



**Elaine Zuckerman
Presentation**

**Globalization and Health IHP Health and Community Program
January 23, 2009**

The Role of IFIs in Our Recent Financial Crisis and the Role of Women

Ensure bio/intro discusses why and when I joined the World Bank when no SALs, no protests, created first job in the Bank dedicating to the social impacts of SALs, pretty isolated. Mention that when young people frequently seek career advice, I always steer them away from IFIs and toward the nonprofit sector.

In the limited time I had to collect some thoughts I focused on the role of the IFIs and less so on the financial crisis and the role of women. But let's see if we can tie them together. In preparing, I carried away on donor aid issues.

Introduction

My ideas today focus on the role of the IFIs in the current financial crisis, especially how it affects the health sector. I assume that you have already learned basics about the IFIs, but if not please ask for clarifications. If I mention any ideas without going into depth that interest you, just ask during our exchange following my presentation. Since the preceding speaker addressed financial liberalization, I assume s/he discussed the IFIs. The IFIs are my main focus today.

LIST TOPICS COVERED

Global Financial Crisis

The deepening global economic crisis in 2008-09 is undermining efforts to address the worldwide crisis in health care, however modest or disjointed past efforts have been. According to one projection, the global crisis could increase the infant mortality rate by between 3.0% and 10% and the malnutrition rate among children by 10%.¹ Other determinants of people's access to health services, including unemployment, poverty and inequality will deepen.

Health Spending

In recent years, overall "donor" spending on health has increased but the quality of spending is very poor. Even the World Bank's 2007 Health, Nutrition and Population Strategy concluded that *"Never before has so much attention – or money—been devoted to improving the health of the world's poor. However, unless deficiencies in the global aid architecture are corrected and major reforms occur at the country level, the international community and countries themselves face a good chance of squandering this opportunity."*

¹ Anupama Rao Singh, UNICEF Director for East Asia and the Pacific as reported by AFP in *IMF Morning Press and World Bank Press Review*, January 6, 2009.

The Global Health Aid Architecture

Development assistance for health increased from \$2.5 billion in 1990 to \$6.8 billion in 2000 to \$16.7 billion in 2006.² These numbers sound large but according to 2008 data, the G8, which accounts for more than two thirds of global development assistance, had collectively fulfilled only 13.8% of the Gleneagles commitments by 2007. The World Bank and the World Health Organization (WHO) used to be the two pillars of the health aid architecture. Today there are more than 40 bilateral donors, 26 agencies, 20 global regional funds, and 90 initiatives in the health sector alone, most of which were launched in this decade. Most of these proliferating donors do not coordinate. There are other issue I won't visit today which I feel passionate about such as that donor aid benefits the donors more than the so-called beneficiaries. Also I am using the word "donor" loosely to include grantors and lenders. How can lenders be called donors? The World Bank is widely assumed to be a donor agency but it is a lending bank which as you know causes borrowers to be in debt. We will discuss debt later.

Most of the increase in health aid spending targets specific diseases, particularly HIV/AIDS, TB, and Malaria. For instance in Mozambique and Zambia, aid that targets specific diseases accounts for at least 60% and 90% of aid for health, respectively.³ Such "vertical" programs — money targeted to specific diseases — cannot be spent effectively in crumbling ("horizontal") national health systems that lack the rudiments, including an adequate health workforce.

Africa is especially dependent on health aid. Aid accounts for approximately 15% of all health spending in Africa, while elsewhere it accounts for less than 3%. Thus, there is a greater than 450-fold variation across countries in per capita health expenditures, which ranges from less than \$13 per capita in the poorest countries to well over \$6000 per capita in the richest.

Despite increased health aid, Africa carries more than 24% of the global burden of disease, including an exploding HIV epidemic, but it has less than 1% of the global financial resources for health.

Enhancing aid predictability. Donor health aid is unpredictable, short-term and volatile, resulting in marginal improvements of existing services rather than significant scale-up and innovation.

Harmonizing and aligning aid. Aid flows and donor requirements are poorly harmonized and frequently unaligned with national health plans.

