The IMF in Zambia: Implications for Health and Development

Summary

This brief argues that macroeconomic policies and targets laid out in Zambia’s IMF program, the Poverty Reduction and Growth Facility (PRGF), are overly restrictive, with implications for the government’s ability to fight HIV/AIDS and tuberculosis, address the health worker shortage, and respond to the economic crisis. An examination of current and past economic policies shows:

• Restrictive policies targeting inflation to 5% and deficit spending to 1% of GDP undermine the country’s ability to respond to the financial crisis by limiting public spending and options for stimulus.

• The “wage bill ceiling” required by past IMF programs contributed to massive health worker shortages.

• Fiscal policies unduly restrict spending, preventing Zambia from training, hiring, and retaining health workers.

• Due in part to IMF conditionalities, from 2004 to 2006, only 6% of aid to Zambia was spent (used to purchase domestic goods and services) and only 30% was absorbed (used to import goods).

• Zambians have little say in these important policies, as the macro policymaking process between the IMF and the government (Ministry of Finance) excludes input from other ministries such as Health and Education, parliamentarians, civil society, and other stakeholders.

The brief concludes with recommendations to allow for a range of feasible, alternative policy options to be considered through a more participatory, transparent, and accountable process.

Confronted with the enormous tasks of alleviating poverty and pursuing economic development, since the 1970s the government of Zambia (GoZ) has shaped its macroeconomic policies through programs with the International Monetary Fund (IMF) and World Bank. Poor countries are required to implement an IMF program in order to access external resources, such as World Bank development loans, bilateral official development assistance (ODA) from donor governments, or multilateral debt relief, giving the IMF considerable influence over macroeconomic policy choices.

IMF programs include a variety of macroeconomic policy conditions, including targets for reducing deficit spending, inflation, and access to domestic credit, which together determine the size of the national budget. By influencing the size of the national budget, IMF programs indirectly impact the size of sector budgets, including health and education. The amount of resources available to invest in these areas impacts the ability of Zambia to achieve the Millennium Development Goals (MDGs) and other national development goals.

A main concern with Zambia’s PRGF is that its macroeconomic framework is too focused on maintaining narrowly defined macroeconomic “stability,” while not sufficiently allowing for a “scaling up” of public investment needed to achieve the MDGs. At a time when the G20 is calling for, and most rich countries are adopting, policies to stimulate their economies in the face of global recession, the PRGF includes restrictive policies that could deepen and prolong the downturn.

The IMF reform period of 1992-1998 led to a loss of employment from IMF-imposed market liberalization and other structural adjustment policies, which contributed to a 20% increase in poverty levels during that time. Zambia’s Human Development Index (an index used by the United Nations to rank countries based on social and economic indicators) has been declining during the period of IMF involvement, falling from 0.470 in 1980 to 0.434 in 2007 (an HDI below 0.5 is considered “low development”).
**IMF Involvement in a Closed Budget Process**

Zambia's budget process starts with the Ministry of Finance (MoF) and the IMF setting macroeconomic policies and determining the “resource envelope” — how much money will likely be available from taxes, external revenues, and borrowing. Based on these projections, the IMF works with the MoF to develop the “budget ceiling,” a target for total government spending of the revenue. Within this ceiling, the MoF decides how much each sector can spend. Weeks and McKinley (2006) observed that after all IMF and World Bank conditionalities are factored in, little room remains for the MoF to make substantial decisions regarding the size of the budget. 1

When surveyed by an independent researcher, key informants in various government ministries expressed that in order to avoid IMF sanctions, MoF tends to closely adhere to the IMF’s policy guidance.

Policy decisions made under the guidance of the IMF at the start of the budget process are non-transparent and impact decisions made throughout the budget process. Limited opportunity exists for key stakeholders to input into important macroeconomic policies or to provide alternatives to the IMF macro policy framework. Government ministries, Parliament, and civil society are consulted only in the last stages of the process, after macroeconomic policies and quantitative targets have determined limits on spending. Parliament is consulted largely to approve the budget that was already developed in line with IMF targets. Civil society input is largely restricted to the Poverty Reduction Strategy Paper (PRSP) process.

**Overly Restrictive Fiscal and Monetary Policies**

The IMF is primarily concerned with maintaining a narrow definition of macroeconomic “stability,” which does not allow for sufficient “scaling up” in public spending needed to achieve the MDGs or fight HIV/AIDS and tuberculosis effectively. Some of the overly restrictive targets set by the PRGF are described below.

