Does The IMF Constrain Health Spending in Poor Countries? Evidence and an Agenda for Action

Report of the Working Group on IMF Programs and Health Spending

June 20, 2007

Preface

It is hardly a secret that the International Monetary Fund has won few friends among the many organizations and individuals who work in global health. Those who have worked hard in the past decade to mobilize unprecedented levels of funding and attention for HIV/AIDS, tuberculosis, malaria and other health programs in low-income countries have contended that the IMF's approach to macroeconomic management has constrained effective use of the donor funds now on offer and has thereby weakened efforts to improve health conditions in countries that are most heavily burdened by disease. The IMF, for its part, has consistently responded to criticism by noting its circumscribed role, which does not include venturing into sector-level decision making, and reminded critics that health priorities must fit within a broader set of social choices that have to take account of an overall budget constraint.

In the on-going argument, we have seen an opportunity to put some new information on the table and to gain a clear-eyed understanding of the impact of IMF programs on health, generating new thinking about whether and how IMF and other organizations' practices should change. Toward that end, in the summer of 2006 Center for Global Development we invited Visiting Fellow David Goldsbrough, who has a deep understanding of the IMF's strengths and limitations, to lead a new Working Group of 15 individuals with a diverse range of experience on health sector and macroeconomic issues. This report is the result of that effort, making a major contribution with dispassionate analysis and clear recommendations – for the IMF, the World Bank, the governments of countries working within IMF programs, and civil society organizations.

The messages are clear but not simple-minded, and the analysis should be welcomed by all those who have struggled to sort out what the debate is really about. The group explored, for example, what assumptions about aid flows enter into IMF projections of available resources, whether those assumptions are well founded, and whether the Fund's characteristically conservative view on fiscal management prevents governments from considering viable options for increasing health spending. It looked at whether and how caps on the overall public sector wage bill used in many IMF programs, especially in Africa, constrain the ability of health sector leaders to recruit and retain health workers. And it looked at whether the IMF's mode of operations keeps the conversation limited to only a few of the stakeholders who should be heard in dialogues about national spending priorities.

These are the nitty-gritty questions underneath headline-style critiques of the IMF; the answers, summarized in this report, demonstrate that there is indeed plenty of room for improvement in IMF policies and practices, while recognizing the important role of the Fund in supporting macroeconomic stability. In short, this report represents precisely the type of challenge we like at the Center for Global Development – where good analysis and broad consultation shed the light on a path forward.

Nancy Birdsall
President
Center for Global Development

Acknowledgements

We are grateful to the many individuals who have contributed to this report through their generous gifts of time and energy. First, we thank members of the Working Group who devoted countless hours of their time and provided thoughtful input and feedback throughout the process. Coming from a variety of perspectives, members continually approached the task at hand with open, critical minds focused upon solutions that would yield a better integration between macroeconomic and health sector policies and thereby improve the health and lives of the poor.

The report draws heavily on the work of a collection of background papers undertaken to improve the evidence base on IMF programs and health expenditures. Caesar Cheelo, Coordinator of the Health Economics Project at the University of Zambia provided invaluable insights into health policy-making in Zambia. Paolo de Renzio contributed a major analysis of how IMF programs, budgetary processes, and health sector policies have interacted in Mozambique. Karin Christiansen and Tom Leeming provided a similarly insightful examination of the Rwanda case. We are grateful to David Bevan for his careful analysis of the circumstances under which various types of expenditure protection might be useful.

The project has benefited from extensive discussions with a wide range of policy-makers from developing country governments, leaders of civil society involved in health sector issues, representatives of donors, as well as with many staff of the IMF and other multilateral institutions. We would also especially like to thank Nancy Birdsall, Ruth Levine, Lawrence MacDonald, and other colleagues at the Center for Global Development for comments and critiques.

Valuable research assistance was provided by Ehui Adovor, Ben Elberger, and Jennet Hojanazarova in preparation of the background papers, Working Group meetings, and the final report.

Finally, we thank the Global Health Policy Research Network of the Center for Global Development for hosting the project. The report was made possible by financial support from the Bill and Melinda Gates Foundation and by the generous start-up gift of CGD Board Chairman Edward W. Scott, Jr.

Executive Summary

Controversy surrounds IMF-supported programs in low-income countries and one of the most contentious questions is whether the IMF forces governments to take policy measures that hurt the health of populations. Critics argue that IMF programs have unduly constrained health spending, at a time when more donor money is available and the health sector needs are very great, because the IMF is too pessimistic about how much aid will materialize or because it takes too conservative a view about what policies are needed to sustain sufficient macroeconomic stability. Critics also maintain that ceilings on government wage bills in IMF programs have unnecessarily disrupted much-needed expansions of the health workforce. The IMF response to such criticisms is that governments are responsible for choices on expenditure priorities and that the Fund does not set targets for spending or wages in particular sectors.

To investigate these issues, the Center for Global Development convened a Working Group on IMF Programs and Health Spending. The Group was charged with two broad goals: (i) to establish the facts about what actually happened on these key issues; and (ii) to make practical recommendations for improvements where warranted. The Group's work focused on the interaction between macroeconomic, especially fiscal, policies in recent IMF programs and government health spending in aid-dependent countries; it did not address other health sector or economic policies except where relevant to this mandate. Working group members, serving in individual and voluntary capacities, included experts in macroeconomic and health sector analysis and policy implementation.

The Working Group drew upon a range of background papers on different aspects of IMF programs, including detailed case studies for Mozambique, Rwanda, and Zambia.

IMF influences on health spending: indirect but potentially significant

Health outcomes and economic policies are linked in complex ways, involving many policy issues beyond the IMF's competence or mandate. Governments make the key decisions on what share of their resources to spend on health and on the policies that will determine how effectively those resources are used. Their decisions may not match the political rhetoric given to the importance of health, especially for the poor. For example, the share of total government spending devoted to health has not increased as much as promised in some earlier political statements. Within the health sector, there is considerable scope for improvements in planning, budget allocation and implementation to ensure resources reach frontline service providers and for improving incentives to ensure effective service delivery, including access for the poor. Higher spending on health is a critical part of the solution, as most health systems are funded at levels well below what is judged as necessary to deliver a basic package of health interventions, but the right policy setting is also needed to ensure more money translates into better health. These are issues on which the IMF should have little to say given its expertise and mandate as a macroeconomic risk advisor; in particular, it cannot say how much additional resources health systems can use effectively.

However, the content of IMF programs can have important indirect effects upon the health sector, through the size of overall public spending and other influences (e.g., on the growth rate,

which in turn influences future spending capacity). Furthermore, the nature of many health interventions makes them especially sensitive to fiscal decisions. In countries with weak budgetary processes, the burden of short-term expenditure cuts can fall disproportionately on health spending causing disruptions in the availability of resources. Because of the imperative of ensuring continuity in services and drug supply for HIV/AIDS, tuberculosis and other major diseases, any temporary interruptions in funding can have very serious consequences for health outcomes. Moreover, the nature of much health spending—including the large share spent on wages and the complexity of training and recruitment—increases the importance of forward-looking budgetary planning. Therefore, IMF-supported fiscal policies in particular can have an important influence on the health sector.

In this context, the IMF has two main functions: (i) advising countries on the macroeconomic consequences and feasibility of policies (e.g., on the path of the fiscal deficit and public spending); and (ii) providing signals to the broader international community, including donors, on whether a country's proposed strategy is macroeconomically sustainable.

In assessing how well the IMF has carried out these functions, it is important to recognize that we often know little about some critical economic relationships that have a major influence on macroeconomic policy choices. For example, it is difficult to determine, in advance, how public spending (in the health sector and elsewhere) will affect future economic capacity. Also, how private investment might respond to lower fiscal deficits is not straightforward. So humility is required when pronouncing on the appropriate macro framework unless country-specific evidence on such relationships is available**.** In practice, policy choices must inevitably be made under considerable uncertainty and need to take account of the implied costs of different types of potential mistakes. For example, risks to macroeconomic stability have to be weighed against foregone opportunities for additional public spending.

Even if all these empirical questions could be answered, many policy issues—especially those involving the health sector—would continue to involve fundamental social choices that should be left to national political processes. The IMF job is to help countries explore the consequences of various feasible policy options to clarify the tradeoffs involved. So a key question posed by the Working Group was whether the IMF has unduly constrained the range of feasible policy options that should be left to domestic political processes. Our conclusion is that, in several important ways, the IMF has often been too restrictive by ruling out potentially viable policy options without sufficient consideration.

What has happened to government health spending? Moderate increases but still well short of supporting an effective basic health system

Government health spending in low-income countries has risen moderately, both as a share of GDP and as a share of total government spending, since the late 1990s. Viewed from a longer perspective, these increases have only managed to restore previous shares. However, the data is weak and does not capture most off-budget spending. In dollar terms, average public spending per head on health for the group of countries eligible for the IMF Poverty Reduction and Growth Facility (PRGF) has also increased moderately, rising from $10 in 1998 to $15 in 2005 (at market exchange rates). Most countries, though, still spend much less than the levels estimated

as the minimum necessary for effective delivery of a basic public health system (e.g., around $40 per person, when updated to current prices, according to groups such as the WHO Commission on Macroeconomics and Health).

Comparing countries that have had extensive involvement with IMF programs during 1998-2005 with those that have not indicates that, outside of Africa, broad trends in government health spending are similar for the program and non-program groups. For Sub-Saharan Africa, the average increase in health spending as a share of GDP was larger for the group of program countries. However, not much can be inferred from these relatively small differences. For example, since an IMF arrangement was a pre-requisite for HIPC debt relief and part of the resources from such relief was supposed to support higher health spending, much bigger increases in health spending might have been expected in countries with IMF programs. An earlier study that tried to control for such factors concluded that the presence of an IMF program tends to maintain or slightly increase health spending, but the effects appear to be small and short-lived.

Fiscal content of IMF programs: Too little exploration of more ambitious but still feasible spending options, despite some recent evidence of flexibility.

The evidence suggests that IMF-supported fiscal programs have often been too conservative or risk-averse. In particular, the IMF has not done enough to explore more expansionary, but still feasible, options for higher public spending.

The problem is more complex than suggested by accusations that the IMF pursues a "one size fits all" approach. Cross-country evidence indicates considerable variation in the size of targeted changes in fiscal deficits and public spending. Moreover, on average, recent fiscal programs incorporate moderately higher expenditures and deficits, reflecting better macroeconomic starting conditions.

Nevertheless, a recent study of IMF programs in Africa by the IMF Independent Evaluation Office and the detailed case studies undertaken for the Working Group both found that the IMF has tended to favor additional domestic debt reduction or external reserves increases over additional spending. While the IMF is right to take account of the level of reserves and domestic macroeconomic conditions when designing the fiscal response to additional aid, the degree to which these factors influenced the fiscal strategy seems too conservative and sometimes led to too stringent fiscal programs. A wider range of fiscal paths is often now possible, especially following debt relief, but there was little discussion—at least in publicly available IMF documents—of the rationale underlying the specific path chosen for the fiscal deficit and overall government spending. More ambitious but still potentially feasible fiscal options for higher spending were usually not explored. In Rwanda, for example, an earlier donor-sponsored effort to explore alternative expenditure options, although technically flawed, was a missed opportunity to broaden the debate over fiscal strategy. The case studies show that the IMF has often adapted its programs significantly to changing circumstances at the time of program reviews (i.e., in the middle of programs), but this is not the same as taking the lead in exploring alternative scenarios.

Three factors may account for the reluctance to explore a broader range of options. First, information on the sector-level costs and consequences of higher spending scenarios necessary to make reasonable macroeconomic assessments is often lacking, especially for the health sector. Filling these information gaps goes well beyond IMF expertise and requires better inputs on sector-level issues, drawing on the inputs of country-level stakeholders and bilateral and multilateral partners. If key information is lacking, the IMF should be humble in its macroeconomic pronouncements. But the Fund often responded to the uncertainty by implicitly "assuming the worst" concerning the potential for higher public spending—for example, about the severity of any constraints on the capacity to absorb more aid, the likely permanence of additional aid, the impact of higher public spending on long-term output, and the speed with which a strategy based on paying down domestic debt might 'crowd-in' private investment. Second, the IMF Board and Management have given insufficient guidance to IMF staff on what exactly they are meant to do in this area. Third, tensions between different roles of the IMF weakened incentives to open up the debate to include a broader range of options and stakeholders. For example, negotiations over short-term macroeconomic conditionality may be easier to conclude if kept within a narrow circle and may involve information that the government wishes to keep confidential.

The Working Group also investigated how IMF programs respond when aid is higher or lower than expected. Many programs required that, in the short term, higher-than-projected aid be saved whereas expenditures were to be cut if aid fell short of projections. The balancing of risks implied by such an approach is not justified if the costs of under- or over-shooting targets are no longer asymmetric. If there is a reasonable cushion of reserves and the costs of disrupting medium-term expenditure plans are high, the appropriate policy response would be to smooth expenditure fluctuations. A change in program design to allow greater short-term flexibility could be especially important for the health sector, which tends to suffer disproportionately from short-term expenditure cuts. The case studies suggest that the IMF is already moving, albeit gradually, in this direction.

The IMF and aid projections: unclear expectations create a risk of confused signals

With a few recent exceptions, there was little exploration of the macroeconomic consequences of scenarios for scaling up aid. In some earlier programs in the countries for which case studies were prepared, aid projections were oriented around goals of reducing aid dependency (e.g., Mozambique) or avoiding borrowing even on concessional terms (Rwanda) without strong macroeconomic arguments in favor of the approach taken. In these cases, the IMF programs did eventually adapt when substantially higher aid was forthcoming, but it is not possible to say whether the initial negative signals discouraged any aid.

In-depth analysis of alternative scenarios for "scaling up" aid have been undertaken in a few countries in the last couple of years, and some more are in the pipeline, suggesting some signs of a gradual change in approach. However, expectations of IMF staff in this area are still not clear, and much seems to depend on the initiative of individual mission chiefs. The Working Group was told that it is now the policy of the IMF African Department to undertake such an analysis whenever it is requested by the authorities and sufficient information on sector-level costs is

available. At the time of writing this report, however, that revised approach had not yet been reflected in any general policy statement by the IMF.

The lack of clarity about what is expected with regard to aid has two consequences. First, the IMF has not done as much as it could to help countries (and donors) explore the macroeconomic consequences of higher aid. Second, it risks sending confused signals to donors and recipient governments. For example, if only conservative scenarios are presented, does this mean that the IMF thinks more resources cannot usefully be absorbed from a macroeconomic perspective? Or does it mean that the IMF thinks more resources will not be forthcoming, regardless of whether they could be well-utilized?

In practice, projections of aid to Africa in IMF programs remain conservative—reflecting skepticism by IMF staff, which may be justified, on donors' resolve to deliver on their commitments to double aid by 2010. Of the 27 IMF programs and reviews in Sub-Saharan Africa that were completed in the 18 months after the Gleneagles Summit, baseline projections in only two were consistent with the Gleneagles commitments.

Targets for inflation

Most recent IMF programs with low-income countries have targeted inflation at very low levels (i.e., 5 percent or lower), largely reflecting low starting levels of inflation or membership of currency unions. Empirical evidence does not justify pushing inflation to these levels in low-income countries. The IMF should not be unduly risk-averse by ruling out additional aid-financed government spending options just because they may put some upward pressure on prices. It should explore more macroeconomic scenarios to allow a better assessment of the costs and benefits of more fiscal space, including the potential supply side benefits of additional spending on spare capacity utilization, investment and future output growth.

The targets for inflation that guide monetary policy should take account of country-specific circumstances that are likely to influence the path of prices, including the consequences of any adverse supply shocks. However, an across-the-board relaxation of monetary policy associated with an adoption of higher inflation targets would be unlikely to yield higher growth, because expectations of higher inflation would adapt quickly.

IMF program negotiations: Too narrow a circle weakens political support

The narrow circle of national participants discussing IMF programs had two adverse consequences. First, an overly narrow debate aggravated the lack of integration between discussions about sector-level policies (specifically, choices on the level and composition of expenditures and what was needed to improve their effectiveness) and the overall macroeconomic framework. Second, it weakened political support for key policy choices. In the case studies, it was striking how some decisions affecting the health sector were incorrectly attributed, including by some government officials, to the IMF program. This "blame the IMF" attribution of policy choices is unhealthy because it undermines what should be a robust domestic debate about priorities.

The IMF alone cannot broaden the dialogue (which ultimately depends on the government) but could do much more to provide additional evidence, discuss the rationale for its policy proposals, and encourage more analysis and discussion of various options**.** A shift toward greater emphasis on providing inputs into a broader policy dialogue would require important changes in the IMF way of doing business, including downplaying the Fund's role as a negotiator of short-term conditionality.

Wage bill ceilings have been overused and should be restricted to very specific circumstances

Conditionality related to the wage bill was included in almost half of recent IMF programs with low-income countries. For example, 17 out of the 42 countries with PRGF-supported programs during 2003-2005 included some form of ceiling on the wage bill; all were in Africa or the Central America/Caribbean region. Such ceilings have been especially common in Africa. Our conclusion is that such ceilings have been overused. They have been useful as a temporary device when a loss of control over payrolls threatened macroeconomic stability (e.g., Zambia 2003-2004), but such situations will probably be rare. In practice, they have been used in many other situations, including efforts to influence long-term resource allocation choices (i.e., the share of government spending going to wages) that the IMF is not well-suited to pronounce upon and that should not be addressed by short-term macroeconomic conditionality.

Wage-related conditionality in IMF programs has always used ceilings on the overall wage bill and not sector-specific constraints on hiring or wages in health (or education). Indeed, programs with ceilings on the overall government wage bill usually included some mechanism that attempted to protect expansions of employment and pay in priority sectors, often by trying to build such projections into the baseline ceiling. In practice, however, there was usually no way to enforce such protection or even to monitor what actually happened. Consequently, if space under the ceilings was used up by unanticipated hiring in sectors with more political influence, employment in health could still be constrained.

Although IMF involvement in wage bill issues should be scaled back, governments will still face huge long-term challenges in their efforts to address their large health workforce needs within likely resource availability. Evidence from the case studies suggests that countries often have no clear strategy to match incentives to the most urgent needs for the supply and distribution of skilled staff. In some cases where long-term human resource plans have been developed (e.g., Zambia), the targeted staff increases are large but have not been integrated with medium-term expenditure planning. Consequently, they provide only limited guidance to priority-setting in annual budget discussions.

Strengthened national budgetary and planning processes are needed to reduce the disconnect between fiscal and health sector policies

While the main focus of the Working Group has been on identifying changes in the IMF approach that can improve the framework for choices on health spending, it is important to recognize that the IMF role—for good or ill—is always going to be an indirect and secondary one. Some critical changes can only be made by national governments, supported by donors. In

this regard, our investigation has highlighted a striking disconnect between overall fiscal and budgetary policies and health sector issues. Fixing this disconnect will require actions by many stakeholders, not just the IMF, since it involves many different aspects. First, as noted, a huge analytical and information gap exists: macro-policy decisions are often made with very little understanding of the likely costs and effects of potential choices for health spending; similarly, discussions on longer-term health policy are often not guided by a clear idea of what the overall budget constraints might be. Second, national planning and budgeting capacities—including those of ministries of health—are not strong enough to make meaningful choices on tradeoffs. Addressing these analytical and capacity gaps will usually require additional external technical support. At the international level, the issue is usually discussed in terms of stronger IMF-World Bank collaboration, but it is much broader than that because the relevant external expertise often lies with other multilateral institutions or bilateral donors. Strengthened frameworks are needed for identifying who does what and by when to help governments, with feedback on accountability. Third, donors have contributed to the segmentation of budgetary processes. Keeping important donor-financed activities outside of the normal budget process tends to weaken national priority setting and creates longer-term fiscal problems if donor priorities do not align well with national priorities.

Expenditure protection mechanisms—potentially useful during periods of budgetary stringency but need to be focused and reflect domestic priorities

The Working Group looked at possible mechanisms to protect spending on health, as the health sector has often been particularly vulnerable to budget cuts. While strengthening budgetary and governance processes is the "first best approach" to ensuring that budgetary priorities properly reflect social choices, current budgetary systems are flawed. So, mechanisms that protect (i.e., give special priority to) some categories of spending can be a useful device while overall processes are being strengthened. The evidence on what works best is limited, but the Working Group found three guiding principles on these expenditure protection mechanisms: (i) designation of spending categories to be protected should reflect priorities of domestic constituencies, not donors; (ii) priority categories should be well-focused and not overly broad; and (iii) such mechanisms need to be integrated with macroeconomic strategies for smoothing aggregate public spending, which requires flexibility in related IMF conditionality.

