

**MACROECONOMIC CONSTRAINTS TO HEALTH FINANCING:
A GUIDE FOR THE PERPLEXED**

By Markus Haacker*

This copy printed on: April 5, 2010

* Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel St, London WC1E 7HT.
Email: markus.haacker@lshtm.ac.uk.

MACROECONOMIC CONSTRAINTS TO HEALTH FINANCING: A GUIDE FOR THE PERPLEXED

The link between aid and health spending, and the role that concerns about macroeconomic stability may play here, is an area of much confusion, for several reasons. First, against the backdrop of the MDG agenda and an anticipated scaling-up of external aid, a number of studies addressed macroeconomic constraints to scaling-up. However, translating the lessons from this macroeconomic literature into a public health context is not straightforward. Second, some analyses cover only a short-term horizon, and focus on the extent to which *changes* in aid flows translate into contemporaneous higher government spending. The lessons from this literature, however, give a misleading picture of the link between external aid and government expenditures. Third, a number of “health advocates” propose to increase fiscal space by adopting more expansionary fiscal or monetary policy; we argue below that this is a marginal issue in the context of health system strengthening.

Concerns about the impact of aid on macroeconomic stability were motivated by the vision of a deluge of aid in support of the MDGs (which, however, did not materialize). In this context, two reports discussed the extent to which changes in aid were accommodated in IMF programs (Independent Evaluation Office of the IMF (2007), Working Group on IMF Programs and Health Spending (2007), focusing on the question of whether aid *increases* projected during an IMF program were earmarked for *additional* spending, or whether they were programmed to be put aside to reduce the budget deficit and accumulate additional reserves.

Such projected figures, however, are tricky to interpret, as projections are revised numerous times in the course of an IMF program, and the change may be small in relation to the level of aid. Also, our interest is not confined to countries adopting such a program. We therefore look at actual data on aid disbursements, budget deficits, and balance-of-payments deficits over the period 2000 to 2008, covering 73 low- and lower-middle income countries for budget deficits, and data from 82 countries for balance-of-payments data. We find that budget deficits are uncorrelated with aid disbursements, and changes in budget deficits are uncorrelated with changes in aid flows. This means that overall all additional aid has translated into additional public spending. Similarly, additional aid has not been absorbed through the accumulation of higher reserves. As some of the literature has focused on the role of the IMF, we also add interaction terms to capture the potential impact of IMF programs. These play no role regarding the link between aid disbursements and budget deficits or the balance of payments. Thus, concerns about macroeconomic stability regarding the use of aid are not reflected in data describing the actual use of aid disbursements.

One of the unfortunate aspects of the debate on conflicts between macroeconomic and health objectives is the fact that sometimes themes from the wider discourse on globalization and development are recycled in the public health sphere, without an adequate understanding of aspects of the health sector. The concerns about aid absorption (which –

ex post – appear unfounded, see above) are an example for this. For a number of reasons, the bulk of external financing for health programs occurs through project aid, which means that disbursements are tied to actual spending. In case the government intended to use parts of external aid to reduce the budget deficit rather than finance additional spending, the “project aid” character of health financing implies that externally financed health spending is largely ring-fenced from such an exercise.

Another area in which macroeconomic objectives and the desire to increase health financing may conceivably collide is domestic financing. For example, Rowden (2009) proposes that the IMF’s “official long-standing policies and policy IMF advice to borrowing countries that inflation must be below 5-7 percent and fiscal deficits must be below 3 percent of GDP” are unnecessarily restrictive and constrain investments in health and other development spending. On the surface, this claim is problematic as the policies and practice of the IMF are more varied than Rowden recognizes. This shortcoming, however, does not need to keep us from considering whether higher budget deficits and more inflation could contribute to create fiscal space for increased health spending.