In 2005 donors met in Paris where they pledged, in a document called the Paris Declaration on Aid Effectiveness, to shift their resources from projects to programs, particularly support for national and sector budgets and programs; harmonize their operations; and align them with each government's national or sector strategy. At the signing of the Declaration, the health

² Ibid. In 2005, the dominant contributors to health aid were: 1) bilateral donors financed \$6.5 billion or half of all development assistance for health; UN agencies (\$3 billion); the development banks (\$1.3 billion). The level of World Bank health assistance has risen to \$1.1 billion.

³ Action for Global Health Round Table: "The EU's contribution to health as a tracer sector: Getting a grip on new and innovative aid coordination mechanisms for health," April 2, 2008.
http://www.apha.org/IMG/pdf/2_April_2008_Aid_effectiveness_Round_Table_Report.pdf

sector was chosen as a “tracer” sector for harmonization and alignment efforts, since there is such a multiplicity of actors and challenges in the health sector.

In the harmonization process, donors and creditors are supposed to pool their financing for health. The vehicle for such collaboration is called the “sector-wide approach” or SWAp. Donor resources are disbursed when a government has met specified donor-imposed policy conditions which the donors call country-owned. Donors are supposed to use joint procedures for monitoring, reporting and evaluation.

While harmonizing is actually a donor initiative, the cost of *not* harmonizing aid is prohibitively high. The government of Rwanda spent 27% of its health aid to fulfill its responsibilities to its donors for administration and reporting.⁴

But donor harmonization compromises ownership of governments’ programs, especially when donor funding constitutes a large portion of the government’s budget. A study of Mozambique found that the increasing reliance on programmatic forms of donor support, such as SWAps, essentially involves only two actors, the executive branch of government and foreign donors.⁵ Parliament is excluded. While this problem is especially common in highly aid dependent countries, such as Mozambique, it is also endemic in low-income and some middle-income countries to one extent or another.

Alignment. The process of alignment is to harness aid to meet national health goals. The cost of *not* aligning aid was captured by one Ugandan official who said, “We need national approaches instead of global solutions to each and every problem. There has to be a paradigm shift. Otherwise health systems will eventually crash.”⁶

Citizens’ groups have questioned the validity of H&A efforts, claiming that aid providers have a stronger hand in shaping national development strategies and health sector strategies than do their parliaments or citizens.

I could say much more about donor aid mechanisms such as PRSPs but I need to move to conditionalities which are even more important.

Curbing the public wage bill. The IMF has a history of capping the public wage bill, which negatively impacts health service delivery because it squeezes health workers. Although the IMF claims that it no longer imposes wage ceilings thanks to amazing civil society pressure led by ActionAid, it still does so in practice (e.g., the IMF imposed a wage ceiling cited in the November 2008 Fifth Review of Benin’s PRGF).

Reforms – Public Cutbacks

Promoting Community Health Workers rather than trained professionals. As donors require public spending cuts, they routinely promote the use of unpaid community health workers to staff health facilities. Although the WHO “2008 World Health Report” notes that, where

⁴ WHO/GHWA, “Scaling Up, Saving Lives,” 2008, p. 66.

⁵ T. Hodges and R. Tibana, “Political Economy of the Budget in Mozambique,” 2004.

⁶ Kristin Palitza, “Health-Africa: Who is to Blame for the Crisis?” IPS, Bamako, November 18, 2008. Also, Round Table 8 at the Accra 3rd High Level Forum on Aid Effectiveness, “Non-alignment of aid with government priorities is a significant problem, with a detrimental effect on the funding available for holistic health systems approaches.” Outcome Document, September 2008.

strategies for extending PHC coverage proposed lay workers as an alternative rather than as a complement to professionals, the care provided has often been poor. This has pushed people towards private care which the poor cannot afford.

Conditionalities Intro - Policy-Based Lending

As pre-conditions to receiving loans, for almost 30 years IFIs have promoted a neo-liberal economic ideology prescribing to developing countries -- policies such as , cutting government expenditure on social services, free trade, and capital market liberalization (Gender Action 2007). These kinds of loan conditionalities have serious negative impacts on developing countries which are forced to cut their public spending and reduce government involvement in crucial sectors such as provision of health care services. (Table 4 describes the effects of policy-based lending to reproductive health and HIV/AIDS). Failure to comply with the conditionalities may result in loss of financial support by MDBs and the IMF. Despite claims by the World Bank and IMF that they have reduced loan conditionalities, research demonstrates that they have actually increased (Gender Action 2006). These imposed policy conditionalities often bypass democratic processes, ignoring parliaments and congresses.