Lessons

The Group's main recommendations are directed at the IMF, but our investigation also suggests a number of important messages for other stakeholders, including national governments, donors, and civil society.

Six recommendations for the IMF

The IMF needs to adapt its approach in low-income countries to its expected role and be crystal clear about what that role is. Our recommendations assume that the IMF will remain as an important macroeconomic policy and risk advisor in these countries. In this case, some significant changes in its way of working are needed. To implement the six specific recommended changes summarized below and discussed in more detail in the main report will require action by the IMF Board and Management. Clearly, an alternative division of labor

among international institutions, involving a much-reduced role for the IMF, is also possible. In this case, the Board should make clear that the IMF role in post-stabilization low-income countries will be much more limited, and scale back its involvement and policy pronouncements accordingly. But the worst of all worlds would be for the IMF to pretend that it can continue to play its current major role in these countries without adapting its way of doing business to the new challenges they face.

1. The IMF should help countries explore a broader range of feasible options for the fiscal deficit and public spending. This requires less emphasis on negotiating short-term program conditionality and a greater focus on helping countries strengthen their understanding of the consequences of different options.
2. The IMF Board and Management should adopt and make public clearer guidelines on what is expected of IMF staff in analyzing the consequences of alternative aid paths and on what should drive IMF signals about aid levels.
3. While it is not the IMF's job to decide what aid levels should be, it should do more to promote fuller and more timely information about expectations for aid in its programs
4. Wage bill ceilings should be dropped from IMF programs except in cases where a loss of budgetary control over payrolls threatens macroeconomic stability.
5. IMF programs should give greater emphasis to short-term expenditure smoothing, especially when macroeconomic instability is no longer a significant threat.
6. The IMF should be more transparent and pro-active in discussing the rationale for its policy advice and the assumptions underlying its programs.

Lessons for other stakeholders

Many of the lessons for other stakeholders focus on the need to build better connections between the health sector and overall budgetary processes in order to make sure health interests are a more effective part of the equation in making fiscal choices.

- National priority-setting processes need to be sharpened. In particular, the capacity of Ministries of Health to undertake budgetary planning should be strengthened, with external technical support, to enable them to produce concrete operational plans that will make a good case for additional budgetary resources**.** The capacity of ministries of finance to analyze alternative options should be increased. The role of Parliaments in the priority-setting process also needs to be enhanced.
- Development partners should avoid adding to the fragmentation of budgetary processes and the national dialogue over policy priorities. They should improve the predictability of their aid and make longer-term commitments in order to promote more effective planning and implementation of health spending.
- Bilateral donors, the World Bank, and other multilateral institutions should be more proactive in providing timely sector-specific analysis as inputs to macro assessments of scaling up. In the health sector, they should be more pro-active in giving empirically-based advice on how to translate increased resources into more effective interventions. This should include more concrete advice on how to reform wage structures and incentive systems for countries' health sectors.

- Civil society organizations involved in budgetary and health advocacy issues should give greater attention to monitoring and influencing the setting and implementation of annual budgets

Abbreviations

BHCP	Basic Health Care Package
CGD	Center for Global Development
ESAF	Enhanced Structural Adjustment Facility
FY	Fiscal Year
GDP	Gross Domestic Product
HIPC	Heavily Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IEO	Independent Evaluation Office
IMF	International Monetary Fund
MDG	Millennium Development Goal
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organization
NHA	National Health Accounts
PARPA	Plano de Acção para a Redução da Pobreza Absoluta
PEPFAR	President's Emergency Plan for AIDS Relief
PRGF	Poverty Reduction and Growth Facility
PRSP	Poverty Reduction Strategy Paper
PSIA	Poverty and Social Impact Assessment
SMP	Staff-Monitored Program
SWAp	Sector-Wide Approach
WHO	World Health Organization

I. Introduction

Critics of the International Monetary Fund (IMF) allege that the macroeconomic programs it supports in low-income, aid-dependent countries unduly constrain a scaling-up of health expenditures to respond to the population's health needs. Two main strands characterize this criticism:

- The overall macroeconomic, and especially fiscal, policies in programs restrict spending too much. Specifically, critics argue that the IMF takes too conservative a view of what is needed for macroeconomic stability or that the IMF is too pessimistic in its assessments of the potential for increases in aid.
- Some of the specific policies promoted in programs have harmful side effects on the planning and implementation of effective health spending. In particular, critics charge that ceilings on government wage bills have disrupted desirable expansions of the health workforce.

Responding to these criticisms, the official position of the IMF has been that governments, not the Fund, are responsible for making choices on expenditure priorities.[1] The IMF points out, correctly, that its programs do not set specific targets for spending or wage bills in particular sectors.[2]

National governments certainly bear the ultimate responsibility for choices on priorities. However, IMF programs can indirectly influence the health sector in significant ways, especially since health spending is highly sensitive to overall fiscal policies. Questions about how the IMF is behaving are especially pressing as poor countries try to best utilize foreign aid and their own resources to deal with the myriad demands on the health system, not the least of which is HIV/AIDS. These countries usually have IMF-supported programs because access to some types of financing, including most debt relief, is linked to an IMF arrangement. So IMF activities are important for the health sector.

Recognizing the importance of these issues, and believing that improvements are possible, the Center for Global Development (CGD) convened a Working Group on IMF Programs and Health Spending in the autumn of 2006. The Working Group, chaired by David Goldsbrough, consists of 15 individuals with a diverse range of expertise in analyzing and implementing macroeconomic and health sector policies, serving as individuals in a voluntary capacity (see Appendix 2 for a list of members).

The Group was charged to investigate how macroeconomic policies under IMF-supported programs have interacted with the management of health expenditures during a period in which—at least at the rhetorical level—more donor money is on offer for expanded health programs. The Group did not examine other aspects of health sector or macroeconomic policies, except where relevant to this central mandate. The Group focused primarily on recent IMF programs, with two broad goals: (i) to establish the facts about what actually happened under programs on the key issues where the IMF has been criticized; and (ii) to make practical recommendations for improvements.

This report is based on analyses and discussions of cross-country evidence and specific country case studies, interviews with a broad range of stakeholders, and other inputs from the Working Group. A series of background papers were prepared to assist the Group's deliberations:

- "The Nature of the Debate Between the IMF and Its Critics"
- "What Has Happened to Health Spending and Fiscal Flexibility in Low-Income Countries with IMF-Supported Programs?"
- "What Have IMF Programs with Low-Income Countries Assumed About Aid Flows?"
- "Promoting and Protecting High-Priority Public Expenditures"
- "Inflation Targets in IMF-Supported Programs in Low-Income Countries"
- Country Case Studies of Mozambique, Rwanda, and Zambia

The background studies are publicly available at http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf.[3]

Chapter II of this report briefly discusses why IMF actions can be important for the health sector. Chapter III summarizes the major findings and supporting evidence on the issues investigated by the Working Group. It does not attempt to repeat at length material from the background papers, and readers who seek further details are referred to those papers. Chapter IV identifies a number of specific lessons and recommendations for change directed primarily at the IMF, but also at donors, governments of aid-dependent countries, and civil society.

The report represents the collective views of members of the Working Group as individuals and does not necessarily reflect the position of organizations with which they are affiliated.

II. What Is an IMF Program and What Does it Have to Do with Health?

Most IMF programs with low-income countries are negotiated in the context of three-year arrangements under the Poverty Reduction and Growth Facility (PRGF), the low-interest financing facility of the IMF. Under these arrangements, governments undertake to implement certain economic policies and the IMF undertakes to provide pre-specified financing, provided that certain conditions (referred to as "performance criteria") are met. In practice, the financing provided by the IMF in such cases is now often quite small. The IMF's main leverage usually comes from the fact that other forms of financing (e.g., debt relief or access to budget and balance of payments support from donors) are often linked to an IMF program being "on track."

The government's policy commitments under the program are set out in a Memorandum on Economic and Financial Policies (sometimes referred to as a "Letter of Intent") which typically includes a description of its macroeconomic objectives (e.g., growth, inflation, and external reserves) and poverty-related objectives alongside key macroeconomic (fiscal, monetary, exchange rate, etc.) and structural policies the government intends to pursue to achieve those objectives.[4] These policies are set out in most detail for the next 6-12 months and include a number of specific limits (called "performance criteria" and "benchmarks") on some macroeconomic variables (typically including a measure of the fiscal deficit or its financing; expansion of credit by the banking system or some other monetary target; the level of net

external reserves; and, in some cases, the government wage bill).[5] Programs are usually reviewed by the IMF Board every six months and are often modified if circumstances have changed.

The direct influence of the IMF on health spending should, in theory, be limited, reflecting the IMF's mandate and comparative advantage. The Fund's main role is to help countries manage macroeconomic stability. Decisions on key elements of a country's macroeconomic framework, including the level, composition, and financing of expenditures, involve fundamental political choices on trade-offs between various economic and social objectives. It should be the job of governments, not the IMF, to make these choices.

Moreover, the links between final health outcomes, including those set out in the Millennium Development Goals (MDGs), and economic policies, including the overall level of health spending, are not well understood and involve many policy issues beyond IMF competence. For example, public spending can influence health outcomes through many channels other than health services such as: clean water and sewage treatment; education, especially for girls; nutrition, and improved transport links. This report, however, focuses on the links between macroeconomic policies and health spending.

Cross-country evidence on the relationship between total public spending on health and overall health outcomes is ambiguous.[6] This is not surprising because so much depends on how resources are used. Most public spending on health goes to the non-poor; much of it fails to reach the frontline service provider; and those providers can face weak incentives to deliver services effectively. But this does not mean that higher spending is not a crucial and necessary part of the solution; it certainly is. Work undertaken by the World Health Organization (WHO) suggests that it is difficult for health systems to be effective at very low levels of spending.[7] A variety of costing models from the WHO Commission on Macroeconomics and Health and the UN Millennium Project suggest that a basic effective public health system would require a minimum level of spending of around US$40 per head (at current prices)—well above present levels in most low-income countries (Commission on Macroeconomics and Health, 2001).[8] However, the right policy setting is also needed if the additional spending is to yield desired benefits. The IMF should have little to say about these policies and the extent to which health systems can effectively absorb additional resources, since they are beyond its mandate and expertise.

Nevertheless, macroeconomic programs can be especially significant for the health sector, both through their influence on the size of overall public spending and through other, indirect influences (e.g., via the growth rate, which in turn influences future spending capacity). The nature of many health sector interventions makes them especially sensitive to fiscal decisions. For example, in the past, weak budgetary processes have often caused the burden of short-term expenditure cuts to fall disproportionately on health spending. Such disruptions can undermine the effectiveness of spending, given the importance of continuity of treatment (e.g., for HIV/AIDS). The nature of much health spending—including the large share spent on personnel and the complexities of training and recruitment—also increases the importance of forward-looking budgetary planning. Moreover, unexpected fiscal squeezes that alter the mix between wage and non-wage components of health spending can reduce its effectiveness in ways that may not be well understood by those making macroeconomic decisions.

In this context, the IMF has two main functions: (i) advising countries on the macroeconomic consequences and feasibility of different policy options (such as the size of the fiscal deficit, the rate of monetary expansion, or the choice of exchange rate policy); and (ii) providing signals to the broader international community, including donors, on whether a country's proposed strategy is macroeconomically sustainable (e.g., whether it is consistent with avoiding new debt problems or putting upward pressures on interest rates and prices in a manner that might harm growth prospects). While the IMF also has a financing role, this is of relatively minor importance in most low-income countries and is not a focus of this report.

Different domestic stakeholders—even within the government—are likely to have different views on priorities (e.g., between various economic and social objectives) and on the appropriate balancing of risks. So, to assess whether the IMF has fulfilled its role adequately, it is not enough to look at intermediate outcomes such as the speed with which spending on health has grown. Even if some stakeholders are dissatisfied with the choices that are made—as many undoubtedly will be—the responsibility of governments for these choices needs to be emphasized. The test for the IMF, therefore, is whether it has unduly narrowed the policy space available to governments by ruling out feasible policy options (options such as increased spending rather than paying down domestic debt) or minimizing projections of future donor financing owing to concerns about the consequences of more ambitious, but still potentially feasible, paths for aid and public expenditures.

III. What Does the Evidence Show?

We draw together here the various strands of evidence from the discussions of the Working Group and the background papers on the interactions between macroeconomic policies and the health sector. Section A summarizes the available (but often poor) information on what has happened to health spending. Section B summarizes the main findings from cross-country evidence and the country case studies about the macroeconomic frameworks underlying IMF programs in low-income countries. It provides insights into whether or not IMF-supported programs have been unduly restrictive. Section C examines national budgetary and planning processes—including the role of donors, with a specific focus on the health sector—and provides a sense of whether national priority-setting processes have been effective. Section D examines hiring and wage policies in the health sector and the role of wage bill ceilings in IMF programs, to see whether such ceilings have had the adverse effect that some critics claim.

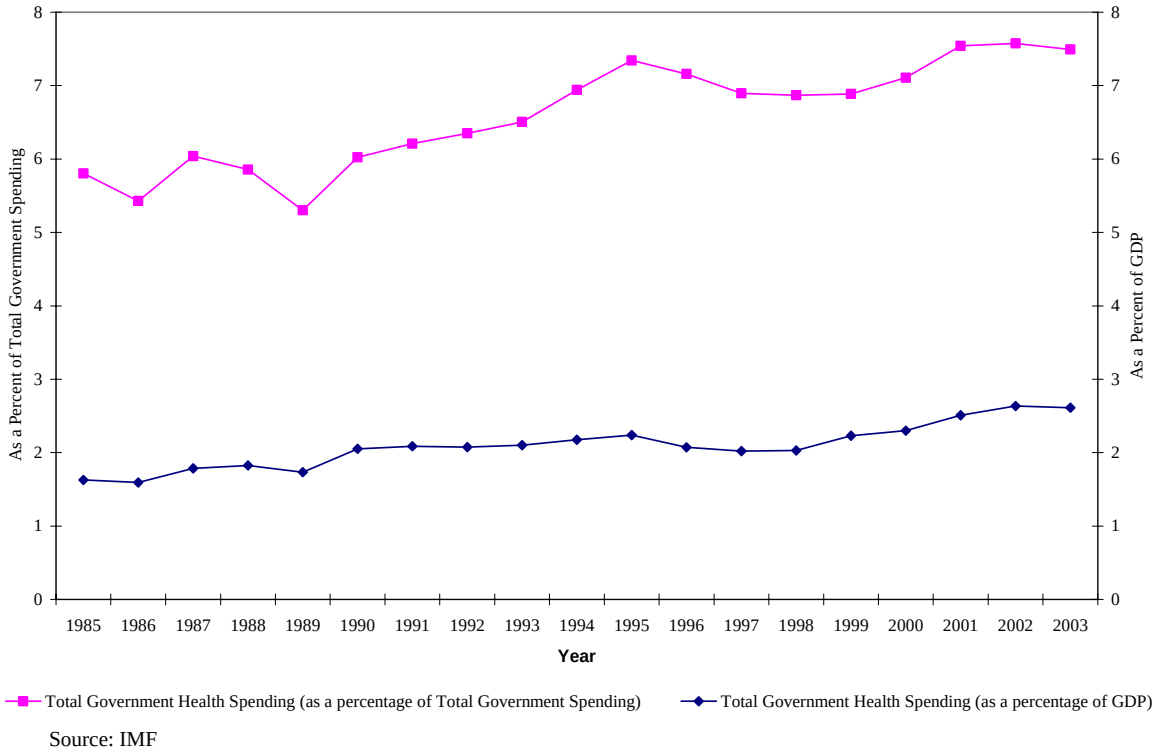
A. What Has Happened to Health Spending?

Despite ongoing efforts to strengthen systems of expenditure tracking through National Health Accounts (NHA), information on trends in health spending in many low-income countries is poor. We present here information from IMF and WHO databases. Both sources of information have significant weaknesses, reflecting problems with the underlying national systems that will take time to correct (including the incomplete coverage of donor-financed, off-budget activities).[9] Nevertheless, they do suggest several broad trends. (For a more detailed discussion, including of the strength and reliability of the data, see the background paper on "What Has Happened to Health Spending and Fiscal Flexibility in Low-Income Countries with IMF-Supported Programs?").[10]

1. Government health spending as a share of GDP and as a share of total government spending has risen moderately since the late 1990s. Viewed from a longer perspective, however, these increases have only managed to restore previous levels. Health spending in relation to GDP rose quite rapidly from 1985 through the early-1990s but then dropped in the mid-1990s (see Chart 1).[11] It began to rise again, moderately, in the late 1990s, a period that coincided with the increased prevalence of debt relief, but only regained its previous peaks of around 2½ percent of GDP in 2000-2001.

Trends in the share of total government spending allocated to health show a similar pattern: a strong trend increase through the early 1990s that was partly reversed in the mid-1990s. Viewed in this longer-term context, the increasing share of total spending going to health since the late 1990s has only managed to restore previous peaks. However, these numbers do not capture the recent substantial increase in donor-financed spending on specific disease-based initiatives, especially HIV/AIDS, much of which is channeled outside the government budget and not recorded in the database. For example, total expenditures of Zambia's Ministry of Health in 2005, including that financed by donors through sector-wide approach (SWAp) arrangements, was US$141 million. In contrast, the total amount budgeted for Zambia under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program in FY 2005 was US$130 million (although the latter includes significant spending that would take place outside Zambia).

Chart 1. Trends in Government Health Spending in Low-Income Countries, 1985-2003



Source: IMF

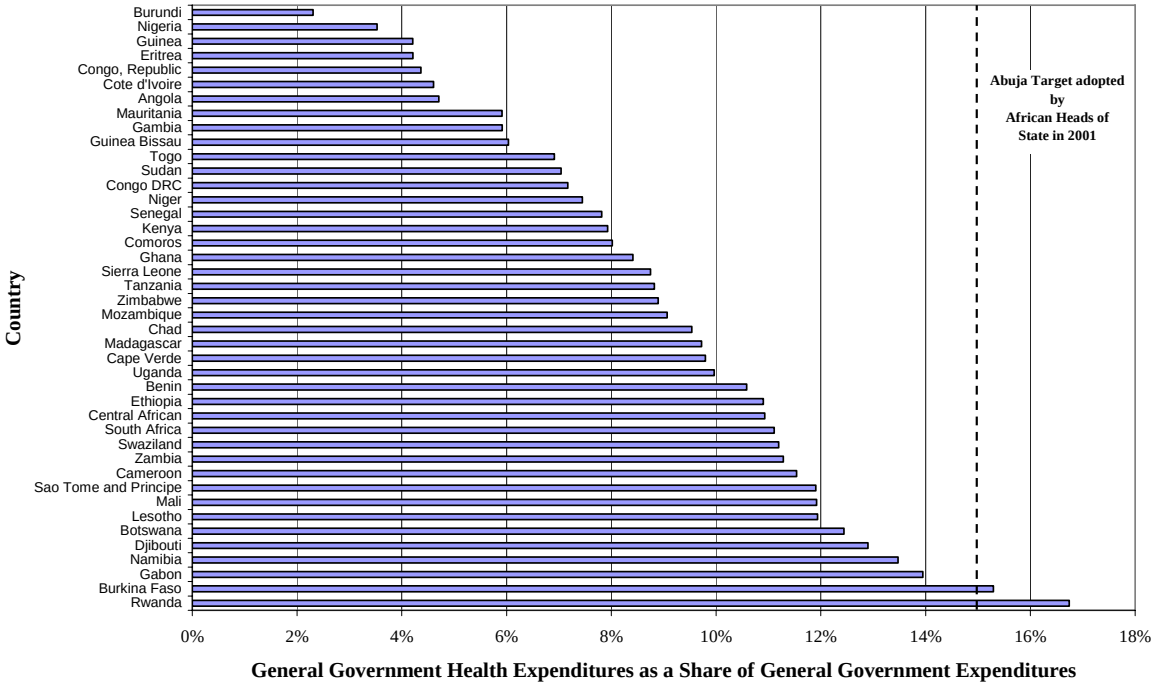
2. In sub-Saharan Africa, government health spending as a share of GDP and as a share of total government spending increased moderately during 1998-2005 but remains well below regional political commitments (Tables 1a and 1b). On average, such spending reached about

2½ percent of GDP and about 10 percent of government spending by 2005. Very few countries in Africa spent close to 15 percent of their total budget on health, in spite of the 2001 Abuja declaration by African leaders to increase spending to this level (see Chart 2).[12]

3. Average government spending per capita has increased moderately in recent years but is still very far below levels estimated to be required to ensure broad delivery of a basic package of health interventions. Average public spending per head on health for the low-income (i.e., PRGF-eligible)[13] group of countries rose from US$10 in 1998 to US$15 in 2005 (at market exchange rates).[14] The level varies widely, with some countries such as Burundi, Guinea, and Niger spending less than US$4 per head in 2005 (see Chart 3). Per capita government spending on health increased moderately in all three of the countries for which detailed case studies were undertaken. According to WHO data, by 2005 estimated government spending on health reached $9½ per head in Mozambique, about $11 per head in Rwanda, and about $18 per head in Zambia. All of these estimates are highly approximate, however, reflecting, inter alia, problems with the ability of national databases to capture donor-financed activities. (See the background papers for further discussion; in particular, the Zambia case study provides a detailed discussion of the different concepts and measurements of government health spending that are being used). Despite these measurement issues, it is clear that in most low-income countries, including the case study countries, government health spending is well below the level of around US$40 per person (in current dollars) estimated by groups such as the WHO Commission on Macroeconomics and Health (2001) as the minimum necessary for effective delivery of a basic public health system

Comparing countries that have had extensive involvement with IMF programs during 1998-2005 with those that have not indicates that broad trends do not differ between program and non-program groups outside of Africa (Table 1a). For sub-Saharan Africa, there were some differences between the two groups: the average increase in health spending over the period was larger for the group of program countries, as a share of GDP, albeit from a smaller base. However, not much can be inferred from these relatively small differences since they do not take account of a variety of potential biases, most notably that the factors influencing whether countries enter into an IMF program may also directly affect the level of health spending. For example, countries that received debt relief under the Heavily Indebted Poor Countries (HIPC) initiatives were required to have an IMF program while part of the resources released by debt relief was earmarked for additional health spending. So the fact that countries with IMF programs do not have even larger increases in health spending could be interpreted as a disappointing outcome.

