have arisen in Tanzania and Mozambique".⁷ As of January, 2004, the issue had yet to be resolved in Uganda;³ in September, 2004, the IMF claimed that no funds for HIV/AIDS projects had been rejected by Uganda because of expenditure limitations, while conceding that only US\$18.6 million of the \$201 million approved for Uganda by the Global Fund had been disbursed.⁸

The rationale for such concerns on the part of finance ministries and the IMF is that the rapid inflow of foreign exchange associated with increased aid receipts can drive up the value of the recipient country's currency. The result would be to increase the price of its exports, "thereby undermining competitiveness"⁹—an occurrence referred to as the Dutch disease.⁹ Since finance ministries organise PRSPs around policies that will elicit favourable reactions from the IMF and other lenders,² the extent of the situation cannot be ascertained by looking for public disagreements.

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HIPC (heavily indebted poor countries) initiative

The industrialised world's major initiative to reduce the external debt of developing-country governments. It was launched in 1996 by the World Bank and the IMF and expanded in 1999. Only 27 of the 38 eligible countries now receive debt relief; many heavily indebted countries with very high levels of poverty remain ineligible.

PRSP (poverty reduction strategy paper)

A plan for economic and social policy that must be produced by a national government and approved by the IMF and World Bank as a condition of debt relief under the HIPC initiative.

MTEF (medium term expenditure framework)

A budget projection that indicates spending targets for various government activities as part of a PRSP.

MDGs (Millennium Development Goals)

A set of development objectives for the year 2015 (in one case, 2005) to which all United Nations members states are committed (see <http://www.un.org/millenniumgoals>). Most of the MDGs are either directly or indirectly related to health.

The difficulty of identifying the exercise of power through “non-decisions”¹⁰ is familiar to political scientists, and the Ugandan example is therefore unusual. IMF documents report little evidence of “flexibility in accepting country choices” on the part of IMF staff.⁷ The Executive Director of UNAIDS, Peter Piot, took the issue of expenditure ceilings seriously enough to raise it in a November, 2003, lecture at the World Bank.¹¹ It is also mentioned in the June, 2004, UNAIDS *Report on the Global AIDS Epidemic*, with the comment that: “The short-term inflationary effects of increased and additional resources applied in tackling the HIV epidemic pale in comparison with what will be the long-term effects of half-hearted responses on the economies of hard-hit countries. AIDS is an exceptional disease; it requires an exceptional response.”¹² Equally revealing was World Bank President James Wolfensohn’s concession at the November, 2003, lecture that expenditure ceilings are “a very real issue”.¹³

Beyond MTEFs: a question of priorities

Irrespective of whether AIDS is “exceptional”, the international community has not taken seriously enough the acute need for new resources to assist health systems in the developing world, especially in sub-Saharan Africa. In 2001, the WHO Commission on Macroeconomics and Health called for US\$27 billion in annual donor funding for basic health interventions and for research on diseases of the poor in the year 2007, rising to \$38 billion in 2015,¹⁴ compared with development assistance for health of about \$8.1 billion in 2002.¹⁵ Included in that estimate of need was \$8 billion for the Global Fund in 2007, rising to \$12 billion in 2015. However, the cumulative total value of commitments to the Global Fund, from governments and private sources such as the Gates Foundation, is just \$5.6 billion; some of these amounts are not payable until 2008.¹⁶ A further complication, pointed out by UNAIDS¹² and other observers,^{17,18} is that in many developing countries inflows of development assistance are dwarfed by outflows of funds to repay external debt—a situation that existing debt relief measures have barely begun to address. Even the HIPC initiative will only eliminate half the external debt of eligible countries, meaning that without substantial increases in development assistance their ability to make long-term budgetary commitments to improved health will remain fragile and vulnerable to the vagaries of export markets for their products.

Expenditure ceilings, then, reflect a more general absence of commitment on the part of the industrialised world to treat meeting basic human needs as an ethical obligation and to judge economic policy choices on the basis of that imperative. This approach has gained ground—eg, in the attention now being paid to the Millennium Development Goals developed from a 2000 resolution of the United Nations General Assembly.¹⁹

Rhetorical support has not been matched by the necessary commitments of resources, leading the World Bank to warn in its contribution to the January, 2004, WHO Forum that: “Even if economic growth accelerates . . . and even if progress toward the gender and water goals were to be substantially accelerated, the developing world will wake up on the morning of January 1, 2016 some way from the health targets—Sub-Saharan Africa a long way.”²⁰

In view of the gap between need and commitment in resources for health systems, this anticipation of failure is perhaps not surprising. It is bitterly ironic that multi-lateral financial institutions could be standing in the way of investment that is, belatedly, being mobilised by the international community through such vehicles as the Global Fund. The irony would almost certainly be lost on Ms Nevas, and the commitment made by the World Bank and IMF in July, 2004, that “where country efforts to achieve their MDG targets will require significant increases in official grant financing, the macroeconomic and structural implications will need to be analyzed on a case-by-case basis”,²¹ is not good enough. Neither is the IMF’s claim that “administrative capacity” has limited the disbursement of funds for HIV/AIDS in Uganda.⁸ Health system capacity is important, but is itself strongly affected by the unpredictability of donor funding and the reluctance of donors to commit funds for budget support.²² At the very least, the World Bank and the IMF owe the developing world an unequivocal commitment that they will be part of a solution to the health-funding problem, instead of perpetuating it.

Conflict of interest statement

We declare that we have no conflict of interest.

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