In a typical low-income country (numbers quoted reflect median values, based on WHO data on health spending for 2006), public health expenditures account for about 2 percent of GDP, and 8 percent of government expenditures (which account for 25 percent of GDP). External financing accounts for the equivalent of 55 percent of public health expenditures, but includes funds in support of private (mainly NGO-delivered) health services. For our illustration we therefore assume that only 35 percent of public health expenditures (0.7 percent of GDP) are financed by external support. Further, we assume that the government receives 5 percent of GDP in external support, of which 3 percent are project-tied, and 2 percent general budget support. This means that the amount the government can freely allocate corresponds to 22 percent of GDP, of which 6 percent (1.3 percent of GDP) are allocated to health (including funds that represent collateral spending on externally supported projects).

How much more resources for health could be generated by additional borrowing or higher inflation? This is a question that can best be addressed for specific countries, but we can offer some pointers. Reviewing macroeconomic policy across developing countries, World Bank (2005) points out that “most countries have yet to convey a convincing impression of fiscal solvency,” which means that the scope for additional borrowing is limited. World Bank (2005) is also useful as it discusses sustainability of public finance not only in terms of the size of fiscal deficits, but also in terms of the composition of public expenditures, noting that “productive public expenditures (...) have also been compressed in the process of fiscal adjustment.” Rather than on additional borrowing, the accent thus lies on the composition of public expenditures.

The other indicator for macroeconomic stability frequently referred to is the inflation rate. A more inflationary policy may contribute to financing higher government expenditures, as it acts like a tax on money or domestic government debt. Using the methods adopted in World Bank (2005), we estimate the “inflation tax” across developing

countries. For the median country, the inflation tax amounts to 0.9 percent of GDP, at an inflation rate of 7 percent. An increase in inflation to 17 percent would raise inflation tax by an additional 1.3 percent of GDP, but only if additional inflation does not lead to a decline in the demand for money. (A discussion of the costs and benefits of higher inflation, as well as distributional aspects, is beyond the scope of this brief discussion.) This is a big if, as very few countries raise inflation tax in excess of 2 percent of GDP, usually at much higher inflation rates or reflecting distortions in the financial system.

Overall, we find the attention given to concerns about macroeconomic stability as a constraint to health spending misplaced. As an illustration, assume that an additional fiscal resources of 2 percent of GDP could be released by adopting more expansionary macroeconomic policies (in light of the cautious assessment of fiscal sustainability in World Bank (2005), and the apparent limits to inflation tax, a very ambitious assumption). These additional government revenues are subject to the national budget processes, where the demands of the health sector compete with other sectors, obtaining (see above) only about 6 percent of domestic revenues. Using this share, the assumed increase in resources therefore translates into additional health spending of only 0.12 percent of GDP. This increase is miniscule compared to what could be achieved by increasing budget allocations for health. For example, raising the share of health of domestically financed public expenditures from only 6 percent to only 7 percent would increase health expenditures by about twice that amount (0.22 percent of GDP, i.e., 1 percent of domestically financed government expenditures of 22 percent of GDP, see above), and – in the context of sub-Saharan Africa – raising budget allocations towards the Abuja targets would typically generate additional health resources well in excess of one percent of GDP.

The real challenge in financing health systems strengthening is securing higher budget allocations for health. The role of the fiscal or monetary policy stance is marginal, and the attention placed on it in parts of the ongoing discourse a distraction from more pressing causes.

I. REFERENCES

- Independent Evaluation Office of the IMF, 2007, "The IMF and Aid to Sub-Saharan Africa" (Washington DC: International Monetary Fund).
- Rowden, Rick, 2009, "The Deadly Ideas of Neoliberalism – How the IMF has undermined Public Health and the Fight Against AIDS" (London/New York: Zed Books).
- Working Group on IMF Programs and Health Spending, 2007, "Does the IMF Constrain Health Spending in Poor Countries? Evidence and an Agenda for Action" (Washington DC: Center for Global Development).
- World Bank, 2005, *Economic Growth in the 1990s: Learning from a Decade of Reform* (Washington DC: World Bank).