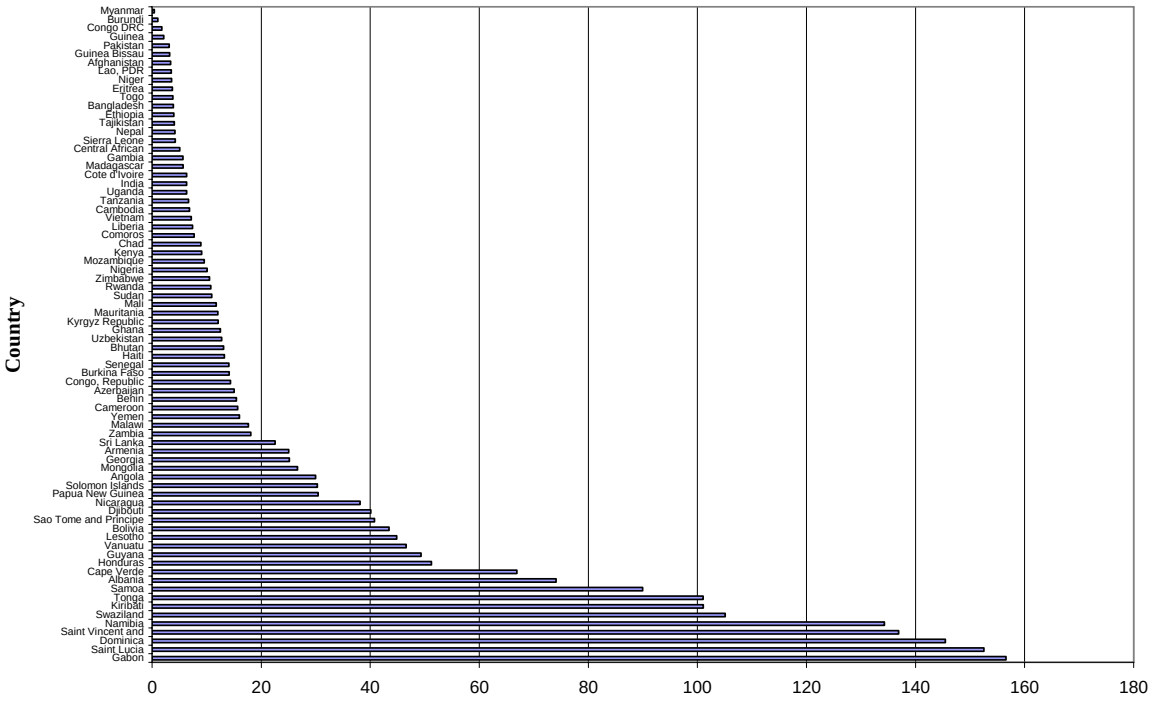
Chart 2. Government Health Spending as a Share of Total Government Expenditures in Selected African Countries, 2005



Source: WHOSIS

Countries not listed include Malawi (37%) and Liberia (29%)

Chart 3. General Government Health Expenditure per Capita, 2005



Source: WHOSIS Detailed NHA estimates available at http://www.who.int/nha/country/en/
Countries not pictured include South Africa ($184/capita), Botswana ($240/capita), and Grenada ($229/capita).

Table 1a. Trends in Average Health Spending (unweighted)

	Total Health Spending (% of GDP)			General Government Health Spending (% of GDP)			General Government Health Spending (% of General Government Expenditures)		
	1998	2005	Change	1998	2005	Change	1998	2005	Change
Low-income countries	5.1	5.5	0.4	2.5	2.9	0.4	8.7	9.6	0.9
Program	4.9	5.3	0.5	2.2	2.6	0.5	8.6	9.4	0.8
Non-Program	5.4	5.7	0.3	3.0	3.5	0.4	8.8	9.9	1.1
Sub-Saharan Africa	5.1	5.4	0.3	2.3	2.8	0.5	8.5	10.1	1.6
Program	4.8	5.4	0.5	2.1	2.7	0.7	8.6	10.0	1.4
Non-Program	5.6	5.5	-0.1	2.9	3.0	0.1	8.1	10.2	2.1

Source: Background paper, "What Has Happened to Health Spending and Fiscal Flexibility in Low-Income Countries with IMF-Supported Programs?"

Table 1b. Trends in Average Health Spending (weighted by population)[15]

	Total Health Spending (% of GDP)			General Government Health Spending (% of GDP)			General Government Health Spending (% of General Government Expenditures)		
	1998	2005	Change	1998	2005	Change	1998	2005	Change
Low-income countries	4.6	4.5	-0.1	1.7	1.9	0.2	7.2	7.3	0.0
Sub-Saharan Africa	5.3	5.3	0.0	2.0	2.4	0.4	8.6	8.8	0.2

An investigation by Martin and Segura-Ubiergo (2004) that attempted to take account of these potential biases using panel data (i.e., combined cross-country and time series data) and controlling for other influences on social spending suggested that the presence of an IMF program tends to maintain or slightly increase health spending, measured either as a share of GDP, total expenditures, or in real per capita terms. But the effects appear to be small and short-lived.

Finally, there is evidence that governments tend to adjust substantially the allocation of resources to health so as to reflect their own, not donor, objectives. For example, the analysis in a paper prepared for the High-Level Forum on the Health MDGs (High Level Forum, 2005a) indicates that the marginal impact of higher aid on the share of health spending was small (about 3½ cents of higher health spending for every additional dollar of aid). In particular, it was—to a distressing extent—smaller than the share that was notionally earmarked for health, which was estimated to have risen from 9 cents on the dollar in 1990 to 17 cents on the dollar by 2003.[16]

B. Have IMF macroeconomic programs unduly narrowed policy options?

Any discussion of the content and analytical basis of IMF programs should begin by recognizing the large gaps in knowledge about some fundamental economic relationships that are important for the design of macroeconomic policies. There continues to be considerable debate on many issues, including: the fundamental influences on economic growth; the potential for higher public spending now to raise output capacity in the future (which is at the heart of the "fiscal space" issue); the size and speed with which private investment responds to reduced domestic financing of the fiscal deficit (referred to by economists as "crowding in"); how the real economy responds

to shifts in the real exchange rate associated with higher aid inflows, including the extent to which higher spending can offset any loss of competitiveness (the "Dutch Disease" issue); and the precise links between inflation and growth. It is beyond the scope of the Working Group to pronounce on these issues, but the background paper on, "The Nature of the Debate between the IMF and its Critics" summarizes briefly the available evidence.[17] The key point to bear in mind for this report is that the macroeconomic consequences of policy choices can differ markedly across countries and will depend heavily on how the real economy responds in specific situations, a subject where our knowledge is often limited.

Even if these empirical questions could be answered, many macroeconomic policy issues involve fundamental social choices and cannot be answered at a purely technical level. Take, for example, a question at the heart of this investigation: how much a country should spend on its government health sector. Even if (and it is a big if) all of the uncertainties about how different types of spending influence growth and health outcomes could be resolved, the answer on how much a government should spend on health will still depend on basic social choices (e.g., how much emphasis to give to improving dire health outcomes irrespective of any influence on growth; how to distribute the burdens and benefits of taxes and spending; how much to borrow on behalf of future generations; and how much aid donors should give). Economics alone cannot answer these questions, although it should help to inform the trade-offs implied by different choices.

These considerations suggest several basic messages that have framed our analysis of the IMF approach:

(i) Some key judgments—e.g., how much additional spending can be absorbed—are sector-level ones, about which macroeconomists, including the IMF, may have little to say.

(ii) Humility is required when pronouncing on the appropriate macro framework, unless country-specific evidence on the micro—and sectoral—foundations are available.

(iii) Policy choices are being made under considerable uncertainty and need to take account of the implied costs of different types of mistakes. Choices that put all of the weight on avoiding one type of risk (e.g., to avoid macroeconomic instability) at the expense of other types of risk (e.g., foregoing opportunities for additional useful public spending) may not always be best.

(iv) Macroeconomic policy choices involve *political* choices among the types of tradeoffs discussed above. The IMF should be helping countries (and potential donors) explore the consequences of various feasible policy options in order to clarify these trade-offs. Therefore, a key test for the IMF is whether it has unduly constrained the feasible policy options that should be left to domestic political processes.

With this background, we focus on four aspects of IMF-supported macroeconomic programs that have been at the core of the debate: fiscal policies (including how aid is used); aid projections and whether alternative scenarios are explored; how programs respond to unexpected developments (in particular higher or lower aid); and inflation targets. For each issue, the main

conclusions are first summarized, followed by a more detailed discussion of the evidence, both from cross-country analysis and the case studies.

a. Fiscal content of IMF programs: Too little exploration of more ambitious but still feasible spending options

Evidence from cross-country analysis and the country case studies suggests the following:

- *In general, the IMF has not done enough to explore more expansionary, but still feasible, options for greater fiscal space. The initial fiscal content of some programs was, as a consequence, too conservative or risk-averse. Recent fiscal programs incorporate moderately higher expenditures and deficits, reflecting better starting conditions and debt relief, but a wider range of feasible policy options could be considered.*
- *The IMF has tended to favor domestic debt reduction or external reserve increases over additional spending even when macroeconomic conditions were quite favorable. The rationale for this very conservative approach was usually not discussed in any depth, but seemed to reflect a concern that additional spending would be wasted or that any aid increases would be short-lived. Such choices need to be based on a fuller examination of the merits of different options, including an explicit consideration of the likely costs of foregone expenditures, including in the health sector.*
- *Programs do adapt—allowing for greater spending, for example—as circumstances, including aid levels, change. However, the IMF has usually been reactive; with a few exceptions, it has not taken the lead in exploring such scenarios.*
- *The weakest analytical link is the lack of sufficient investigation of how the real economy is likely to respond to different fiscal choices, including the effects of domestic debt reduction on private investment and the effects of higher public spending on the supply side. Filling these gaps will require better inputs on sector-level issues, drawing on the inputs of country-level stakeholders and bilateral and multilateral partners. The IMF should also be more pro-active in investigating those linkages that are within its mandate, including by being open to analytical inputs from outside groups. If key information is lacking, the IMF should be humble in its macroeconomic pronouncements.*

There has been some shift toward more expansionary fiscal policies in IMF programs approved since 2003, partly reflecting countries' better starting positions in terms of macroeconomic stability (e.g., lower inflation rates, higher external reserves, and lower debt). However, even recent programs have typically not incorporated substantial aid-financed fiscal expansions, at least initially. In sub-Saharan Africa, the design of IMF programs has leaned quite heavily in favor of using projected additional aid to rebuild external reserves and reduce domestic financing of the deficit. Recent evidence from the IMF's Independent Evaluation Office (IEO, 2007) indicates that, on average, only 27 cents of every additional dollar of expected aid was programmed to finance a fiscal expansion (see Box 1). Only when initial macroeconomic conditions are very stable do programs target most additional aid to be "spent" through additional fiscal expansion.

This conclusion is consistent with the findings of the case studies undertaken for the Working Group where the initial focus of the analysis underlying the derivation of the fiscal targets was typically on the requirements to maintain stable public debt dynamics—especially domestic financing of the deficit—given conservative assumptions about aid. Following substantial debt relief, however, debt sustainability considerations are no longer a sufficient benchmark for the fiscal path. A wider range of paths for the fiscal deficit is now possible but in many cases the Fund provided little discussion—at least in publicly available IMF documents—of the rationale underlying the specific path chosen for the fiscal deficit and overall government spending. Original IMF programs usually targeted a conservative path with limited exploration of alternatives. The case studies also suggest a continuing tendency to assume that "crowding in" of private investment will take place smoothly when the fiscal deficit is reduced. In fact, empirical evidence on the strength of this effect is less clear-cut and much depends on particular country circumstances.[18] Previous reviews similarly detected a tendency for IMF program design to overestimate such effects (IEO, 2003 and IMF, 1996). However, programs showed more flexibility in adapting to changing circumstances at the time of reviews. Such flexibility seems to have increased in the last two years, especially in response to changes in aid levels.

The reluctance to explore more expansionary but still feasible paths appears to reflect a frequent lack of concrete operational plans (including in the health sector) for scaling up and concern by the IMF that additional public spending could be wasted due to absorptive capacity constraints. Given the poor track record of much public spending, focusing on the likely effectiveness of expenditures is reasonable, especially in countries where improvements in the basic institutions of public financial management are lagging. But judgments on whether key sectors, including health, can effectively absorb additional resources are not within the IMF's expertise. The World Bank, which had primary responsibility for such analysis, was often slow in helping to analyze the consequences of alternative expenditure options. In practice, macro assessments typically were not well integrated with any analysis of the composition and effectiveness of expenditures, leaving an insufficient basis for concluding that a conservative fiscal path was justified.

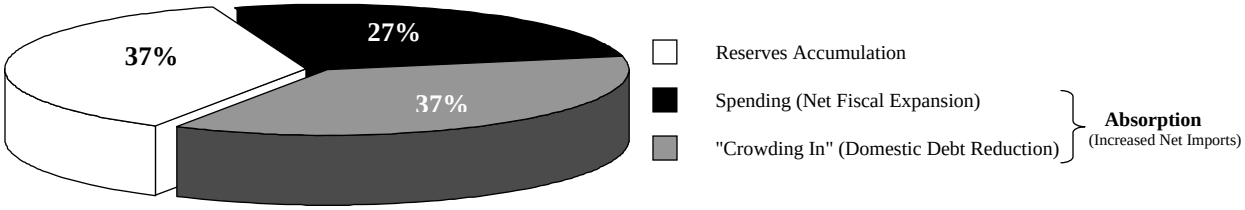
The Rwanda experience of 2002-2003 is an example of a missed opportunity to explore such links. A donor-sponsored effort to explore alternative, more expansionary, fiscal options had technical shortcomings that the IMF was right to point out, but did not help to correct. The exercise should have been used as the starting point for a more collaborative exploration of what was (and is) the central issue of Rwanda's long-term fiscal strategy: namely, the likely longer-term effects on the supply side of a substantial expansion in public spending and the implications for fiscal sustainability (see Box 2).

Alternative in-depth investigations of "scaling-up" scenarios are still infrequent, with some recent exceptions (Ethiopia, 2005a, Madagascar, 2006a and Zambia, 2006b).[19] Much seems to have depended on the initiative of individual mission chiefs, because of what appear to be continuing differences within the IMF Board on how much the IMF should be involved in such issues. However, the Working Group was told that it is now the policy of the IMF African Department to undertake such an analysis whenever it is requested by the authorities and sufficient information on sector-level costs is available.

Box 1. Aid Absorption and Spending in IMF Programs in Africa

A recent report by the IMF's Independent Evaluation Office (IEO) examined how programs in sub-Saharan Africa had targeted aid to be used. Using the concepts of *absorption* (i.e., a widening of the external current account through higher net imports) and *spending* (i.e., a widening of the fiscal deficit) in response to higher aid, the IEO used regression analysis to examine the shares of additional aid targeted to different uses. The results indicated that each additional dollar of expected aid was associated with a targeted fiscal expansion (i.e., additional *spending)* of only 27 cents (see chart).

Average Programmed Use of Aid in Recent IMF Programs with African Countries (in percent of anticipated aid increase)



Source: IEO (2007).

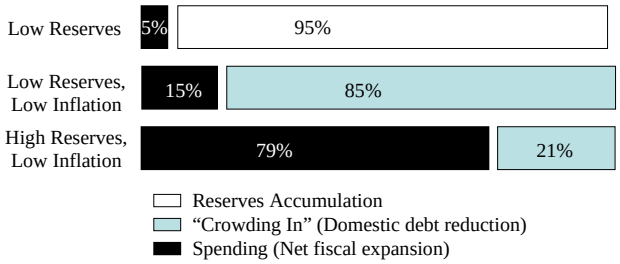
While there was considerable variation from program to program, the results also suggest that what the IMF recommends for the use of additional aid depends critically on a country's starting conditions (see chart below):

(i) If external reserves are low (less than 2½ months of imports), virtually *all* aid is programmed to be saved in the form of higher reserves.

(ii) If reserves are above this level, but domestic macro conditions do not meet a high test of stability—proxied by an initial inflation rate at or below 5 percent in the IEO study—the vast bulk of extra aid (85 cents on the dollar) is channeled to reducing domestic debt.[20]

(iii) Only if reserves are above 2½ months of imports and domestic macro conditions are highly "stable" is most additional aid programmed for higher fiscal spending.

Average Programmed Use of Aid Increases in IMF programs in Africa
Segmented by Initial Conditions



Source: IEO (2007).

This pattern suggests a very conservative policy stance. The IMF is right to take account of the level of reserves and domestic macro conditions when considering how additional aid should be used, but the *degree* to which these factors are influencing the allocation seems excessive. For example, reserve accumulation is an appropriate initial response to higher aid when reserves are low; it also allows greater scope for smoothing expenditures in the event of future adverse shocks. But the share allocated to reserves should depend on how long the higher aid flows are expected to last. IMF programs seem to be implicitly assuming that *all* aid increases will be very temporary.

Also, it is not clear that countries with relatively high reserves ought to use virtually all additional aid to reduce their domestic debt, even if inflation is moderately high.[21] The exact linkages between domestic debt reduction and objectives such as growth are opaque, at best, and highly country-dependent. Even assuming that domestic debt reduction allows for "crowding in" of private investment, there are key trade-offs to be considered, including the effect of government spending on both growth and social objectives.

The case studies undertaken for the Working Group also suggest that the IMF favored domestic debt reduction over fiscal expansion. Looking at what the IMF programs in the case study countries targeted for reserve accumulation and comparing these targets with actual outcomes indicates the following (see table below):

- Most of the original programs targeted a modest build-up of reserves. The largest increase, in Zambia, was equivalent to 13 percent of the total aid flow over the period but 32 percent of the total additional aid received over the pre-program (2003) level.
- In general, the targeted accumulation of reserves increased at the time of subsequent program reviews when aid projections also increased, but actual reserve accumulation was typically higher than that programmed. For example, in Rwanda the authorities continued to accumulate reserves in order to prevent a nominal exchange rate appreciation although the IMF advice was to curtail such intervention and allow the exchange rate to appreciate.
- In terms of actual outturns, each country "saved" 13 to 20 percent of total aid received over the period. However, measured as a share of the increment in aid over the level of the pre-program year (which is what the IEO exercise uses), Zambia 'saved' about half of the additional aid and Mozambique (where foreign investment was also surging) about 90 percent.

