The International Monetary Fund and the Ebola outbreak

Published Online
December 22, 2014
http://dx.doi.org/10.1016/S2214-109X(14)70377-8

In recent months, the International Monetary Fund (IMF) has announced US$430 million of funding to fight Ebola in Sierra Leone, Guinea, and Liberia.[1] By making these funds available, the IMF aims to become part of the solution to the crisis, even if this involves a departure from its usual approach. As IMF Director Christine Lagarde said at a meeting on the outbreak, "It is good to increase the fiscal deficit when it's a matter of curing the people, of taking the precautions to actually try to contain the disease. The IMF doesn't say that very often."[2]

Yet, could it be that the IMF had contributed to the circumstances that enabled the crisis to arise in the first place? A major reason why the outbreak spread so rapidly was the weakness of health systems in the region. There were many reasons for this, including the legacy of conflict and state failure. Since 1990, the IMF has provided support to Guinea, Liberia, and Sierra Leone, for 21, 7, and 19 years, respectively, and at the time that Ebola emerged, all three countries were under IMF programmes. However, IMF lending comes with strings attached—so-called "conditionalities"—that require recipient governments to adopt policies that have been criticised for prioritising short-term economic objectives over investment in health and education.[3] Indeed, it is not even clear that they have strengthened economic performance.[3]

Here we review the policies advocated by the IMF before the outbreak, and examine their effect on the three health systems. The information was extracted from the IMF archives of lending agreements covering the years 1990–2014.

First, economic reform programmes by the IMF have required reductions in government spending, prioritisation of debt service, and bolstering of foreign exchange reserves. Such policies have often been extremely strict,[4] absorbing funds that could be directed to meeting pressing health challenges. Although the IMF has responded to concerns about its programmes by incorporating "poverty-reduction expenditures" to boost health spending, these conditions were often not met (table). Thus, in 2013, just before the outbreak, whereas all three countries achieved the IMF's macroeconomic policy prescriptions, they failed to meet targets for social spending.[5–7] Writing to the IMF, Guinean authorities noted that "unfortunately, because of the reduction in spending, including on domestic investment, it was not possible to respect the indicative targets for spending in priority sectors".[5] Similarly, the Sierra Leonean government reported that priority spending targets (including on health) were missed due to low domestically financed investment.[7]

Second, to keep government spending low, the IMF often requires caps on the public-sector wage bill—and thus funds to hire or adequately remunerate doctors, nurses, and other health-care professionals. Such limits are "often set without consideration of the impact on expenditures in priority areas",[8] and have been linked to emigration of health personnel.[9] In Sierra Leone, for example, IMF-mandated policies explicitly sought the reduction of public sector employment. Between 1995 and 1996, the IMF required the retrenchment of 28% of government employees,[10] and limits on wage spending continued into the 2000s.[11] By 2004, the country spent about 1·2% of GDP less on civil service wages than the sub-Saharan African mean.[11] At the same time, figures supplied to WHO reported a reduction of community health workers from 0·11 per 1000 population in 2004 to 0·02 in 2008.[12] In 2010, as the country launched its Free Health Care Initiative, IMF staff "stressed the need to carefully assess the fiscal implications" and favoured "a more gradual approach to the [associated] salary increase in the health sector".[13]

Third, the IMF has long advocated decentralisation of health-care systems. The idea is to make care more responsive to local needs. Yet, in practice, this approach can make it difficult to mobilise coordinated, central responses to disease outbreaks.[14,15] In Guinea, from the early 2000s, the IMF promoted fiscal and administrative decentralisation. Following IMF advice, the country transferred budgetary responsibilities from the central government to the prefecture level.[16,17] Only 5 years later, an IMF mission to the country reported "governance problems" that included "insufficient and ineffective

	Total	Of which implementation data available for	Of which implemented
Guinea	23	12	3
Liberia	9	9	6
Sierra Leone	36	31	13

Data are Number of targets (spending floors). These spending floors were set for "priority expenditures" that include health, education, and other social sectors. Sources: various IMF lending agreements retrieved from the IMF archives.

Table: **Targets on health and other social spending increases since 2000**

decentralization".[18] At the same time, IMF staff noted that the quality of health-service delivery had deteriorated.[18]

All these effects are cumulative, contributing to the lack of preparedness of health systems to cope with infectious disease outbreaks and other emergencies. The IMF's widely proclaimed concern about social issues has had little effect on health systems in low-income countries. Although Lagarde's comment on prioritising public health instead of fiscal discipline is welcome, similar comments have been made by her predecessors.[19] Will the result be different this time?

The Ebola outbreak has tested many global institutions and lessons will have to be learned. Many of these lessons relate to the detection and control of the outbreak, but it would be unfortunate if underlying causes were overlooked. In a timely intervention, *The Lancet*'s Commission on Investing in Health called for increases in public health spending and attention to hiring and training health workers.[20] The experience of Ebola adds a degree of urgency to the implementation of its recommendations.

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AK and LK acknowledge financial support by the Institute for New Economic Thinking (INET Grant INO13-00020: 'The Political Economy of Structural Adjustment'). We declare no competing interests.

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