Conditionalities – Introduction to the Role of the IMF and Its Policies

Among IFIs, the IMF has played a disproportionate role in deepening poverty, curtailing social including health spending, and contributing to the global financial crisis. The IMF plays a gatekeeper role, signaling to all multilateral and bilateral donors whether every developing country is a worthy candidate for so called aid. The IMF must approve a country's macroeconomic program in order for that country to access grants and loans from virtually all bilateral and multilateral financiers. The IMF provides quick-disbursing loans which poor countries often find irresistible during a financial crisis, called stabilization loans, which help a country buy imports and finance required reforms, also called conditionalities. IMF loan conditionalities require countries to implement harmful reforms such as cutting public spending and laying-off civil servants in the name of efficiency and productivity. The poor are always the losers from these reforms.

The IMF has focused heavily on cutting public employment and capping public sector wages. The Independent Evaluation Office (IEO) of the IMF in its report called, "An Evaluation of the IMF and Aid to Sub-Saharan Africa", found that, over the years 1999-2005, the IMF "blocked the use of available aid to SSA through overly conservative macroeconomic programs." That is, aid was diverted to reduce the domestic debt or expand foreign reserves in order to meet IMF targets for levels of inflation, deficits, and foreign reserves. Diversion of aid in turn has shrunk "fiscal space" especially in low-income countries in Sub-Saharan Africa.

Privatization

Besides cutting the public sector, another famous IFI reform is privatization – the transfer of control of public owned resources from the government to the private sector. It has shifted control of health, education, energy, water and other social services to the private sector. Privatized health care limits access to those who cannot afford to pay for the services, eliminating the pre-privatization notion that health care is a citizen's right that needs to be provided for free. Privatization often results in loss of jobs and unaffordable health, water, education and other basic services.

Much health aid channeled through private and non-governmental organizations to combat specific diseases by-passes government channels. Despite the efforts to harmonize aid, much aid bypasses government channels. In Rwanda, only 14% of total donor support for health is

channeled through the Rwandan Ministry of Health and another 12% by local governments or health districts. The remaining 75% of donor aid goes directly to NGOs (54.8%) or is directly managed by the donors through their own projects (19%).⁷

Privatization - Unregulated. Both the CSDH Report as well as the WHO's "World Health Report 2008" highlighted the problems with unregulated privatization which shifts the cost of health services to users." Health services are reduced to a commodity that can be bought and sold on a fee-for-service basis without regulation or consumer protection.⁸

In low-income settings, unregulated fee-for-service privatization is particularly damaging to health outcomes.

The overarching corporate strategy of each multilateral development bank was changed in 2001-2002 to one that focuses on private sector development (PSD) in "frontier" sectors, particularly health care, education, water and electricity. Integral to these IFI reforms is a change in the role of the state, from a provider of services to a regulator.

Decentralization

Another ubiquitous IFI-imposed reform is decentralization of responsibilities for health care from the federal to the local level. This decentralization is often not accompanied by funding transfers from the central to subnational governments. This creates pressure for unregulated privatization of health care, including through the imposition of user fees.

User Fees

User fees exclude the poor from health services.

User fees were instigated from the notion of "cost-sharing", a practice promoted by MDBs and the IMF whereby people are responsible for contributing towards the total cost of public services such as education and health. User fees are also a result of transfer of responsibility for financing public services from the public sector to private sector. Education user fees can be either official (for example school registration and exam fees) or unofficial (for example charges for uniforms or books). Health user fees are mostly charges that occur at the service delivery point for costs of medical consultations, equipment, and drugs.

IFIs justify user fees by arguing that they help pay for the cost of education and health ironically because governments have pressured by MDBs and the IMF to cut their spending on social services provision. IFIs also argue that user fees will increase efficiency in education and health service delivery. In practice user fees have a huge impact on the health of the poor. Overstretched poor households with low or seasonal income are forced to make out-of-pocket payments for basic health care and education. Civil society organizations and other stakeholders are against user fees because they deny people their right and access to basic education and health care, services that should be universal and were previously provided for free.

"In rural Uganda, 43% of people falling sick do not seek health care due to a lack of money". (Action Aid 2002).