**Low Inflation Target:** Zambia’s PRGF is designed to bring annual inflation under 5%, despite no empirical evidence nor consensus among economists that it is necessary or even desirable to drive inflation to such low levels. When prioritized over other indicators, such a policy comes with costs to economic growth, as spending is restricted and interest rates are increased to meet the target. This limits both the government’s and private sector’s ability to invest and borrow and build a future revenue base. This does not mean inflation should be left unchecked, but “policies that are overly concerned with macroeconomic stability may turn out to be too austere, lowering economic growth from its optimal level and impeding progress on poverty reduction.” 2

**Low Budget Deficit and Government Spending:** The GoZ determines its budget based on the resource envelope, designed to prevent or restrict deficit spending. Zambia’s PRGF is designed to restrict deficit spending to 1% of GDP. This target is primarily intended to restrict inflation and ensure the government does not default on its debt. Such a policy restricts options for increasing public investment and stimulating the economy through properly managed deficit spending. In turn, this limits the amount of resources that could be allocated to health and education. During the current economic crisis, when Zambia will likely receive less international aid and other revenue, the PRGF is not flexible enough to permit exploration of higher deficit financing to maintain spending — the opposite policy approach that many developed countries are pursuing.

**Ineffective Debt Relief Policies:** Zambia qualified for debt relief through the Highly Indebted Poor Countries Initiative (HIPC), which aimed to reduce Zambia’s debt owed to the IMF, the World Bank, and other multilateral donor agencies. To qualify for HIPC, Zambia had to meet the PRGF’s requirements and other conditions, limiting Zambia’s options for scaling up spending for development. A significant portion of Zambia’s external debt was cancelled as promised, yet public debt did not shrink from U.S.$4.5 billion in 2005 to U.S.$581 million in 2006 as predicted, largely because the GoZ had not reached full agreements with all of its creditors. Continuing debt payments means less space to invest in development.

**Diverting Aid to Accumulate Foreign Exchange Reserves:** Much of Zambia’s development aid is diverted to build foreign currency reserves. Zambia’s reserves were expected to increase to total an equivalent of 3.2 months of imports by the end of 2009 and 5.5 months by 2010. The PRGF’s reserve requirement means that some aid does not get used as intended. Recent estimates suggest that only 30% of aid to Zambia was absorbed (used to import goods) and only 6% was spent (used to purchase goods and services domestically) from 2004 to 2006. 3

**Restrictive Wage Bill Ceiling:** The wage bill limits total spending to employ the civil service. From 1992, IMF programs in Zambia required the government to decrease the wage bill to meet PRGF deficit-reduction targets. “Reform” policies downsized the civil service and froze public sector employment. Although the IMF no longer uses wage bill ceilings as a binding policy condition, the strict deficit-reduction target constrains the hiring of needed health workers. This not only hinders the government’s ability to administer public health programs but also to create jobs.

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2. Ibid., p. 10.
Implications for the Health Sector
The fiscal and monetary policies championed by the IMF unnecessarily restrict the size of the national budget. The following explains implications for the health budget and consequent shortfalls in human resources and service delivery.

Healthcare Workforce Crisis: The freeze in the public sector wage bill impacted the health sector in Zambia. The government’s health wage bill declined from 67% in 2004 to 47% in 2007 of the total government health spending budget. Inadequate funding for health workers translated to limited hiring of new health workers and retention of current workers.

Health workers are poorly distributed between rural and urban areas. Despite the need for additional health workers, during the retrenchment period, trained workers left the public sector for lack of opportunities, inadequate pay, and poor working conditions. Some entered the private or nonprofit sectors, while others found jobs in other countries, contributing to the “brain drain.” Staff has also been lost to the HIV/AIDS epidemic. Although the wage bill ceiling was lifted as a binding condition of the PRGF in 2007, the PRGF maintains a wage bill cap of about 8% of GDP, preventing Zambia from training, hiring, and retaining health workers.

User Fees: Zambia introduced health user fees in 1993 to cope with severe budget cuts. User fees increased health care costs for poor patients, lowered usage of health care facilities, and reduced Zambians’ health status. In 2007, after realizing their harmful impacts on people, user fees were lifted in 54 rural districts and 18 urban municipalities, but only for primary care. User fees are still utilized for all other levels of health care.

Human Impact: The result of declining and inadequate health budgets, severe workforce shortages, and user fees has proved to be a devastating combination for Zambians. UNAIDS observed that in the absence of major changes in the treatment and prevention of People Living with HIV/AIDS in Zambia, AIDS will increase the number of annual deaths in the country by 83%, and cumulatively, 2.8 million people will die of AIDS by the year 2015. These devastating predictions are intensified by the upsurge in the number of new TB cases, due mainly to HIV/AIDS-associated TB. WHO estimates there were around 67,800 TB cases in 2007 alone. The Ministry of Health estimates that TB is complicating and shortening the lives of 30-40% of all persons infected with HIV in Zambia, yet only about 35% out of all people infected are getting TB-HIV treatment.