Programmed and Actual Changes in Reserves Over Three-Year IMF Arrangements

	Actual			*Original Program*		
	US$ Million	As % of Total Actual Aid Flows	As % of Increment of Aid	US$ Million	As % of Total Projected Aid Flows	As % of Increment of Aid
Mozambique (2004-2006)	315	13%	91%	0	0%	0%
Rwanda (2002-2004)	247	19%	N/A*	34	4%	N/A*
Zambia (2004-2006)	301	20%	47%	187	13%	32%

* Not applicable because aid declined over the program period.

Cross-country evidence on fiscal content of programs

An investigation of targets for fiscal deficits, before and after grants, and for total government spending in programs under the PRGF or its predecessor, the Enhanced Structural Adjustment Facility (ESAF), during 1995-2006 indicates a moderate shift toward targeting larger deficits and higher spending deficits, especially since 2003. The shift partly reflects lower starting deficits (Table 2):

- Recent PRGF programs targeted a small (1 percent of GDP) increase in the deficit before grants, the most aid-inclusive measure of the deficit, in the first program year, with the expansion tapering off thereafter. In contrast, deficits under the ESAF had been targeted for substantial cuts (by about 3 percent of GDP over the three-year program. period).

- Within these averages, however, the fiscal strategies incorporated in programs for individual countries varied substantially (see Chart 4). For example, out of the 46 PRGF arrangements analyzed, government spending as a share of GDP was targeted to *rise* by 3 percentage points or more in six countries and *decline* by 3 percentage points or more in seven countries.[22] This does not suggest the IMF is following a "one size fits all" strategy.

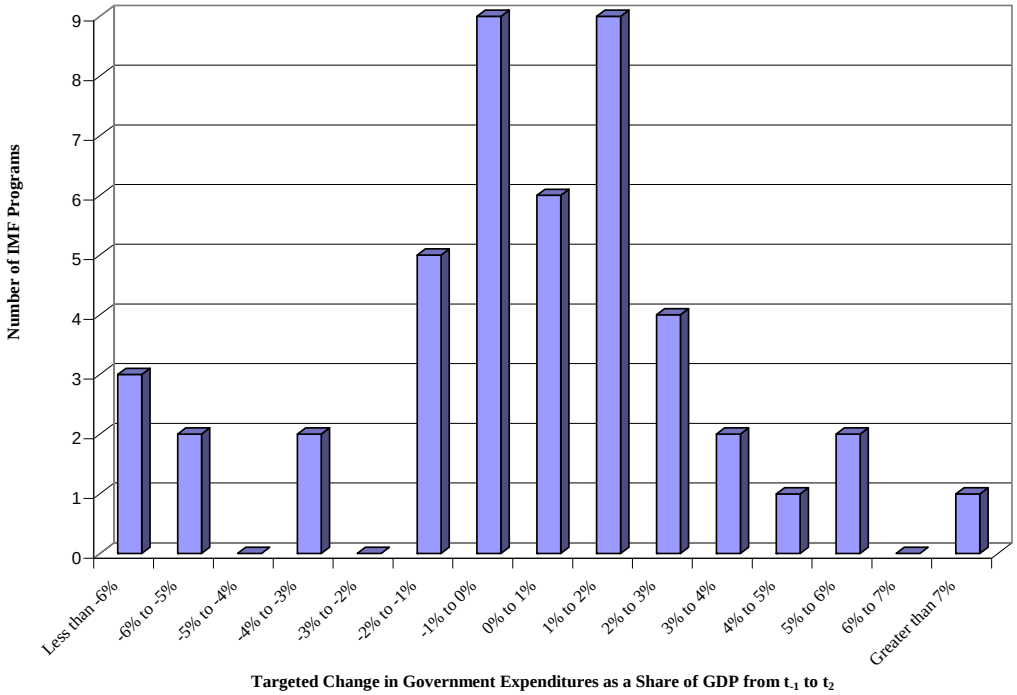
Table 2. Fiscal Targets in IMF-Supported Programs, 1995-2006
(group means, in percent of GDP)

		Change*	
General government balance, after grants**	**Level at t_{-1}**	$t_0 - t_{-1}$	$t_2 - t_{-1}$
ESAF (1995-1999)	-4.1	0.7	2.0
"early" PRGF (2000-2002)	-5.3	0.9	1.9
"late" PRGF (2003-2006)	-3.1	-0.5	-0.1
General government balance, before grants**			
ESAF (1995-1999)	-8.2	0.9	2.9
"early" PRGF (2000-2002)	-9.2	0.1	1.6
"late" PRGF (2003-2006)	-6.6	-1.1	0.1
Total government expenditures**			
ESAF (1995-1999)	25.7	-0.3	-1.6
"early" PRGF (2000-2002)	27.9	0.5	-0.2
"late" PRGF (2003-2006)	23.0	1.0	0.6

** Positive change means increase in surplus or decline in deficit.*

*** Classified by year in which 3-year arrangement was originally approved.*

Chart 4. IMF Program Targets for Changes in Government Spending for PRGF Programs



Evidence from the case studies on the fiscal content of programs

The case studies discuss in detail the content and rationale of the fiscal strategies as well as the treatment of aid projections in the programs. They support the conclusion that programs did not sufficiently explore more expansionary but still feasible spending options, although recent programs are more flexible in this regard. Appendix Table 6 summarizes the fiscal content of each of the original programs and the analytical basis provided in IMF documents.

Rwanda

The initial program design (in 2002-2003) was too cautious in terms of the potential risks and rewards of scaling up spending. The two fundamental reasons for this caution were considerable uncertainty that donors would actually deliver higher aid at a time of regional political uncertainties (and a consequent concern not to have underfinanced programs), and the lack of any reliable analysis to help judge what would be the impact of higher spending on growth and poverty. As already discussed, a donor-financed Poverty and Social Impact Assessment (PSIA) was a missed opportunity to explore alternative policy options. The IMF could have done more to explore alternative scenarios for aid and expenditures, but this would have also required better analysis by others of specific expenditure initiatives. In particular, it is critical to "think long term" when considering the fiscal consequences of scaling up aid-financed health spending. This would require the IMF to diversify the types of analysis and models it employs to take greater account of longer-term supply-side factors. The aid projections underlying IMF programs were generally too conservative, although the programs did adapt to accommodate higher aid when it was realized.

Because of Rwanda's low exports, its forward-looking indicators of debt-to-export ratios were above the threshold levels set in the IMF debt sustainability assessment framework. However, too much weight was put on this single indicator of potential debt distress, causing borrowing on quite concessional terms to be ruled out. This issue was not specific to Rwanda but reflects a problem with the IMF debt sustainability assessment framework and how the framework interacts with HIPC debt relief. It is not possible to say whether any desirable spending was not financed as a result, since substantially higher grants were forthcoming. Most fundamentally, the original program was not sufficiently oriented toward what was Rwanda's key macroeconomic challenge—managing the consequences of a substantial scaling-up of aid-financed expenditures.

From 2004 onwards, IMF programs have taken a more flexible approach. The fiscal deficit before grants was allowed to widen (Chart 6) and additional "contingent spending" was allowed if further grants became available. Until 2007, this contingent component was not well integrated with domestic budgetary processes, but no health spending was affected.

Box 2. Rwanda: The 2002-2003 Debate Over the Macroeconomic Framework – A Missed Opportunity to Broaden the Dialogue

Beginning around 2002, the Rwandan Government and the IMF disagreed over fiscal strategy. The government took the view that a widening of the fiscal deficit—financed by higher borrowing on concessional terms—was justified in light of what they saw as considerable opportunities for productive higher public spending, including on infrastructure. The IMF disagreed, arguing that unless steps were taken to strengthen the domestic resource base, the associated increase in the deficit would pose significant threats to macroeconomic stability and risk a substantial deterioration in debt sustainability. The impasse led to an interruption of arrangements with the IMF and a lapse in interim debt relief under the Enhanced HIPC Initiative.[23] Eventually, agreement on a new PRGF arrangement was reached. The IMF view largely prevailed, mainly because the government wanted to move ahead with debt relief that was linked to an IMF program being in place.

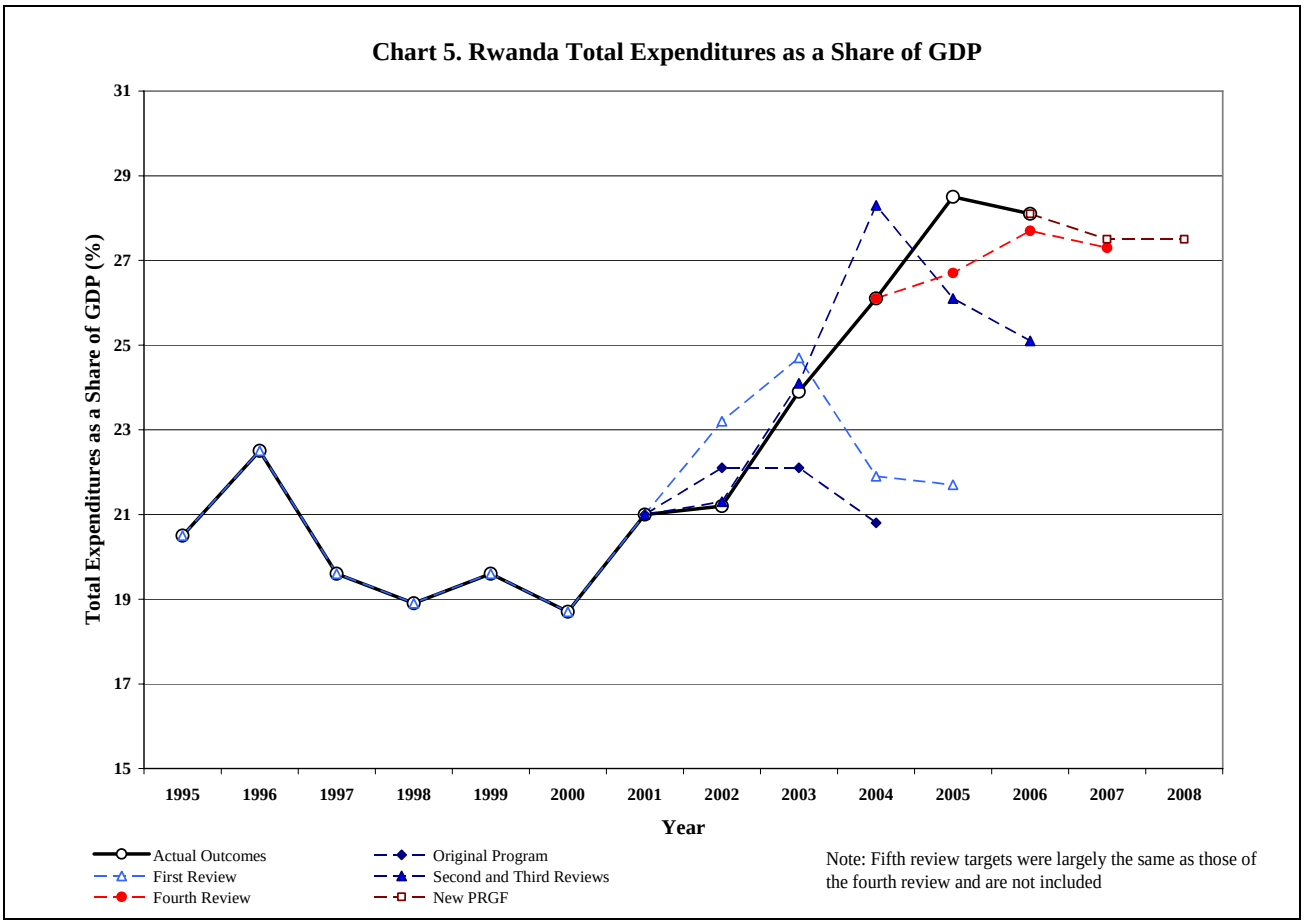
The Rwandan government and some donors (notably the U.K.) wished to explore further the policy options for financing larger anti-poverty expenditures.[24] The vehicle used was a Poverty and Social Impact Assessment (PSIA) by a team of external consultants and Rwandan officials.[25] The analysis produced tried to assess the rationale of the overall macroeconomic framework and the impact of two alternative scenarios for increased expenditures, drawn from Rwanda's PRSP (Mackinnon et al., 2003).

The response of the IMF staff to the initial draft of the PSIA was strongly negative. They criticised the macroeconomic model underlying the PSIA, arguing that it was technically flawed and understated the risks to sustainability. Given the strength of the IMF response and the need to agree on a PRGF program to obtain debt relief, the government and key donors backed off from the PSIA. Subsequent IMF reports made little reference to the PSIA or to options for alternative fiscal strategies. They confined themselves to an exposition of the framework that was finally negotiated, which was largely unchanged from the original program.

Nevertheless, the debate over the scope for additional expenditures and financing without posing unacceptable risks to longer-term sustainability remained a central policy issue. For example, in 2004 the Rwandan authorities again argued that the benefits from scaled-up expenditures would exceed the costs; if additional external grants were not forthcoming, they viewed higher borrowing on concessional terms as a viable option. The IMF staff disagreed, arguing that projections of debt indicators called for tight limits on new external borrowing until the potential for export and productivity growth had been established. Eventually the program was modified substantially to accommodate a surge in grant-financed expenditures (see Chart 4).

The PSIA was a missed opportunity to broaden the debate over fiscal strategy for several reasons:

- The initial version contained significant gaps that resulted from a rushed process. The tone of the first draft was also counterproductive and set up an antagonistic response by the IMF. The authors of the PSIA said that, in retrospect, they had not included IMF staff in the process early enough. All this contributed to a response that did not focus on identifying key information gaps and seeking collaborative approaches to filling them, which might have yielded better outcomes.
- The main objections from the IMF were, first, that this was not an appropriate subject for a PSIA (which was not a valid critique) and, second, that the PSIA relied too heavily on a simple debt dynamics model (linking growth and the interest rate, with problematic assumptions around what would generate the necessary foreign exchange resources to service the debt). The latter criticisms were valid, but the IMF made no attempt to explore the implications of different assumptions and formulations.
- The initial idea of a PSIA was to link micro-level analysis to the macro-level (i.e., to look at what would be the growth and poverty impacts of specific expenditure initiatives) but the PSIA ultimately focused on building a macro model. An external review of the PSIA concluded that the model structure was systematic, but that there was a mismatch with the purpose of the work. The nature of the questions being asked meant that no single model would have been appropriate. The macro-modeling approach taken in the PSIA meant that it was difficult to link it with specific micro-level analysis and its assumptions and conclusions were therefore easily challenged. However, the same criticisms were true of IMF analysis of the issue.



Mozambique

The medium-term projections for aid underlying the original program were too pessimistic and alternative scenarios were not explored sufficiently. In the early period, the focus was on reducing aid dependency but without any strong macroeconomic justification for taking this position (see Box 3). The ex-post assessment of earlier IMF programs concluded that there was little evidence of aid-related Dutch disease (export growth was strong and the measured real effective exchange rate had been stable or declining), so it is surprising that there was not more discussion on this point. The only argument on aid dependency mentioned in subsequent program documents was that the high share of total government spending that is foreign-financed (over 50 percent) left pro-poor spending increasingly vulnerable to aid volatility. However, subsequent programs did adapt to changing circumstances, both in terms of the degree of optimism about expected aid flows and the flexibility with which the fiscal programs used the additional aid (Chart 6).

The original program targeted a decline in the fiscal deficit, excluding grants. After taking account of projected aid, domestic financing of the deficit—which was already zero by 2003—was targeted to shift to net debt repayments. The rationale underlying this fiscal path was to "crowd in" credit to the private sector and to reduce pressure on domestic interest rates. While the broad objectives of such a strategy were reasonable (and in line with the authorities' own announced objectives), the programmed path for the fiscal deficits assumed, rather than

analyzed, that a specific deficit reduction was needed. In fact, cross-country experience suggests that the response of private sector activity and investment in such circumstances can be very difficult to predict.[26] Government domestic debt levels were already very low (5 percent of GDP in 2003). While domestic debt markets in Mozambique were indeed thin, which limited the likely scope of domestic financing of the deficit, the causes of high domestic loan rates were complex. Structural problems in the banking system and high contract enforcement costs were probably more important factors in very high interest rate spreads but both were unlikely to be affected by more stringent fiscal policies targeting domestic debt reduction.[27]

Zambia

The initial program focused on reducing domestic financing of the deficit, which had reached 5 percent of GDP by 2003. This was reasonable because total domestic debt was already quite high (over 20 percent of GDP in 2003) in relation to Zambia's thin domestic financial markets and was growing fast. It is impossible to say whether the precise path chosen (especially the heavy front-loading of deficit reduction in 2004) was the ideal one, but the adverse domestic debt dynamics did call for some significant adjustment. However, the rationale underlying the initial fiscal strategy suffered from several shortcomings:

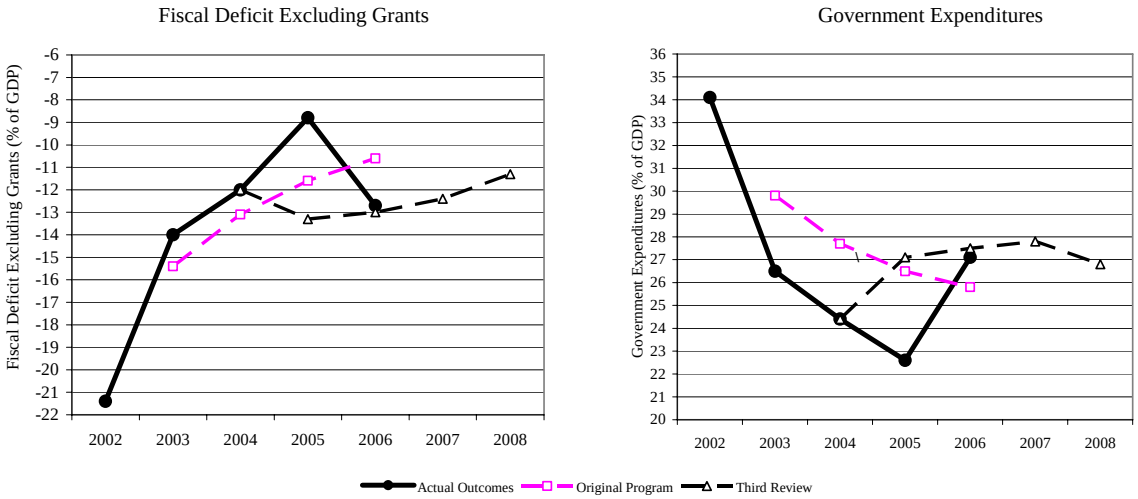
- The most significant initial shortcoming was the lack of exploration of alternative aid and expenditure scenarios.
- The classification of "poverty" and "non-poverty" spending underlying early analysis of fiscal options was misleading since it classified all spending on wages as not reducing poverty. Since a large proportion of health (and education) spending is on wages, this treatment did not give a true picture of the critical trade-offs.
- While it is true that Zambia's revenue/GDP ratio was already relatively high for sub-Saharan Africa, there were probably more feasible policy choices on the revenue side than the initial IMF analysis suggested.[28]

Subsequent analysis did explore alternative options for higher spending in the context of a potential scaling-up of aid—including by trying to take account of some of the supply-side constraints that were likely to be of most importance for Zambia (including the supply of health professionals). Zambia's case illustrates the difficulties of integrating sector-level expenditure analysis into the macro assessment.[29] IMF staff working on Zambia took two radically different approaches at different times. An initial (2002-2003) analysis, based on work of World Bank staff, extrapolated on the basis of the estimated links between public spending and growth/poverty outcomes in earlier decades. Given Zambia's poor governance record during this earlier period, it is not surprising that the results suggested a poor macroeconomic outcome from higher spending. But such a backward-looking analysis could not say anything about the merits of scaling up health spending to deal with the current situation, including new challenges such as HIV/AIDS. A later (2005) analysis assumed that the additional resources would be used effectively (i.e., with a reasonably high rate of return on the investments) and analyzed the macro consequences of an aid-financed scaling-up of spending divided between health, education, and infrastructure. The indicated macroeconomic results were quite favorable. In practice, macroeconomic analysis by itself can say little on likely expenditure effectiveness, but it is

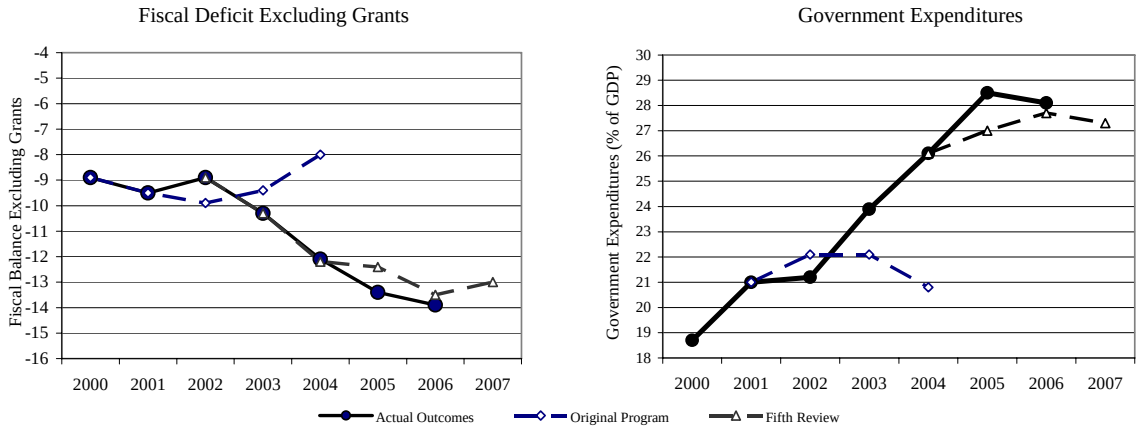
important to avoid presenting what are essentially judgments on absorptive capacity as definitive macroeconomic assessments.