⁷ The World Bank Group Concessional Finance and Global Partnerships Vice Presidency, "Aid Architecture: An Overview of the Main Trends in Official Development Assistance Flows," May 2008, p. 12.

⁸ World Health Report 2008, Primary Health Care — Now More Than Ever, WHO, 2008, pp. 11, 13, and 14.

Civil society organizations opposing user fees succeeded in getting the U.S Congress to pass the 2001 Foreign Operations Appropriations Bill requiring the U.S Treasury to instruct U.S representatives to the World Bank and IMF to “oppose any loan, grant, strategy or policy of these institutions that would require user fees or service charges on poor people for primary education or primary healthcare.

Although the World Bank claims that it no longer promotes user fees for primary health care and education, it never did so consistently. The new World Bank HNP Strategy includes language praising and reviving user fees (Gender Action 2007). The elimination of user fees has proved to be successful in some countries where its removal in primary education has resulted in huge increase in school enrollment. Action Aid cites Tanzania as an example of a country where user fees were eliminated for primary education in 2002 with the support of the World Bank, and as a result school enrollment have surged – perhaps by as much as 1.5 million children (Action Aid 2002).

User fees hinder poor people from accessing reproductive health care and HIV/AIDS treatment, care and support. A handful of developing countries such as Thailand and Tanzania charge little for ART but the vast majority of country charge fees often instigated by the IFIs.

“People need to make a decision on either buying food for their family or spending money on transport to access a medical facility. Most people decide to go for the short-term solution and provide food to their family”(VSO and Action Aid 2007).

User fees bar women and girls from accessing reproductive health services such as family planning, antenatal care, delivery care and post-abortion care.

User fees have restricted access to health care and increased privatization of health care has raised the cost of health care, particularly for poor people. Comparative data show that the poorer the country, the larger the amount of out-of-pocket health fees, which is the most inequitable source of health financing. In low-income countries, about 70% of total health spending is out-of-pocket, declining to 15% in high-income areas.

Studies have found that women feel the effect of user fees for health services most acutely. When poor people to lose access to public health services, women quit jobs and lose previous income in order to care for sick family members.

Debt

While IFIs call themselves non-profits, their urls end in .org, not .com, they are actually intensely profit and corporate driven.

While IFIs claim their mission is to reduce poverty and stimulate economic growth in developing countries, anyone who has worked inside the IFIs and outside critics – I represent both -- know that pushing loans is the IFIs mainstay. IFIs make loans which are repaid with interest, sometimes at a low rate, and fees which add up. IFI's actual net flows to borrowing countries has long been negative. Poor countries repay more money to IFIs than they receive in so called donor aid. This situation is scandalous. And poor country debt repayment to IFIs and commercial banks prevents countries from spending on health. Most poor countries debt to IFIs and to commercial banks is odious, that is poor country debt results from loans made to

illegitimate governments, which have used the funds to oppress people or for personal purposes. Then the illegitimate governments collect poor people's taxes to repay the odious debt.

Debt is a major obstacle to development which often pushes developing countries into extreme poverty. Civil society organizations around the world have called for cancellation of debts for the poorest countries calling the debts odious, unfair and illegitimate. Developing countries are burdened by debt that they unjustly inherited from their colonizing states. These unfair debts should be written off as they divert funds from human and economic development.

It is the reason why many groups critical of IFIs, led by the Jubilee Debt campaign, of which Gender Action is a proud member, constantly pressure for cancellation of poor country debt to the IFIs.

During my first-hand experience inside the IFIs, I learned that the main beneficiaries of IFI projects are transnational corporations and not poor people whom IFIs claim are the main beneficiaries. The IFI procurement process is the key to corporate dominance. Describe procurement process.

Job and Wage Cutting

The IMF-World Bank pressure to cut public spending places downward pressure on wages.

IFI health reforms have caused health systems to become segmented and fragmented, and weakened the role of the state in providing health services and direction for public health. Many governments cannot regulate health services because IFI-required public downsizing eliminated regulators' jobs.

A popular World Bank reform requirement is labor flexibility. In reform processes, the World Bank uses labor flexibility as the main instrument to increase productivity of health services. People who previously held secure jobs with benefits lose job security and benefits. Americans understand this process first-hand. It has long been an integral process in the neo-liberal agenda. Flexibility creates precarious employment conditions. It also leads to migration of medical workers.