Declining, Inadequate Health Budget Allocations: The GoZ must also increase health allocations within the national budget. Zambia’s health budget fluctuated from 1990 to 2007, but with a downward trend. In 2007, Zambia dedicated about 10.5% of its national budget on health — less than the 15% target to which the GoZ agreed to in the Abuja Declaration and has since re-committed. This equates to about U.S.$8 per person spent on health between 1995 and 2006. Although funding increased in 2007 to U.S.$14.1, it is far short of the U.S.$33 the World Health Organization’s Commission on Macroeconomics and Health recommended Zambia to spend to provide a basic health care package. Given these inadequate funding allocations, Zambia’s National Health Strategic Plan for up to 2010 faces a U.S.$756 million funding gap.

The GoZ’s lack of funding for HIV/AIDS has significant consequences. Donors have consistently provided the largest share of HIV/AIDS funding since 2002. As donors have doubled their HIV/AIDS funding over 2002 levels, government funding has fallen by almost half. Households contributed more than the government, with implications for equity to access as 70% of the population is poor. Despite the dramatic increase in donor funding, Zambia’s National HIV/AIDS Strategic Framework for 2006-2010 still faces a total funding gap of approximately U.S.$106 million in 2009 and nearly U.S.$108 million in 2010. Likewise, the fight against TB, which is directly linked to HIV/AIDS, is also chronically underfunded: out of a total budget of U.S.$57 million needed to adequately implement the National Stop TB Strategic Plan for 2007-2011, only U.S.$32 million is available, a gap of over 40%.

Recommendations to the IMF and the Government of Zambia, particularly the MoF
Zambia’s PRGF policies, especially in the context of the global economic crisis, limit options for expanding the national budget, with potentially harmful consequences for health and for social safety nets. Pursuing more expansionary policy options could potentially yield a bigger national budget, from which increased investments in health, education, and other critical social sectors

Tanzania Aid Spending (Ratio expressed as a share of GDP)

<table>
<thead>
<tr>
<th>Periods compared</th>
<th>Amount of aid absorbed</th>
<th>Amount of aid spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before aid surge (2001-03) vs. aid surge period (2004-06)</td>
<td>39%</td>
<td>6%</td>
</tr>
<tr>
<td>Relevant aggregates</td>
<td>Relevant periods</td>
<td></td>
</tr>
<tr>
<td>Inflation</td>
<td>Before aid surge</td>
<td>21.7</td>
</tr>
<tr>
<td></td>
<td>Aid surge period</td>
<td>18.1</td>
</tr>
<tr>
<td>Real effective exchange rate</td>
<td>Before aid surge</td>
<td>108.2</td>
</tr>
<tr>
<td></td>
<td>Aid surge period</td>
<td>139.6</td>
</tr>
<tr>
<td>Average reserves level (U.S.$ millions)</td>
<td>Before aid surge</td>
<td>322.1</td>
</tr>
<tr>
<td></td>
<td>Aid surge period</td>
<td>373.3</td>
</tr>
</tbody>
</table>

(including for infrastructure and human resources) could be allocated. This would help achieve Zambia’s poverty reduction strategy and the MDGs. Toward this end, the IMF and MoF should:

- Fully spend and absorb ODA. This would provide more space to spend aid to upgrade the health system’s infrastructure, expand human resources, and improve service delivery and quality, thereby improving health outcomes.
- Explore more flexible ways to allow higher levels of domestic financing of the deficit, to support targeted programs to respond to the HIV/AIDS and TB crises and finance the health sector.
- Explore more expansionary fiscal and monetary policies geared towards stimulating the economy and building the future revenue base of the country.
- Work with the GoZ and other Paris and non-Paris Club members to finish canceling Zambia’s debt as agreed through HIPC; remove harmful policy conditionalities attached to debt cancellation that unduly limit Zambia’s fiscal space and open debt contraction to a broader group of stakeholders, so human and economic development can be more aggressively pursued.

“Only 30% of aid was absorbed and only 6% was spent from 2004-2006.”

- Abolish all user fees for health care as they increase costs for patients, lower utilization of health facilities, and reduce health status.
- Engage a wider spectrum of stakeholders in the formulation and review of IMF program policies, particularly other government ministries and departments apart from MoF, as well as parliamentarians and civil society. More transparent and participatory civic engagement would allow for broader input into macroeconomic policy options and should happen much earlier in the policymaking process — before macroeconomic targets are set. The policymaking process should be more transparent and better ensure accountability.

Notes