Chart 6. Fiscal targets and outcomes in the Case Study Countries

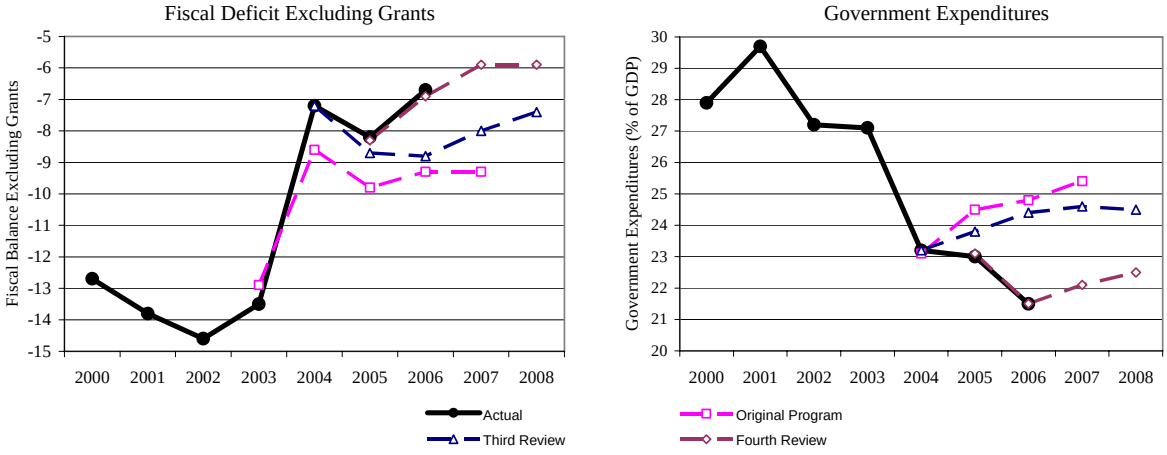
Mozambique



Rwanda



Zambia



b. IMF programs and aid projections: a risk of confused signals

Evidence from cross-country analysis and the case studies suggests the following:

- *Until recently, there was little exploration of the macroeconomic consequences of scaling-up scenarios. In some of the case studies, earlier projections were oriented around a goal of reducing aid dependency, with little macroeconomic justification.*
- *Exploration of the potential consequences of higher aid paths have been undertaken in a number of cases, suggesting some change, albeit a very gradual one, in the IMF approach. However, what is expected of the IMF staff in this area is still not clear, with a consequent risk of confused signals to donors and recipient governments. (For example, if only conservative scenarios are presented, does this mean the IMF thinks more resources cannot usefully be absorbed from a macroeconomic perspective or only that the IMF does not think more resources will be forthcoming, however well they could be used?)*
- *Projections of aid in most IMF programs in Africa continue to assume only small increases over the medium term—reflecting skepticism by IMF staff that donors will deliver on their commitments to double aid by 2010.*

In discussing the IMF approach to aid projections, it is useful to distinguish between the short and medium term. For the short term (i.e., the first 6 or 12 months), projecting aid for IMF programs has largely been a question of making the best estimates—based on extensive consultations—of what donors already have planned. Drawing on previous experience, these projections often assume actual disbursements will fall short of donors' commitments, although the extent of any discounting is rarely discussed explicitly. Such short-term projections say nothing about the desirable or appropriate levels of aid, but are largely concerned with ensuring that programs are not underfinanced.

Beyond this short term, there is greater scope for varying the level of aid channeled to a particular country. In practice, however, the general "profile" of medium-term aid projections in IMF programs has been conservative, assuming on average that aid declines gradually over the medium term. The rationale behind this approach—i.e., whether the projection is simply a "best estimate" of donors' intentions or whether it is meant to have some prescriptive content on what *should* happen—is often unclear. In some cases (e.g., Mozambique and Rwanda), the discussion in the original IMF program documents appeared to suggest, with little macroeconomic justification, that an increase in aid levels was undesirable. However, program projections for aid in the country case studies were ratcheted upward sharply at subsequent program reviews as it became evident that donors were prepared to provide more aid. In other words, the IMF did not play a positive catalytic role in exploring the macroeconomic consequences of higher, but still potentially feasible, aid flows, but did adapt its program design when higher flows appeared. It is not possible to say whether this practice of "following" rather than "leading" on the scaling-up of aid had any adverse effects on actual aid levels. For instance, aid did increase substantially in Mozambique and to a lesser extent in Rwanda, despite earlier signals from the IMF (see Chart 6). Nevertheless, with some commendable exceptions, the IMF was slow in providing to the countries themselves and to donors a macroeconomic analysis of more ambitious aid paths.

Cross-country evidence on aid projections in IMF programs

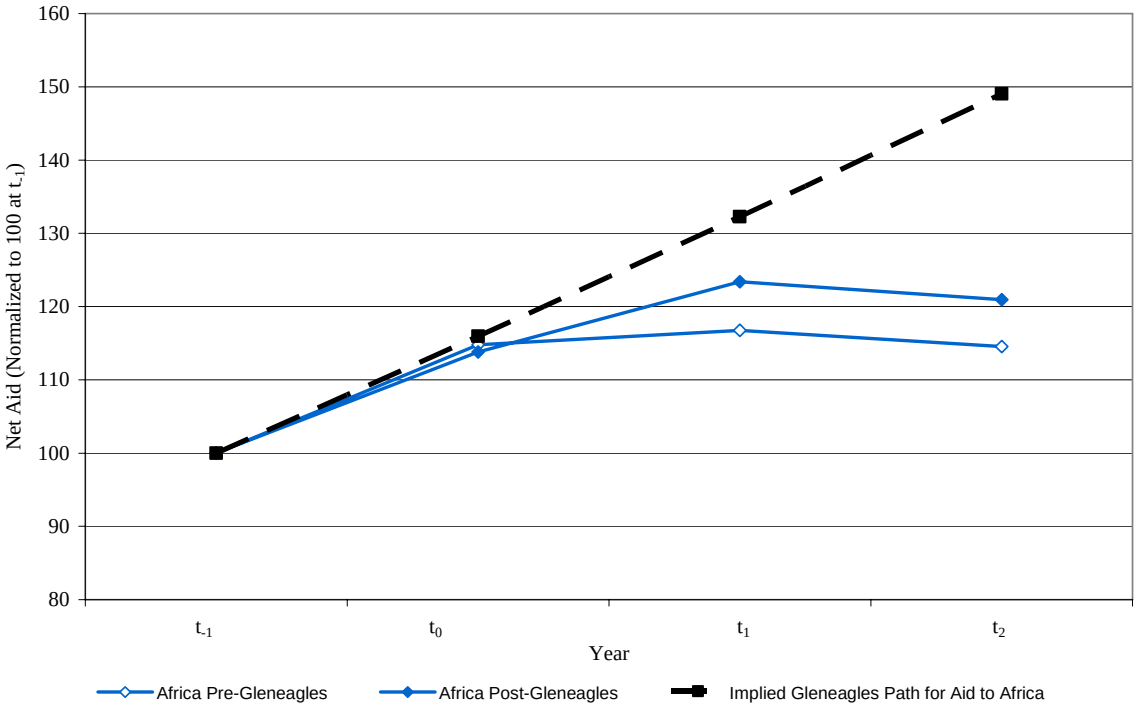
An examination of the projections for aid flows (after debt relief) in IMF programs with low-income countries indicates a number of important trends. We summarize the main conclusions here, with details provided in the background paper on "What Have IMF Programs in Low-Income Countries Assumed about Aid Flows?"[30]

- The profile of IMF aid projections for countries in sub-Saharan Africa has not changed much in the post-Gleneagles period and remains well below the growth rate implied by donors' statements of their intentions to double aid to Africa by 2010 (Chart 7). Of the 27 IMF programs and reviews in sub-Saharan Africa that were completed in the 18 months after the Gleneagles Summit, only two were at least as optimistic as the path consistent with the Gleneagles commitment.

- Program projections assume that countries with low levels of aid will benefit from faster growth in aid (i.e., that their share of global aid will gradually increase).[31]

- After allowing for the effects of initial per capita aid levels, programs for sub-Saharan Africa project aid to grow more slowly than do programs in other low-income countries. This is surprising given donors' recent emphasis on increasing aid to Africa.

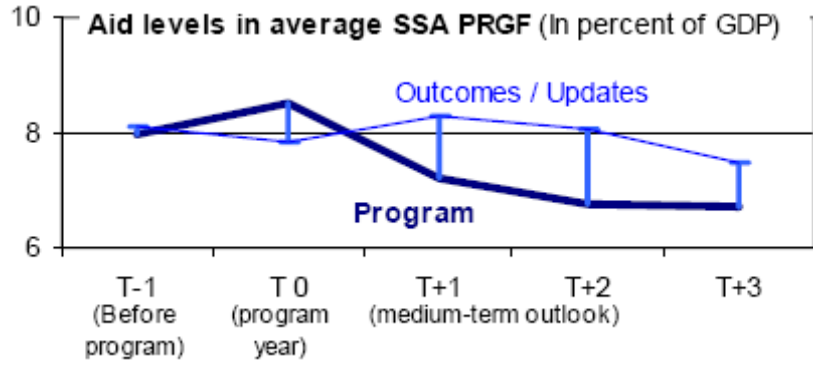
Chart 7. IMF Net Aid Projections to Africa*



* Weighted by initial levels of aid

Moreover, recent estimates by the IEO comparing projections with actual outcomes for programs in sub-Saharan Africa indicate that, while aid forecasts are accurate (or even a little optimistic) for the program year, they under-predict significantly for the outer years (see Chart 8).[32]

Chart 8. Program targets for aid and estimated outcomes in Sub-Saharan Africa



Source: IEO (2007).

Evidence from the case studies on the treatment of aid in IMF programs

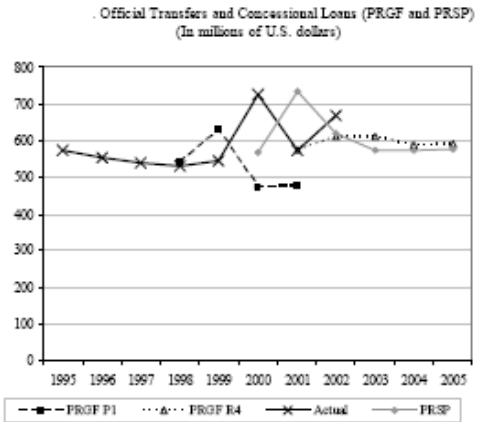
The case studies examined the optimism or pessimism of IMF aid projections against three benchmarks: historical trends, actual aid disbursements, and global donor commitments. They found that:

- Original program projections for Rwanda and Mozambique were highly pessimistic and targeted a net decrease in aid. For all three cases, the original programs under-projected aid over the medium term (Charts 9 a-d).
- In both Mozambique and Rwanda, the IMF initially sent signals that tended to discourage a substantial increase in aid, with limited macroeconomic justification (Boxes 2 and 3).
- Aid projections became notably more optimistic in subsequent reviews (with the exception of Zambia where earlier projections largely reflected optimism about the timing of debt service relief) and the programs adapted significantly.

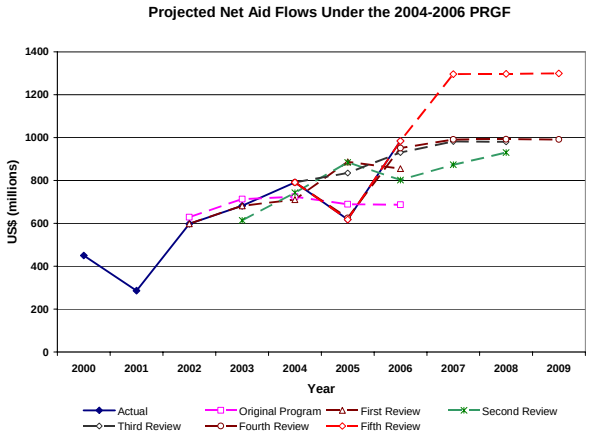
Box 3. Mozambique and IMF Aid Projections

Projections for aid to Mozambique have been a particular source of controversy. Critics of the IMF have charged that it was unduly pessimistic about aid flows and intentionally signaled to donors that they should not increase aid to Mozambique because the country was already too aid-dependent.

The case study of Mozambique reviewed how aid was treated in two PRGF arrangements, covering the periods 1999-2003 and 2004-2006, respectively. For the first PRGF arrangement, the case study found that aid projections were pessimistic over the medium-term with aid targeted to decrease or remain unchanged. Moreover, while the IMF never explicitly said that more aid was unwarranted, it gave a strong emphasis to potential downside risks and to the desirability of reduced aid dependence. Implicitly, these statements sent a negative signal to donors against increasing aid.[33]



Source: IEO & OED (2004)

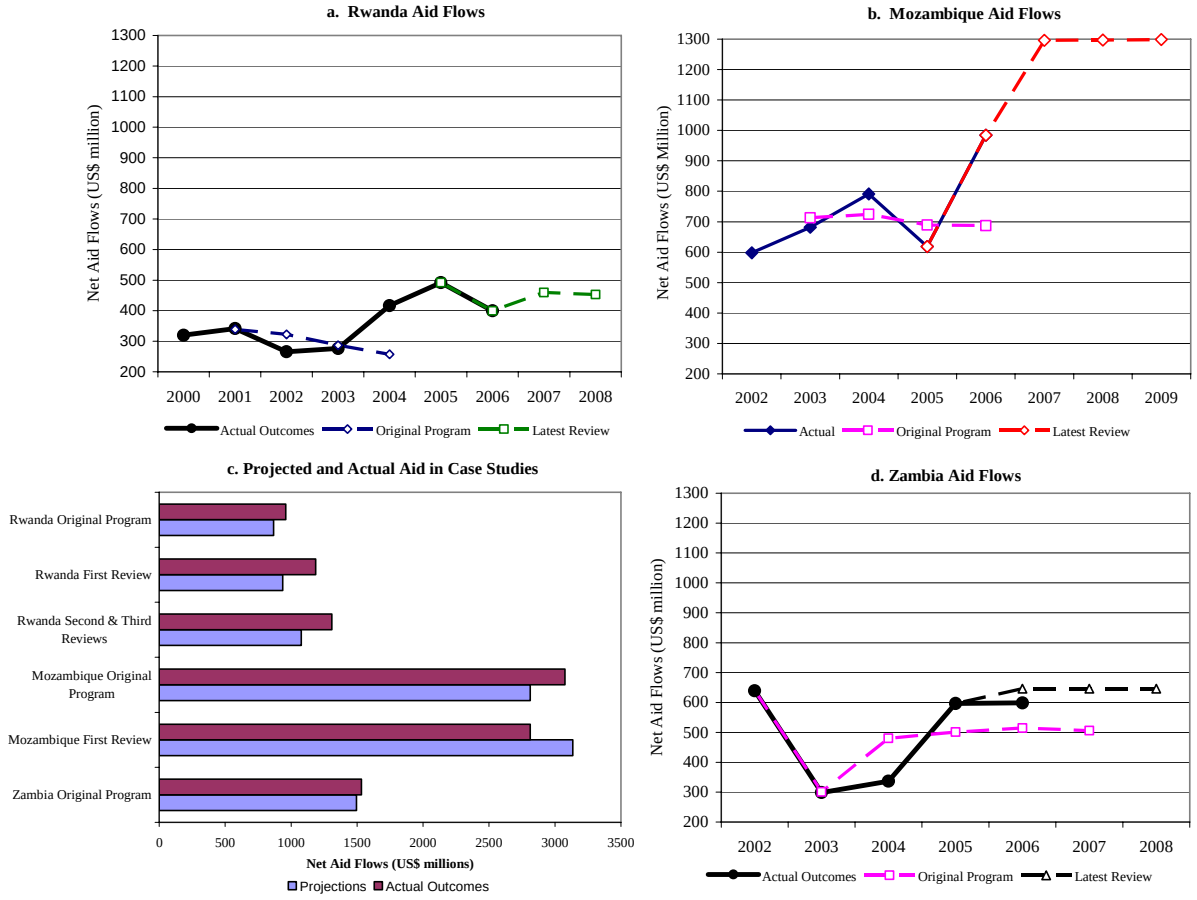


Source: Background paper on Mozambique case study

Initially, the second PRGF arrangement also emphasized the need for reduced aid dependency. Little macroeconomic justification was provided, although such a goal was also part of the government's own political rhetoric. Over time, however, the IMF adopted an increasingly optimistic stance on aid to Mozambique—responding to the signs that higher aid flows were available. For example, by 2006, IMF aid projections for Mozambique were more optimistic than the path implied by a doubling of aid to Africa, one of very few cases where this was so.

In practice, aid did increase substantially, so it is hard to know how important any negative signals from the IMF were.[34] However, during the earlier stages discussed above, the IMF presented only a partial picture of the potential macro consequences of higher aid.

Chart 9. Aid flows in case study countries



c. How programs respond to aid surprises: insufficient expenditure smoothing

The evidence indicates the following:

- *Many IMF programs required that, in the short term, higher-than-projected aid be saved whereas expenditures were to be cut if aid fell short.*
- *Such an approach gives insufficient emphasis to the benefits of smoothing expenditure, once macroeconomic instability is no longer an immediate threat. A change in program design to allow greater short-term flexibility could be especially important for the health sector, which tends to suffer disproportionately from short-term expenditure cuts.*
- *The case studies suggest that IMF programs are adapting—albeit only gradually—to allow greater short-term flexibility.*

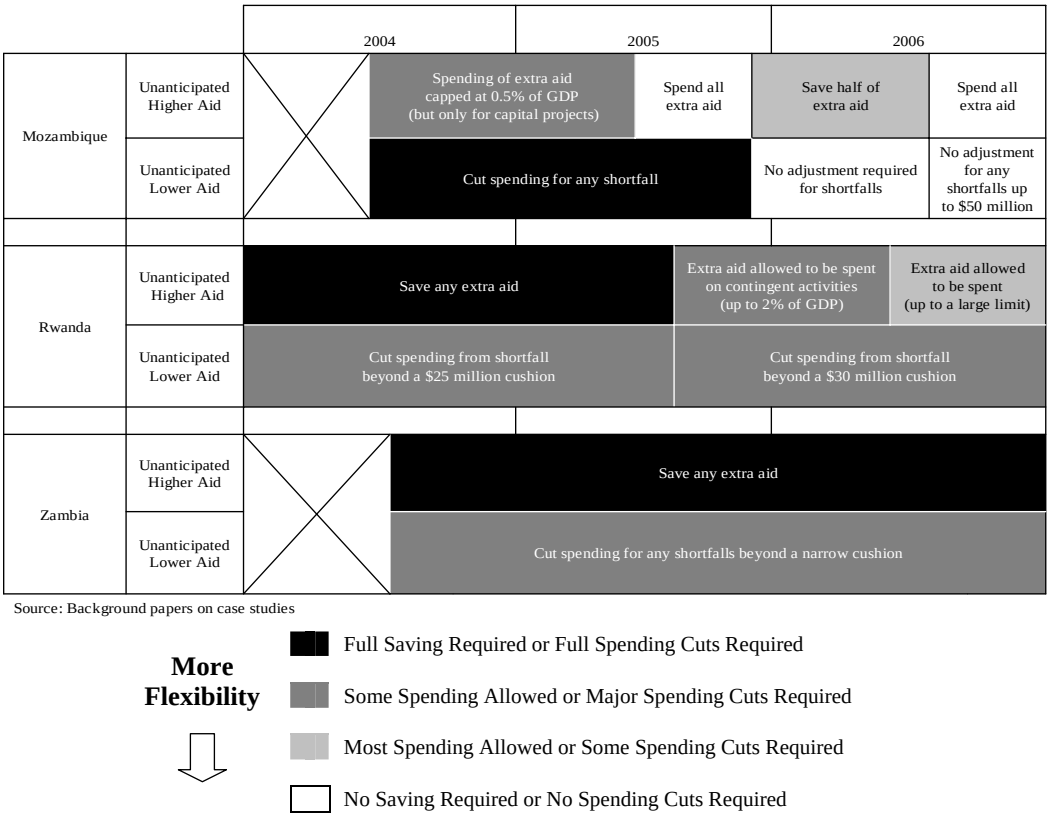
The technical design of IMF programs—in particular, the way in which program ceilings on domestic financing of the budget and targets for net international reserves are adjusted in the event of shocks to aid flows—often limits the extent to which expenditures can be smoothed in response to adverse shocks. In contrast, programs often include adjustors that limit additional spending in response to higher-than-anticipated aid.[35]

A detailed examination of how macroeconomic policy responded to aid fluctuations in eight African countries with IMF-supported programs (Celasun and Walliser, 2005) suggests that these design considerations can be of considerable significance. Episodes of lower-than-programmed budget aid led to lower public investment while higher-than-projected aid did not lead to higher investment (being saved instead). This implies that the asymmetric nature of the adjustment response would lead to lower public investment over the medium term if, as seems inevitable, significant year-to-year errors exist in the forecasts of budget aid.