Health Impacts from Non-Health IFI Interventions

To understand the social including the health impacts of IFI reforms, besides looking at health sector reforms, it is important to look at the health impacts of every type of IFI investment. For example, Gender Action's Boom Time Blues project exposed the tragic gendered impacts of IFI-financed oil pipelines. Through fieldwork surveys at two IFI-pipeline sites, one in Russia's Sakhalin and the other the BTC pipeline carrying oil and gas from the states to western Europe, we demonstrated that IFIs ignored their own commitments to prevent harmful impacts.

These IFI-financed pipelines led to a dramatic rise in prostitution, human trafficking, HIV/AIDS, and violence against women. Our report, entitled "Boom-time Blues: Big Oil's Gender Impacts in Azerbaijan, Georgia, and Sakhalin," challenges EBRD and IFC claims that they promote gender equality and combat HIV/AIDS.

Both the EBRD and the IFC have turned a blind eye to the increased prostitution, human trafficking and HIV/AIDS that the BTC and Sakhalin II pipeline projects generate. Lacking gender policies, both institutions are ill-equipped to identify and address such tragic social outcomes of their investments. Gender Action has been pressuring for the EBRD and IFC to develop and implement binding gender safeguard policies.

Other IFI-financed pipelines have identical outcomes, for example the West Africa and Chad Cameroon pipelines, to name just two in west Africa. Gender Action hopes to analyze their outcomes too.

Precarious Health Work

While globally the medical profession is male dominated, the nursing professions – constituting the largest single occupational group in the health sector – remain predominantly female with up to 90 per cent share.⁹ Women in health labor markets are at the bottom of the hierarchy in terms of authority, remuneration, and qualifications.

Moreover, health sector reforms have not been gender-neutral. Retrenchment measures in the public health sectors impacted especially the nursing workforce and low-paid health jobs with limited qualifications, cutting back women's employment opportunities since women are over-represented in these employment.¹⁰

Health Insurance Mechanisms

Another favorite IFI health loan requirement is private health insurance for poor people. Does this sound familiar to Americans? The World Bank says private health insurance will improve access to quality health care.

Civil society organizations question whether this method of financing health care is beneficial to the poor. They demonstrate that health insurance mechanisms in developing countries have “so far been unable to sufficiently fill financing gaps in health systems and improve access to quality health care for the poor” (Oxfam et al. 2008). Research has shown no evidence that PHI has played a significant role in scaling up universal access to health care. Instead it has an adverse impact of increasing inequalities since it benefits a small group of people – less than 10 per cent of the population in low- income countries (Oxfam et al. 2008). The costs of PHI are especially high for women which limits their accessibility to health care including reproductive health care. In Chile, for example, premiums were set 2.5 times higher for women than for men (Oxfam et al. 2008).

Oxfam concludes that these private insurance schemes leave the poor without access to important health care such as childbirth and pregnancy-related illnesses and exclude people living with HIV (Oxfam et al. 2008). While CBHI has proven to help the poor access health care in developing countries, SHI has been successful only in developed countries and not in developing countries context where most people are either unemployed or work in the informal sector (Oxfam et al. 2008).

⁹ *The World Health Report 2006 – Working together for health*, WHO, 2006: 4-6.

¹⁰ ILO Sectoral Activities Program, “Terms of employment and working conditions in health sector reforms,” ILO, 1998.

In order to achieve universal access to health care, it is crucial that health care insurance mechanisms

Relevant Themes for EZ from Course Description

- Effects of IFIs' economic globalizations policies such as financial and trade liberalization, labor market deregulation, , stabilization, healthcare and education reforms.
 - User fees for primary health and education.
- Impact of structural adjustment policies on different health outcomes such as HIV/AIDS and malnutrition.
- Alternative proposals for economic globalization and the role of the global justice movement.
 - Mention Jubilee Campaign, IMF Campaign

Materials

Gender Guide

Mapping, Tracking, Toolkit (RH & H/A)

ILO Paper

End Question

Will any students chose the ideas discussed today as the focus of their final project?

Describe – touch on from Mapping if not already addressed

Wolfowitz battle

Ghana conditionalities

HNP worst performing sector

Mapping