The balancing of risks suggested by such an approach is not justified if the costs of under- or over-shooting targets are no longer asymmetric. If there is a reasonable cushion of reserves and the costs of disrupting medium-term expenditure plans are high, the appropriate policy response would be to smooth fluctuations by saving some of the aid in high-aid years and drawing down reserves when aid shortfalls emerge. The case studies suggest that the IMF is already moving, albeit gradually, in this direction (see Chart 10).

Of course, donors can help by making longer term, more predictable aid commitments, bilaterally or through arrangements to pool their contributions—an issue we will return to later.

Chart 10. How Programs Respond to Aid Surprises in Case Study Countries



Source: Background papers on case studies

d. Targets for inflation

Evidence from the background papers suggests the following**:**

- *Most recent IMF programs with low-income countries have targeted inflation at low levels (i.e., 5 percent or below), largely reflecting low starting levels of inflation (itself often an outcome of earlier IMF programs) or membership of currency unions.*
- *Empirical evidence does not justify pushing inflation to these low levels in low-income countries. The IMF should not be unduly risk-averse by ruling out more expansionary aid-financed fiscal options just because they may put some upward pressure on prices. It should explore more macroeconomic scenarios to allow a better assessment of the costs and benefits of more fiscal space, including the potential supply-side benefits of additional spending on spare capacity utilization, investment and future output growth.*
- *Targets for inflation that guide monetary policy should take account of country-specific circumstances that are likely to influence the path of prices, including the consequences of any adverse supply shocks. However, an across-the-board relaxation of monetary policy associated with an adoption of higher inflation targets would be unlikely to yield higher growth because expectations of higher inflation would adapt quickly.*

A review of all PRGF arrangements since 2003 shows that initial IMF programs have a strong tendency to target inflation in single digits, with a large proportion of inflation targets clustered around 5 percent or lower (Table 3). Setting aside programs with countries in currency unions pegged to the Euro or U.S. dollar—where the choice of exchange rate arrangement compels a low inflation rate—about half of programs targeted inflation at 5 percent or lower; in almost all these cases, inflation was already low at the start of the program, typically reflecting the goals of earlier programs.

The evidence on the association between inflation and growth from a large number of cross-country studies (see IMF, 2005c and Chowdhury, 2005 for reviews) indicates that the relationship is non-linear: at low initial rates, higher inflation may have no effect on growth or the effect may even be positive, but after some threshold, higher inflation is typically associated with poorer growth outcomes. Precisely where this threshold lies is a matter of considerable debate; some results suggest a threshold around 5 to 10 percent while some suggest the threshold could be as high as 20 to 40 percent.[36] The precise magnitudes estimated in various cross-country studies should be taken with a grain of salt because the benefits of more stable prices for an economy are likely to depend considerably on populations' expectations of whether they will last. This can vary enormously from country to country depending on the credibility of institutions and each country's past history with inflation. In practice, therefore, the targets for inflation that guide monetary policy will need to take account of country-specific circumstances, including the extent of any inflation inertia and the consequences of any adverse supply shocks.

Table 3. Inflation Targets in PRGF-Supported Programs, 2003-Feb. 2007
(Number of IMF Arrangements)

Initial inflation rate in t_{-1} (percent)	**Targeted inflation in t_{+1}** (percent)					
	3% or below	**3-5%**	**5-10%**	**10-20%**	**Above 20%**	**Total**
3% or below	8 (6)					8(6)
3-5%	2 (2)	3				5(2)
5-10%	2 (2)	5	4			11(2)
10-20%		2	5			7
Above 20%				1		1
Total	12 (10)	10	9	1		32

Source: Background paper, "Inflation Targets in IMF-Supported Programs in Low-Income Countries."
Numbers in brackets are the number of countries in currency unions (CFA franc or East Caribbean Currency Union).
t_{-1} refers to the pre-program year and t_{+1} to the second year of the program.

For example, the weight of the theoretical and empirical evidence suggests that programs should generally avoid pushing inflation below 5 percent in low-income countries because of risks of an unintended contractionary stance. This is the view of the most recent IMF staff paper on the subject (IMF, 2006d). Since low-income countries can be subject to substantial shocks that push up some prices, targeting very low inflation can result in situations where a significant proportion of nominal prices and wages have to decline to maintain the inflation target. Such reductions can be difficult to achieve and costly in terms of lost output. Judging by this benchmark, a number of programs may have gone beyond the available evidence in targeting very low inflation.

However, it is unlikely that a unilateral adoption of more expansionary monetary policies, guided by higher inflation targets, would yield sustained higher growth. Much will depend on how quickly expectations of future inflation and wage-setting behavior, including in the public sector, respond. But they eventually will, so there is unlikely to be a simple permanent trade-off between inflation and growth. Moreover, the small size of domestic financial markets in most low-income countries means that the direct additional fiscal space that could be created by more expansionary monetary policies is relatively small.[37]

A more important question, therefore, is whether the IMF, in seeking very low inflation in its programs, has been unduly risk-averse in ruling out some fiscal options involving higher aid-financed spending because of concerns that the resulting demand pressures could yield to higher prices. The evidence from the IEO evaluation of IMF programs in Africa (2007), cited in Box 1, suggests this may have been the case, although other considerations, including creating additional space for private sector expansion, also influenced the fiscal strategy.[38] In practice, it is very difficult to predict in advance what will be the impact of different fiscal spending choices on domestic prices: much depends on the composition of spending (e.g., how much is spent on the wages of health professionals versus imported medicine); the extent of spare domestic capacity (e.g., are there unemployed nurses or teachers); and the impact of additional public spending on domestic supply (e.g., how quickly and efficiently the training of health and

education professionals can be expanded or the impact of higher spending on infrastructure).[39] In light of the considerable uncertainty about how the supply side, and especially the prices of non-traded components, will respond, the previous success in bringing inflation down to low levels gives scope for exploring more macroeconomic scenarios to allow a better assessment of the costs and benefits of using more fiscal space.

e. The nature of IMF program negotiations: too narrow a circle weakens political support

The case studies suggest the following:

- *The debate over macroeconomic policy takes place within a narrow circle of officials, which weakens political support for some key decisions and aggravates the lack of integration between sector-level policies and the overall macroeconomic framework.*
- *The IMF alone cannot broaden the dialogue (which ultimately depends on the government) but could do more to discuss the rationale for its policy proposals and encourage more analysis and discussion of various options. This would probably also involve downplaying the Fund's role as a negotiator of short-term conditionality.*

"Ownership" is hard to define and measure, but interviews conducted as part of the case studies suggested that the key objectives and overall macroeconomic strategy were broadly shared at least within the relatively narrow confines of officials directly involved with such policies. (See Box 2 for an exception in the case of Rwanda). However, the discussions over macroeconomic policy took place within a relatively small circle. Others (including in ministries of health, as well as stakeholders outside official circles) often had limited knowledge on how or why certain decisions had been taken. Many interviewed for the case studies said that the debate was too closed and the role of Parliaments was too limited.

The small circle of the discussions had two adverse consequences. First, it weakened political support for key policy choices. In interviews for the case studies, it was striking how frequently some decisions affecting the health sector were wrongly attributed, including by government officials, to the IMF program (To give but one example, many people in Zambia, including in the Ministry of Health, referred to a hiring freeze in the health sector imposed by the IMF. In fact, no IMF program ever included such a freeze). This "blame the IMF" attribution of policy choices is unhealthy because it undermines what should be a robust domestic debate about priorities. Second, an overly narrow debate aggravated the lack of integration between discussions about sector-level policies (specifically, choices on the level and composition of expenditures and what was needed to improve their effectiveness) and the overall macroeconomic framework. The following excerpt from the Mozambique case study illustrates the nature of the problem:

> The lack of a broader dialogue, coupled with existing fragmentations within government, means that those responsible for budgeting in sectors like health are seldom aware of the nature and scope of macroeconomic constraints to health spending. At the same time, the lack of credible strategies and information from the health sector means that central budgetary agencies within government do not trust the Ministry of Health in delivering and executing on what they view as overly ambitious plans to spend more to recruit

additional personnel and expand health services. Such lack of reciprocal dialogue and understanding hampers effective integration of macroeconomic and sector-level policies.

While fostering a broader debate is primarily the government's responsibility, the IMF could do more by being more open about the rationale and analysis underlying its policy recommendations and encouraging more exploration of feasible options (by itself and others). The case studies indicate that many IMF papers do not explain in any substantive way the rationale underlying key policy choices (e.g., on the fiscal path). Until recently, they contained limited discussion of alternative policy strategies and the potential trade-offs involved. Indeed, there was a tendency to downplay disagreements over strategy. IMF staff said in interviews that this reflected a reluctance to convey an impression to the IMF Board and external stakeholders that there were any doubts about government commitment to the program. But this is not a good reason for avoiding an open discussion of such differences.

A shift in the IMF toward greater emphasis on providing inputs into a broader policy dialogue around macroeconomic policy would entail some changes in the IMF way of doing business. There are certainly obstacles to such a shift in approach. One is staffing: with the equivalent of about three full time staff working on each low-income country (and slightly less in Africa), the IMF is limited in what it can do directly.[40] The second constraint involves the tension between the Fund's different roles—as a negotiator of short-term conditionality; as a "confidential advisor" to the authorities; as a signaler to donors about the feasibility of the macroeconomic framework; and finally, as a "knowledge institution" bringing its particular expertise to help inform a broader internal policy debate. Acknowledging and exploring alternative feasible options and recognizing that policy choices are being made with limited information (and hence involve considerable gray areas) will inevitably complicate the short-term negotiations. However, if the IMF is to play as productive a role as possible in those low-income countries where the main challenge lies in managing the longer-term macroeconomic consequences of scaling up, it should downplay the role of negotiator of short-term conditionality and emphasize its role as a macroeconomic risk advisor and "knowledge institution" on related macroeconomic policies. This means concentrating on helping countries to explore the consequences of alternative policy options and to improve decision-making by domestic political institutions. As part of this shift in emphasis, the IMF will need to integrate itself better into the broader frameworks for coordination that are gradually being developed between the government and donors.

C. Budgetary and planning processes and their implications for priority-setting

While our main focus is on identifying changes in the IMF approach that can improve the framework for choices on health spending, it is important to recognize that the IMF role—for good or ill—is always going to be an indirect one. Some critical changes can only be made by national governments, supported by donors. We discuss here two related issues: first, why national budgetary processes have been generally ineffective in setting clear priorities for the use of resources and, second, whether special budgetary mechanisms that attempt to "protect" specific categories of spending, such as health, can be useful to offset these weaknesses.

a. National budgetary processes do not set sufficiently clear priorities and leave too little scope for domestic political debate

Although many countries are gradually improving their systems of budgeting and public financial management, existing processes are often unable to set clear medium-term priorities that are effectively implemented through annual budgets. The case studies suggest that such difficulties can be especially severe in the health sector, with the result that the high emphasis accorded to improving health outcomes in statements of long-term national priorities may not be translated into an effective case for additional resources in annual budget negotiations. While each country is different, a common set of institutional problems often undermines the integration of macroeconomic policy-making with the planning and implementation of health spending. Underlying these problems are more fundamental issues concerning too narrow political inputs into national debates over priorities.

1) ***Planning and budgeting processes are weakly integrated, especially for the health sector.*** In practice, the broad objectives set out in national plans and poverty reduction strategies are often not linked effectively to medium-term expenditure allocations that set clear, politically-endorsed priorities to guide the annual budgetary process.

   First, an effective political mechanism ("challenge function") for making hard choices between a long list of objectives is often lacking. For example, in Mozambique, the medium-term expenditure framework (MTEF) was not, until recently, even presented to the Cabinet.[41] The role of Parliaments in debating and influencing priorities is often negligible. In Rwanda, the MTEF is not presented to Parliament, nor does the presentation of the annual budget include the two outlying years of the MTEF. Evans et al. (2006) note that this drastically reduces the value of the MTEF as an instrument for building consensus and predictability around policy priorities.

   Second, a deeper political debate over choices requires better information on what types of interventions are being "bought" with extra resources, but this information is often unavailable (e.g., in terms of costing as well as identification of how budgetary choices are translated into particular sector strategies). For example, in Zambia, the health strategy is oriented around a Basic Health Care Package (BHCP), which defines key health interventions that the public health system should provide within the available resources. Although the BHCP has been defined at all levels, it has not been used effectively to guide resource allocation for and within the health sector. In practice, the package is severely underfunded.

2) ***The capacity of ministries of health to undertake budgetary planning is often weak, undermining their ability to make a case for additional priorities*.** In Mozambique and Zambia, for example, longer-term plans for the health sector were in place, linked to a broad strategy, but concrete operational plans for the next several years were less clear. Ministry of Finance officials indicated that the budgetary process was weakened because line ministries, including Health, often found it difficult to present substantive cases for their priority budgetary requirements. In Zambia, for instance, the Ministry of Health was often in the process of lobbying for additional financing for recruiting badly needed health

workers when information on recruitment in previous years was still not available. Budget and performance outcome information were not sufficiently integrated, which made it difficult to analyze how higher spending was meant to contribute to specific objectives. These problems were reflected in the frequently heard comment from finance officials in Mozambique and Zambia (although not in Rwanda) that they were not sure what additional health interventions (let alone outcomes) would be "bought" with greater resources.

3) ***Identified priorities are often too broad to be an effective guide to making choices. Donors add to these problems through a proliferation of activities, many of which are not well-aligned with the national strategy***. Many health sector plans are not really *national* plans, in the sense of reflecting clear country-driven priorities. Rather, they are often an aggregation of "broad tent" aspirations, designed to accommodate the many donor-driven priorities, including disease-based global objectives, and associated external financing. Among the case study cases, this tension over priorities seems to have been especially acute in Rwanda, perhaps because considerable progress has been made in developing concrete operational plans. Donor alignment issues are especially important for the health sector since donors are usually a leading contributor of health financing. In each of the case study countries, the government and donors have agreed on a framework and agenda for strengthened aid harmonization, but significant problems remain. One of the main challenges is how best to integrate donor funding that is targeted at specific diseases into national frameworks.[42]

4) ***Substantial variations can occur between budgetary allocations and actual outturns***. The health sector has often been the victim of large shortfalls in budgetary implementation with the burden typically falling on non-personnel spending. In the past, such shortfalls were a recurring problem in Mozambique and Zambia. At a technical level, they reflected previous weaknesses in the budgetary process (e.g., systems of monthly or bimonthly cash disbursements based on actual resource availability) in the context of unrealistic initial budgets. Recent improvements have helped to alleviate, but not eliminate, these weaknesses.

   More fundamentally, these problems were no accident and reflected deeper political economy influences. For example, ad hoc cash budgeting moves the effective decisions on priorities out of an arena (the annual budget process) where they can be influenced by broader political debates into a smaller circle of decision-makers subject to less transparency. Lawson et al (2006) report that, in Mozambique, significant in-year budget adjustments were decided without the knowledge or involvement of the ministries and agencies concerned. Donors often try to offset some of these pressures by earmarking their program funds for particular activities, but the result can be a highly complex set of influences on priority-setting that is potentially subject to disruption when donor financing modalities change (See Box 4).

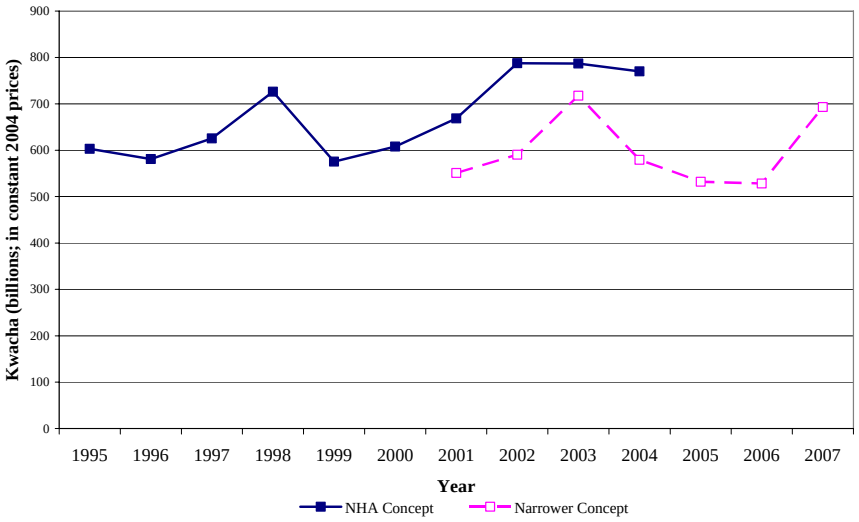
5) ***Large "off-budget" expenditures—mainly reflecting donor activities —reduce incentives for effective formulation and execution of the central budget.*** Despite recent progress, the use of national procedures in managing donor-financed activities remains low in many countries, and information on many program and especially project activities are not well-integrated with the budget. This reflects, in part, donors' concerns about weaknesses in

national public finance management systems. But it also tends to prolong those weaknesses by encouraging continued fragmentation of monitoring and priority-setting systems. The precise extent of such off-budget activity is hard to measure, but one recent estimate for Mozambique suggests that 29 percent of the total resources channeled through the public health sector remained off-budget at the programming stage and 60 percent at the execution stage (Cabral et al., 2005).

Box 4. Influences on Priority-Setting: The Case of Zambia

There is no easy way of judging whether Zambia's health sector is given sufficient priority, given the many competing claims on resources. However, the needs are enormous and current spending falls short of several benchmarks; in particular, Zambia's agreed-upon Basic Health Care Package is substantially underfunded. Until the 2007 budget, total government spending on health (excluding significant off-budget spending, especially by PEPFAR) had not grown substantially in real terms (see Chart below).

Chart 11. Trends in Real Government Health Spending (1995-2007)



In practice, Zambia's choices on health spending are influenced by a complex set of actors:

a) ***The various Ministries involved in the budgetary process, Cabinet, and Parliament.*** Despite some undoubted improvements, the political system is still not effective at making clear choices between competing priorities, for three reasons. First, the budgetary process does not generate the information that would allow clear choices among outputs. Health (and education) ministries lack sufficient technical capacity to make a clear operational case for greater priority in budgetary discussions, so such choices rely on various rules of thumb. The Ministry of Health is improving in this respect, since there is at least now a long-term strategy—including for human resources—to anchor their case. Second, the debate over budgetary priorities is fragmented, with spending ministries like Health devoting much of their attention to the dialogue with donors who fund their sector rather than to the discussion with the Ministry of Finance. Third, Parliament does not play an effective role in the debate over priorities. It discusses and approves the annual budget but not in a manner that provides any serious challenge or input to strategic expenditure choices.

b) ***Donors*** influence the share of government resources going to health as well as allocations within the sector through sector-specific financing, explicit conditionality (e.g., in the context of HIPC debt relief), and the overall dialogue with the government. The sector-specific funding has grown into a complex series of "basket funds" through which various donors provide support for specific activities. Many of those interviewed agreed that this attempt to influence domestic priorities had grown overly detailed and could hamper the development of stronger domestic budgetary institutions capable of setting and enforcing priorities. However, the mechanisms had also helped to channel more resources to the district

level so there is a risk that, during a transition to financing based more on general budgetary support, health expenditures could be adversely affected

c) ***Civil society*** was more heavily involved at the stage of formulating and costing broad strategies than in monitoring and influencing their implementation through the budget. This reflects: more active government encouragement of inputs at the earlier stages; greater availability of external technical support for participation at the planning stage; and inadequate access to information. Civil society representatives thought they had too little "space" in the debate over budgetary priorities, which they saw as largely a dialogue between the government and donors. Notably, this was not the perception of some government officials who thought that some important opportunities to influence the debate had been missed. In their view, civil society could have been more effective if, while pushing for greater priority for health spending, they had also recognized overall budgetary constraints by calling attention to areas where less should be spent. Defense spending and the large number of Ministries were areas for potential savings that were frequently mentioned.

d) ***The IMF.*** While the Fund has no direct involvement in choices on expenditure composition, its actions do have an indirect influence, and it is important to avoid unintended adverse consequences, for example:

- The use of the wage bill ceiling can interact with other devices to influence spending priorities in ways that are hard to predict. Some of those interviewed who were familiar with Zambia's priority-setting processes said that the existence of the wage ceiling had adversely affected the ability of the Ministry of Health to press for more resources in the annual budgetary negotiations. As one person put it, the existence of an overall wage ceiling had been "one more head wind for the Ministry of Health to struggle against" in the debate over priorities, even if that had not been the IMF intention.
- In the past, district-level non-wage health spending has been especially vulnerable to cash budget squeezes and could be again during the transition to new donor financing modalities. This argues for greater emphasis on expenditure smoothing when designing how Zambia's fiscal programs respond to short-term shocks.

6) ***Relatively little analysis has been undertaken, including by the World Bank, of the long-term implications for national budgets if some rapidly expanded, externally financed health activities were to be left to the governments to finance directly (Rwanda is an exception).*** But once started, donors should be in for the long haul on such initiatives because it will be beyond the fiscal capacity of governments to take them over for a very long time (see next section).

b. Expenditure protection mechanisms: potentially useful, especially during periods of budgetary stringency, but need to be focused and reflect domestic priorities

A review of various devices to give special priority to particular categories of expenditures suggests the following: [43]

- *Strengthening budgetary and governance processes so that they truly reflect social choices, including during periods of budgetary stress, is the first best approach. In practice, however, current budgetary systems are flawed. Health spending in particular has often been vulnerable during periods of budgetary stringency. In these circumstances, mechanisms that protect (i.e., give special priority to) some categories of spending can be a useful device while overall processes are being strengthened.*
- *While evidence on what works best is limited, the examples reviewed suggest a few broad principles:(i) designation of spending categories to be protected should reflect domestic, not donor, priorities;(ii) priority categories should be well-focussed and not overly broad; and (iii) such mechanisms need to be integrated with macroeconomic strategies for smoothing aggregate public spending, which requires flexibility in related IMF conditionality.*

- *Long-term fiscal threats (e.g., if high levels of aid for specific health activities were to be withdrawn) probably cannot be dealt with effectively through such expenditure protection mechanisms, although actual experience is limited. Donors should do much more to increase the persistence and predictability of such aid. Pending such efforts, recipient governments may have no other choice than to accept the potential fiscal contingency risks associated with such aid in order to address massive present needs.*

In many aid-dependent countries, inadequacies in budgetary and governance processes have led to the designation of some categories of public expenditure as warranting special protection mechanisms--either to protect them from cuts in the short term during periods of budgetary stringency or to ensure that their share of resources grows more rapidly over the longer term. If normal processes were working satisfactorily, budget allocations would reflect the government's considered judgements on society's priorities, and all forms of spending would be equally valuable at the margin. Any adjustments caused by surprises would also be handled in a manner that accurately reflected social choices. In practice, however, budgetary processes are often flawed in two basic ways: (i) a lack of sufficient emphasis to cushioning some expenditures in the face of (adverse) budgetary shocks; or (ii) a failure to achieve an "appropriate" level of spending in the longer term.[44] Expenditure protection mechanisms—which in some way give a special priority to some spending categories—attempt to offset the consequences of these flaws.

The health sector can be especially vulnerable to the first type of system failure because many health interventions are less effective if subject to stop-go budgetary pressures and because ministries of health have often been less politically influential in protecting their cash allocations during periods of budgetary stringency. For example, in Zambia actual spending on health was often heavily squeezed in the early 1990s when budget implementation was handled through monthly cash budgets (Dinh and Myers, 2002).

In light of such potential pressures, designating some minimal levels of spending on key health and other initiatives that would be protected from budget vicissitudes has obvious appeal, although evidence on the effectiveness of different possible mechanisms is limited. None of the three in-depth country case studies or desk reviews of another nine country cases suggested an obvious "best practice" approach. Classified according to the extent they involve separate budgetary procedures, a wide range of options are possible, including: (i) "virtual" funds (of the type used in Uganda), which are a pre-commitment device, backed by subsequent monitoring, to spend a certain allocation on specified categories without involving any actual separate treatment of government financial resources; (ii) more explicit ring-fencing mechanisms such as dedicated budgetary funds (whether on- or off-budget)—Zambia's "basket funds" are one example; (iii) sector stabilization funds, which attempt to smooth spending in the face of volatile incomes such as resource rents, with the resources dedicated to certain uses (e.g., of the type used in Chile); and (iv) parallel delivery, outside the regular budget, of donor-financed activities (e.g., PEPFAR).[45] We do not have sufficient evidence to conclude what would work best in particular circumstances, but the country examples suggest a few broad principles:

(i) The designation of the expenditures to be given special priority should be as far as possible the outcome of domestic political debate. In fact, both the detailed case studies

and the desk reviews indicate that donors were usually the main drivers of the process. While no evidence suggests that any of the governments actively resisted the principle of prioritization, the excessive orientation around donors' priorities risked weakening national budgetary processes. This factor seems to have been important for the health sector in Mozambique and Zambia.

(ii) The expenditure categories covered by such mechanisms should be well-focused. In practice, the categories involved were often quite broad or fluctuated significantly over time. For example, in Mozambique, 65 percent of total budgetary resources (excluding debt service) were targeted to be spent on priority sectors. In Zambia, the priority designation began with a very narrow focus on capital spending and was subsequently expanded to cover a wider array of recurrent expenditures (including health). In Rwanda, it began with an emphasis on the social sectors, but then diversified far more widely to include, for example, electricity and law enforcement. Setting the priority net very wide gives little guidance to how trade-offs should be handled *within* the priority category. It also magnifies the burden of any budgetary shocks on those sectors that are not designated as priorities. The focus on broad sectoral allocations also distracts attention from identifying specific programs in the health sector that may have an especially important impact on the MDGs.

(iii) More attention needs to be given to the links between protecting certain categories of spending and the *macroeconomic* policy choice on how much to smooth aggregate expenditures. Chile's experience suggests that mechanisms to smooth aggregate spending are not necessarily sufficient to smooth spending in all key sectors that may deserve protection.[46] But if the designated priority sectors are of any significant size, they may need to be accompanied by some form of aggregate expenditure smoothing mechanism. For most low-income countries this may be nothing more complicated than arrangements on how to use the cushion of external reserves. As discussed earlier, this would require that IMF conditionality be designed more flexibly to allow such expenditure smoothing (see Section 2c).

The success of prioritization mechanisms in protecting against actual spending shortfalls is difficult to establish. In Zambia, the operation of earlier cash budget mechanisms had led to substantial instability and unpredictability in budget releases for health. So the combination of dedicated "basket funds" by donors and the prioritization mechanisms probably did help protect health spending—including the share spent in rural areas—from short-term shocks. But the dedicated donor financing modality may have hindered the longer-term strengthening of truly national processes to set priorities (see Box 4). In Mozambique and Rwanda, similar factors were at work, but the priority categories were often so wide that it is hard to detect any influence on the health sector alone. It is notable that the case studies do not seem to have turned up any regular process of review of the operation of the prioritization mechanisms from this perspective. In all cases, the share of total health sector expenditures rose, but this was frequently due more to the rise in donor-financed expenditures.

Because of the large magnitudes involved, explicit budgetary devices to protect certain expenditures may not be an effective way of dealing with the more intractable problem of

longer-run risks (arising from a potential lack of constancy of aid). Little practical experience exists on how such mechanisms might cope with such circumstances, but they are of major importance for the health sector since donor-financed activities, including those off-budget, are in some cases large in relation to the regular Ministry of Health budget (e.g., in Zambia). The best solution would be for donors to find ways of making more reliable and longer-term commitments, or alternatively, setting up effective stabilization mechanisms themselves. Various proposals for donor-financed buffer funds have been suggested (Eifert and Gelb, 2005). Another option worth exploring would be to pool individual donors' contributions into a global fund that would then be in a position to make somewhat longer-term commitments. Indeed, the Global Fund to Fight Aids, Tuberculosis, and Malaria has some of these characteristics, which could be built upon and extended.[47] In the interim, however, the practical choice for recipient governments is whether or not to agree to accept substantially increased resources which are not under their own control and involve some inevitable long-term fiscal risks. Given the desperate needs for increased funding for health initiatives, they probably have no option other than to accept the risks involved. There may be a range of problems in accommodating these inflows in the short term, and much more serious ones if they are subsequently withdrawn. However it would seem wrong to reject these badly needed resources in the context of real present, but hypothetical future, difficulties.

More generally, explicit mechanisms to give special priority to certain expenditure categories should not be seen as a substitute for improved budgetary processes and governance, and should not divert attention from the fundamental challenge of how better to manage the budget.

D. Hiring and wages in the health sector

The 2006 World Health Report documented that many of the poorest countries are facing a health workforce crisis characterized by severe shortages, inappropriate skill mixes, and geographic imbalances leading to major gaps in service coverage. This crisis and its possible solutions have many dimensions that go beyond the scope of the Working Group. We focus here on only a narrow set of issues: (i) the role of wage bill ceilings in IMF programs; and (ii) problems with hiring and wage strategies and their integration with overall budgets.

a. Wage bill ceilings in IMF programs: overused, despite attempts to protect hiring in priority sectors.[48]

The key findings from our review are that:

- *Wage bill ceilings have been overused in IMF programs, especially in Africa. They have been useful as a temporary device when a loss of control over payrolls threatened macroeconomic stability (e.g., in Zambia from 2003 to 2004), but such situations will probably be rare. In practice, they have been used in many other situations, often without a clear rationale.*
- *The IMF has not imposed any wage bill ceiling (or hiring freeze) specifically on the health or education sectors. Indeed, most programs try to protect additional hiring in priority social sectors, including health, from the effects of the aggregate ceilings. However, such protection cannot be monitored or enforced in practice.*

- *Wage bill ceilings do not fit well with other efforts to protect certain priority expenditure categories, including health.*

Some form of IMF conditionality related to the wage bill was included in about half of recent programs with low-income countries. In some cases the conditions were related to specific structural actions (e.g., develop a payroll roster or consolidate allowances into the salary schedule) but 17 out of the 42 countries with PRGF-supported programs during 2003-2005 included some form of ceiling on the wage bill; all were in Africa or the Central America/Caribbean region (Table 4). Such ceilings were especially common in Africa (13 out of 24 cases during the period), although senior staff from the IMF African Department told the Working Group that they were being used less frequently in more recent programs, following a recent decision to subject any use of such ceilings to greater internal review.

The ceilings usually included some mechanism that attempted to protect expansions of employment and pay in priority sectors, often by trying to build such projections into the baseline ceiling. In practice, however, there was no way to enforce such protection or even to monitor what actually happened. If the ceilings are used up by unanticipated hiring in "non-priority" areas, employment in health and education could still be constrained. This seems to have happened in Zambia, although the evidence for Mozambique is less clear (see Box 6). Only one program (Malawi) allowed for explicit adjustment to the wage ceiling for donor financing linked to the health sector, under a Sector-Wide Approach (SWAp) arrangement.

Table 4. Wage Bill Ceilings in PRGF-Supported Programs, 2003-2005

	Coverage		
	Central government	**General government**	**Non-financial public sector**
Quantitative performance criteria*	Chad, Ghana, Kenya, Malawi, Dominica, Honduras, Nicaragua		Guyana
Quantitative benchmarks	Burundi, Mozambique, Niger, Sierra Leone, Zambia	Benin, Burkina Faso, Mali, Senegal	
Total	12	4	1

Source: Fedelino, Schwartz, and Verhoeven (2006).
* Performance criteria (PC) are conditions which if breached imply an automatic interruption of access to IMF financing unless the Executive Board grants a waiver. Indicative benchmarks have no such explicit link to the interruption of the program (and associated financing), but are taken into account in judging progress at the time of reviews of the program, which usually take place every six months.

The rationale provided for the use of the ceilings has often been vague and sometimes shifts over time. The IMF has argued that the wage bill ceiling is used in cases where the wage bill is a source of serious macroeconomic pressures, but this is hard to reconcile with its use in many cases where countries have succeeded in restoring a substantial measure of macro-economic

stability. The case studies of Zambia and Mozambique suggest that the ceilings are also used to reflect concerns over longer-term resource allocation (i.e., how much to spend on wages) or to provide an incentive for broader civil service reform, but they are not well-suited to such roles (see Box 5). For example, the Zambia case study concludes that the initial use of the wage bill ceiling in 2003 was justified as a short-term device to help prevent a loss of budgetary control, but that it had outlived its usefulness by about 2005. Moreover, the use of such ceilings does not fit well with budgetary mechanisms, discussed earlier, that try to give priority to some "poverty reducing" categories of government spending such as health or education. It is impossible to ensure a proper fit between the wage-bill ceilings and such priorities without undertaking a comprehensive analysis of how human resource costs would evolve over the medium term. This is beyond the expertise of the IMF. In practice the ceilings are not supported by any such analysis of the appropriate share of government spending on wages for the medium term, which greatly undermines the validity of maintaining such ceilings for lengthy periods.

Box 5 . Experience with Wage Bill Ceilings in Zambia and Mozambique

Zambia

Explicit wage bill ceilings were first introduced in Zambia's IMF programs as a second best way of counteracting major weaknesses in budgetary controls and public sector pay policies. Payroll systems were ineffective, so the government was unable to determine accurately the total numbers employed or translate announced strategic priorities into hiring and payroll decisions.[49] Government bodies hired with impunity, without reference to the Ministry of Finance or payroll regulations (Lewis, 2005). In addition, generous separation benefits, which cost an average of 12 years of salary per retrenchment, meant that it was often "cheaper" for ministries' budgets, in the short term, to delay formal retirements and keep staff on the payroll even though they were no longer working. The civil service wage structure had been severely compressed, making it hard to retain qualified professional staff--a particular problem in the health sector. But a complicated system of allowances made the cash pay of senior civil servants a very small part of their total compensation and made it difficult to assess in advance the budgetary implications of agreements on such allowances. Previous attempts to address these structural weaknesses had failed.

The overall wage bill began to increase sharply in 2000, rising from 5.3 percent of GDP to 8 percent by 2002 (see chart below). IMF programs during this period discussed the need for controlling the wage bill as part of overall fiscal consolidation, but did not include any conditionality on the wage bill (with the exception of a hiring freeze in 2002 that *specifically excluded* recruitment of doctors, nurses, and teachers). The shift to explicit conditionality was triggered by events in 2003 that threatened a major macroeconomic disruption. The approved 2003 budget envisaged an overall wage bill equivalent to about 8 percent of GDP. Several months later, the authorities granted large wage increases and introduced a new housing allowance. If paid in full, these increases would have raised the full-year wage bill to an estimated 10½ percent of GDP—for reasons that had little to do with expanded recruitment in priority sectors. Payment of the higher wages and allowances began to constrain ministries' cash budgets (which had not taken account of such increases), leading to disruptions in planned recruitment and ad hoc hiring freezes. The IMF staff-monitored program (SMP) that was negotiated for the second half of 2003 included steps to roll back part of the housing allowance and also introduced monthly ceilings on overall wage payments (equivalent to an overall wage bill of 8.7 percent of GDP). The wage bill ceilings have been a feature of all subsequent IMF programs and have generally targeted an overall wage bill of around 8 percent of GDP.

The rationale underlying the ceilings has changed over time. Initially, it was viewed by the IMF staff as a short-term response to a major threat of loss of macroeconomic control. However, once any threat to macroeconomic stability had receded (which most would agree had occurred by 2005), two other purposes of the ceilings emerged: (i) as an incentive to encourage broader civil service reform; and (ii) as a rough benchmark for medium-term resource allocation goals. Neither was a suitable objective of short-term macroeconomic conditionality.

The conditionality on the wage bill was a blanket one, covering both priority and non-priority sectors, because the payroll monitoring systems were not strong enough to distinguish between different activities. The program ceilings were generally derived taking account of concrete plans for hiring in health and education.[50] In practice, however, there was no way to enforce or even systematically monitor whether such priority uses of the ceilings were implemented. Weaknesses in the payroll and establishment systems made it hard to track the exact numbers employed

in the health sector and some of the new "recruitment" allowed for was actually regularization of staff already working but not formally recognized as being on the government payroll. Not surprisingly, subsequent program documents said little about what had actually happened to recruitment and employment. In practice, part of the hiring room under the ceilings appears to have been preempted by politically more powerful ministries.

Mozambique

Explicit ceilings on the wage bill are relatively recent features in IMF arrangements with Mozambique. They were not used in the 1999-2003 programs, although wage policies were discussed at that time. They were introduced in mid-2004 as part of the original PRGF arrangement for 2004-2006 and were continued until June 2006, when Mozambique became the first case where such a ceiling was withdrawn.

Prior to the ceilings, the government wage bill increased markedly (see chart below). Only part of the increase appears to have reflected increased hiring in priority areas, although weak payroll systems make a precise explanation impossible. Previous efforts at civil service reform had achieved little and there were no clear figures on overall government employment (Lawson et al., 2006). The year 2003 was particularly difficult, as long-lasting negotiations with the trade unions also led to a final wage bill that was much higher than originally forecast. There was no discussion in IMF documents of the rationale for a wage bill ceiling as an instrument for addressing these systemic shortcomings, but IMF staff indicated that part of the reason for introducing the ceiling was to "call attention to the issue." Interviews conducted for the case studies suggest that senior budget officials were also keen to see a ceiling included in the program as a way to offset domestic political pressures to increase wages.

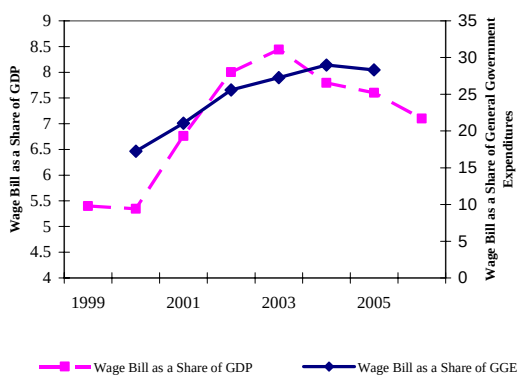
The original program targeted a slight decline in the overall wage bill, as a share of GDP in 2004-2005, to about 7 percent of GDP. The ceiling was increased (to about 7½ percent of GDP) for 2006. Given the rapid underlying growth in real GDP, this latest increase implied real growth in the overall wage bill ceiling of about 23 percent in 2006; the actual outcome was well under the ceiling. As in Zambia, the targeted ceilings incorporated explicit numbers for additional recruitment in priority sectors (mostly health and education).[51] However, the program documents are silent on what actually happened to hiring in priority areas and there is no discussion of how such numbers might fit into a medium-term strategy or whether they are judged as adequate.

Given the large real increases implied by the ceilings during the later period, the IMF program does not seem to have imposed a major squeeze on the wage bill at least during that time. However, it is difficult to get a clear picture of health sector employment and recruitment, mostly for lack of reliable data and due to the decentralization of the human resources function to the provincial level. The wage bill ceiling also had the adverse side effect of pushing some personnel spending into the investment projects components, with the workers involved recruited outside the regular civil service.

The wage bill ceiling was dropped at the time of the fourth review. No reason was given in program documents, but IMF staff and Mozambican officials indicated that (i) the IMF was more confident that the government was committed to containing wage bill spending regardless of an IMF-imposed ceiling; and (ii) given the shortcomings of the payroll system and the extent of donor-funded personnel expenditure, it made more sense to focus on improving the systems rather than focus on a numerical target. A comprehensive civil service census is to be undertaken, using biometric data, in order to establish a clearer picture of the size of the civil service, its composition and cost.

a. Mozambique

b. Zambia



b. Hiring and wage strategies in the health sector: Still not well-matched with needs

Evidence from the case studies and other countries suggest the following key messages:

- *In many countries, no clear strategy exists to match incentives to the most urgent needs for the supply and distribution of skilled staff.*
- *In some cases where long-term human resource plans have been developed (e.g., Zambia), the targeted staff increases are very large but have not been integrated with medium-term expenditure planning. Consequently, they may provide only limited guidance to priority-setting in annual budget discussions.*
- *Development partners, including the World Bank, have not provided sufficient evidence-based advice on wage policies for the health sector.*

Among the case study countries, Zambia illustrates many of the problems faced in implementing hiring and wage strategies to address a dire human resource situation, but many other countries, with and without IMF programs, face similar challenges. Zambia's health workforce is insufficient to deliver the government's announced basic package of health services, with the mismatch between needs and resources greatest in rural areas. The overall wage bill for the Ministry of Health has been about 1 percent of GDP in recent years and has generally accounted for less than half of all government health spending.[52] As discussed in Box 4, the budget for health is now increasing, after a number of years of little growth in real terms, but the government has not yet resolved two fundamental issues: (i) prioritizing the targeted increases in the health work force so that they fit into the medium-term expenditure framework; and (ii) reforming the wage and payroll structure so that the supply and distribution of health staff matches the most urgent needs.

The government has recently approved a health worker establishment set out in the Human Resources for Health Plan, which calls for an eventual increase in staffing levels from the current level of about 23,000 to 51,000. The latter figure is what was determined as necessary for effectively delivering health services in accordance with the Basic Health Care Package. However, no timeframe has been decided for the increase and it is not yet clear how the planned increase would be integrated with the Medium-Term Expenditure Framework. The aim would be to begin by increasing the staffing levels of the most critical cadres, but what that means in practical terms for the medium term is not yet clear. In the interim, overall recruitment levels continue to be determined in the context of annual budget discussions. An indicative figure of 1,700 gross recruitments has been accommodated in the 2007 budget. Even though this is more than double the 2006 increase, it would still take a long time to reach the approved establishment.

The problem of how to create an effective incentive structure and how to fit that structure within overall resource constraints continue to this day. An attempt to de-link employment and terms of service in the health sector from the civil service structure in the second half of the 1990s was abandoned mid-stream, leaving Zambia with a fragmented payroll and wage system that is not well-suited to matching incentives with performance and needs. Many of the problems stemmed from the way the reform attempt was implemented. The idea of the original de-linking was to

discriminate in favor of core health workers, particularly those involved in service delivery. In practice, the new wage structures depended on which institution previously employed each cadre. The result was a dual employment system, with significant disparities in pay and benefits that were not linked to needs. So an overall wage strategy for the sector is still needed. Many of those interviewed, both within and outside the World Bank, said it had been too slow to help identify concrete proposals for reform, in Zambia and in other cases.

Similar tensions are present in Mozambique. While there have been some improvements over recent years in addressing the shortfall of qualified personnel in the health sector, the capacity to train, recruit and deploy additional staff is still limited. This is due not only to the limited capacity in the country's training facilities but also to the lack of a clear human resources strategy for the sector as a whole. In 2006 the Ministry of Health did formulate a more articulated training plan which tries to respond to the need for scaling up health services and which provided inputs for the medium-term plan (PARPA II). However, funding for such an accelerated plan is still not secured. The tensions between the clear need to recruit additional personnel in key sectors and the lack of adequate planning and control is summarized in a recent *Aide Memoire* on the review between the government and its program aid partners, which states that:

> "Overall numbers of 'frontline' workers in health and education, in spite of some additional recruitment in 2005, appear to be totally inadequate in terms of meeting the minimum requirements for service delivery expansion. It is essential that 2007 budget negotiations for recurrent cost to each of these ministries are based on a thorough analysis of the needs but also of the risks of continued underinvestment in human resources. At the same time, the issues of absorptive capacity and reform of human resources management, including payroll reform require special attention." (April 2006)

IV. Lessons

Since the main focus of the Working Group has been on IMF activities, the thrust of our lessons is directed toward the IMF. However, the evidence discussed in the previous chapters also suggests a number of important lessons for governments of aid-dependent countries, development partners (including the World Bank), and civil society.

The central question we have investigated is whether the IMF, through the programs it supports in aid-dependent countries, has unduly constrained a desirable scaling-up of health spending. National governments are responsible for deciding how much of their resources to spend on health, and in many cases their decisions have not matched the political rhetoric on the importance of health. However, even though any influence of the IMF on health spending will be indirect, it can still be important. Our conclusion is that in a number of ways IMF actions have unduly constrained countries' policy choices and that it needs to do more to help explore a broader range of options, especially if donors are serious about their undertakings to expand aid.

Three broad messages from our investigation underlay the more detailed lessons. First, IMF-supported fiscal programs have often been too conservative or risk-averse. In many cases, they have unduly narrowed the policy space by not investigating sufficiently more ambitious, but still potentially feasible, fiscal options for higher spending and aid. There have been some commendable exceptions in recent years, where the IMF has explored alternative options more systematically. The IMF has also often been quite flexible in adapting its programs to changing circumstances, including the availability of higher aid. But adapting after the fact is not the same as signaling in advance, to recipient countries and donors, that a broader range of options are feasible.

Why has the IMF often not explored a broader range of feasible fiscal options? Three factors seem important. First, information on the sector-level costs and consequences of higher spending scenarios to make reasonable macroeconomic assessments is often lacking, especially for the health sector. This lack is not the fault of the IMF, but the Fund often responded by implicitly "assuming the worst" (from the perspective of the potential for higher public spending)—e.g., about key uncertainties such as the impact of public spending on the supply-side, absorptive capacity constraints, the likely permanence of additional aid, and the speed with which a strategy based on paying down domestic debt might "crowd-in" private investment. Second, the IMF Board and Management have given insufficient guidance to IMF staff on what exactly they are meant to do in this area. For example, the IMF Board has sent mixed signals reflecting continuing differences of views over the role of the IMF in low-income countries. This ambiguity has not been resolved by discussions over the IMF Medium-Term Strategy. Third, the inevitable tension between different IMF roles (i.e., as a negotiator of short-term conditionality and as the macroeconomic policy advisor in a broader debate on policy options) can influence the incentives faced by IMF staff to open up the debate to include a broader range of options and stakeholders. In our view, this tension should be resolved by downplaying the emphasis given to short-term conditionality when macroeconomic instability is no longer a major threat.

The second broad message is that some of the tools used in IMF programs—especially wage bill ceilings—can be harmful to the planning and implementation of health spending. The evidence

indicates that the more extreme criticisms of the IMF on this issue are not accurate. In particular, IMF programs have not imposed specific constraints on hiring in the health sector; to the contrary, programs with wage bill ceilings have usually tried to protect hiring in priority sectors such as health and education. However, such efforts at protection cannot be enforced in practice so aggregate wage bill ceilings can have unintended adverse consequences, including for sectors like health where wages are a large share of total spending. Moreover, the ceilings have sometimes been used in an effort to influence long-term resource allocation choices that the IMF is not well-suited to pronounce upon and that should not be addressed by short-term macroeconomic conditionality.

The third message highlighted by our investigation is the striking disconnect between the macroeconomic and health sector policy issues. The disconnect involves many aspects, and fixing it will require actions by many stakeholders, not just the IMF. Many of our recommendations for recipient governments, donors, and civil society are directed at this issue. First, as noted, a huge analytical and information gap exists: macro-policy decisions are often made with very little understanding of the likely costs and effects of potential choices for health spending; similarly, discussions on longer-term health policy are often not guided by a clear idea of what the overall budget constraints might be. Second, national planning and budgeting capacities—including those of Ministries of Health—are not strong enough to make meaningful choices on trade-offs. Addressing the analytical and capacity gaps will usually require additional external support. At the international level, the issue is usually discussed in terms of stronger IMF-World Bank collaboration, but it is much broader than that since the relevant external expertise often lies with bilateral donors or other multilateral institutions. Strengthened frameworks are needed for identifying who does what and by when to help governments, with feedback on accountability. Third, donors have contributed to the segmentation of budgetary processes. Keeping important donor-financed activities outside of the normal budget process tends to weaken national priority setting and can create longer-term fiscal problems if donor priorities do not align well with national priorities.

For the IMF

The IMF needs to adapt its approach in low-income countries to its expected role and be crystal clear about what that role is. Put simply, if the IMF is to continue being heavily involved in these countries once macroeconomic stability has been achieved—by advising governments on longer-term macroeconomic challenges and signaling to donors on the suitability of macroeconomic frameworks—it needs to adapt its analytical approach and way of doing business. Clearly, an alternative division of labor is possible in which the IMF confines itself to short-term stability issues and makes no pretence of pronouncing on issues such as the longer term challenges of scaling up aid and expenditures. But the IMF cannot expect to play the broader role that the international community seems to want (and which its own pronouncements suggest) without some significant changes in approach. Our detailed recommendations assume that the IMF will continue to play this broader role. To implement the changes discussed will require action by the IMF Board and Management. Alternatively, the Board should make clear that the IMF role in post-stabilization low-income countries will be much more limited, and scale back its involvement and policy pronouncements accordingly.

In any event, IMF direct involvement on issues concerning health spending should be very limited, reflecting its comparative advantage and mandate. Its main function should be to explore and advise on the macroeconomic consequences of different policies, being careful not to rule out feasible options. Governments, not the IMF (or donors), should determine priorities, including on the size of overall public spending, the wage bill, and the shares devoted to health, provided the choices are consistent with broad macroeconomic stability.

1. **The IMF should help countries explore a broader range of feasible options for the fiscal deficit and public spending. This requires less emphasis on negotiating short-term program conditionality and a greater focus on helping countries strengthen their understanding of the consequences of different options.** In many cases, the IMF did not explore more ambitious, but still feasible, paths for higher public spending. Its cautious approach to fiscal expansion (e.g., favoring a pay-down of domestic debt) appears to reflect a tendency to assume that additional spending would be wasted in the frequent absence of adequate sector-level information for judging how effectively additional resources could be absorbed. It also appears to reflect an inclination to assume a strong "crowding-in" response by the private sector to lower deficits, which may or may not occur, depending on each country's circumstances. Concerns about the efficient use of scaled-up spending may well be warranted, given the past poor track record in many countries. But judging how much more money can usefully be spent in particular sectors, including health, is not within IMF expertise. It must rely on inputs from others, and if the necessary sector-level information is not available, the IMF should be humble in making assessments about the appropriate path for the fiscal deficit and public spending. A range of options is likely to be feasible and the IMF role should be to help countries explore better the potential trade-offs among these options and to present clear policy choices to their political institutions.

2. **The IMF Board and Management should adopt and make public clearer guidelines on what is expected of IMF staff in analyzing the consequences of alternative aid paths and on what should drive IMF signals about aid levels.** The IMF medium-term strategy still leaves important ambiguities about what the staff should be doing with regard to assessing prospects for scaling up aid. The IMF Board should set out explicitly what is expected. There are four broad options:

    a. The IMF would take the level of aid as given, based on a survey of donors' existing intentions. It would derive a macroeconomic framework consistent with this aid level and objectives of macro stability. But it would state explicitly that it took no view whatsoever on the compatibility of this framework and level of aid with any objectives related to development or achieving the MDGs, which were beyond its expertise.
    b. The IMF would take the level of aid as given and prepare the macro framework as in the first case. Based on inputs from others, it would also indicate if there were strong reasons to doubt that this framework was compatible with the MDGs.[53]
    c. The IMF would make an assessment, based on sector-level inputs, of the macroeconomic effects of a significant scaling-up of aid so as to help the international community and the country itself judge whether there are any *macroeconomic* constraints to absorbing more aid. The obvious benchmark to use

in such a scenario would be that aid grows at least as fast as implied by donors' global commitments (e.g., provided there were not massive governance problems, each African country would have a scenario consistent with a doubling of aid by 2010).

d. The IMF would devise a macroeconomic framework and estimates of aid requirements to achieve the MDGs (i.e., the full-fledged "needs-based" approach).

There are good reasons for adopting option "c," but whatever option is chosen, the IMF should be careful not to signal that a scenario built around status quo estimates of aid levels is somehow the desirable or appropriate one.

3. **While it is not the IMF's job to decide what aid levels should be, it should do more to promote fuller and more timely information about expectations for aid in its programs.** Feasible steps could include: (i) more explicit analysis of how aid profiles incorporated into specific country programs compare with donors' global commitments; (ii) making public what its collective program projections for aid would imply for global aid flows; and (iii) feedback on donors' actual performance, collectively and individually, in delivering aid assumed in programs.

4. **Wage bill ceilings should be dropped from IMF programs except in cases where a loss of budgetary control over payrolls threatens macroeconomic stability.** Such situations (e.g., Zambia in 2003-2004) will be fairly rare. In practice, these ceilings been used in many other circumstances. Although some of the criticisms of the IMF in this area have been overstated, such ceilings sit uneasily with the designation of priority poverty-reducing expenditures, especially given the heavy wage component of health and education spending. The IMF has made efforts to "protect" hiring for such sectors in its programs, but there is no way of enforcing such protection in practice. Moreover, the ceilings foster various distortions if left in place for too long.

5. **IMF programs should give greater emphasis to short-term expenditure smoothing, especially when macroeconomic instability is no longer a significant threat.** The use of an asymmetric response to aid shocks in program design should be restricted to cases where countries clearly have insufficient external reserves. Where reserves are comfortable, programs should allow greater flexibility for countries to smooth the impact of adverse shocks, including their fiscal consequences. In the same spirit, the IMF should implement a Board-endorsed recommendation from the 2003 IEO evaluation of fiscal adjustment in IEO programs that called for greater dialogue, in advance of any program negotiations, of those expenditure categories that should be protected from budgetary pressures:

   "The IMF could invite the authorities regularly during Article IV consultations to suggest what are the existing critical social programs that they would like to see protected in the event of adverse shocks. Participation on the part of the authorities would clearly be voluntary." (IEO 2003, page 11)

6. **The IMF should be more transparent and proactive in discussing the rationale for its policy advice and the assumptions underlying its programs**. This would help broaden the debate on macroeconomic policies and provide scope for analytical inputs by others. Steps

could include: (i) adopting a more proactive communications strategy at the local level; (ii) establishing a model "communications package," written in clear non-technical language, about the content and goals of its programs (the latter could be undertaken initially for a few pilot cases and feedback sought on the results); and (iii) making available its internal database on IMF program targets and results to outside analysts.

For Governments of Aid-Dependent Countries

1. **The capacity of Ministries of Health to undertake budgetary planning should be strengthened, with the focus on producing concrete operational plans that will make a good case for additional budgetary resources.** The capacities of ministries of finance to analyze alternative policy options should also be strengthened.

2. **Governments should do more to sharpen national priority-setting processes and involve Parliaments in the process.** Deeper political debate over choices requires better information on what is being "bought' with extra resources. Strategic plans for the health sector provide the basis for such information but need to be translated into prioritized and costed proposals for the next several years that make an effective case for greater budgetary priority. Parliaments should formally debate and approve proposed medium-term expenditure frameworks, and the technical capacity of parliamentary oversight committees should be strengthened.[54]

3. **Budgetary mechanisms that help protect key expenditure categories, including components of health spending, can be useful when regular budgetary processes are weak.** The ongoing efforts to strengthen public financial management and overall budgetary processes are critical to a longer term solution to setting clear priorities. In the meantime, expenditure protection mechanisms can help to put a floor under spending on some key initiatives in the event of budgetary stringency, but the priorities should not be defined so widely as to be ineffective and they should be guided by national processes. As discussed above, one way to improve the integration of such mechanisms with macroeconomic policies would be *ex ante* identification of such spending categories in discussions with the IMF.

For Development partners, including the World Bank

1. **Donors should improve the predictability of their aid and make longer-term commitments in order to promote more effective planning and implementation of health spending.** There have been improvements in the predictability of aid recently, especially for direct budget support, as donors signal their commitments early in the annual budgetary process. However, much longer-term assurances of levels of support are needed if countries are to embark on a major expansion of health (or other social) initiatives that have substantial recurrent cost implications and would be difficult to reverse. The shorter the timeframe of any aid commitments, the greater the fiscal risk for these countries, which will inevitably affect their ability to undertake such an expansion.

2. **Development partners should avoid adding to the fragmentation of budgetary processes and the national dialogue over policy priorities.** In this context, the rapidly growing size of

the "disease-specific" funds and their operation largely outside the existing government health system raise many issues that go beyond the focus of this Working Group. But it is clear (e.g., from the Rwanda case study) that there can be major challenges if donor priorities are not reasonably well aligned with national priorities within the health sector. In any event, once started, donors have to be in for the long haul on such initiatives, because it will be beyond the fiscal capacity of most governments to take them over for a very long time.

3. **Bilateral donors, the World Bank, and other multilateral institutions should be more proactive in providing timely analysis on the micro-foundations for macro assessments of scaling up.** Despite all of the attention given to the issue of World Bank-IMF cooperation, timely inputs analyzing public expenditure proposals are often still lacking. But the expertise on specific health sector issues important for a good understanding of the macro-micro links may often lie elsewhere, including with the WHO or bilateral donors who are very active in the sector. Strengthened (and country-led) frameworks for setting clear understandings on who does what and by when are needed to strengthen incentives for better coordination.

4. **In the health sector, development partners, including the World Bank, should be more active in giving empirically-based advice on how to translate increased resources into more effective interventions. This should include more concrete advice on how to reform wage structures and incentive systems for countries' health sectors.** The latter is one of the critical policy issues facing the health sector, but the World Bank, for example, has often been slow to propose concrete solutions. The advice should cover such issues as whether to de-link terms of service and recruitment issues in the health sector from broader civil service reform.

For Civil Society Organizations

1. **Civil society organizations involved in budgetary and health advocacy issues should give greater attention to monitoring and influencing the setting and implementation of annual budgets.** There are significant obstacles to increasing civil society input at the implementation stage, including lack of access to full information and limited capacity to analyze technical issues. But this is an area where greater input into the policy dialogue is likely to yield the most results. To support such efforts, the analytical capability of civil society on fiscal issues should be strengthened**,** probably with initial external support. This could include fostering in-country independent research institutes to strengthen the policy debate over budgetary priorities and the exploration of alternative fiscal options.

Appendix 1
Table 5. Country Case Studies:
Content and Rationale for Key Fiscal Components of IMF Programs, 2003-2006

Country	**Key content of original program (**over 3-year period)	**Analytical basis provided in IMF documents**	**What actually happened** (over 3-year period)
Mozambique	Large targeted decline (by 4.8% of GDP) in deficit before grants, mainly from lower expenditures. Domestic financing to shift to a surplus (i.e., debt reduction).	Debt sustainability analysis showed that, after debt relief, larger fiscal deficits could have been sustained. Rationale for programmed fiscal path (and negative domestic financing) was to channel credit resources to the private sector ("crowding in") and to reduce pressure on domestic interest rates. But there was no analysis to justify the assumed importance of this link.	Deficit reduced by 1% of GDP. No change in level of spending (declined in 2004-2005, but returned to original level of 27 percent of GDP by 2006).
Rwanda	2002-2004 program targeted a decline in deficit before grants by 1½% of GDP, all from higher revenues. Deficit after grants targeted to be in surplus in original program (i.e., domestic debt reduction). No change targeted in government spending as a share of GDP. 2006-2008 program targets a small (½% of GDP) decline in deficit, all from lower spending.	Debt sustainability assessment concluded that Rwanda was in danger of future debt problems, even after widespread debt relief, because one indicator—the net present value of debt to exports—was above identified warning thresholds. The weight given to this indicator was overstated, reflecting flaws in how HIPC debt relief was calculated and peculiarities of Rwanda's situation. Opportunities to explore alternative aid-financed expenditure scenarios were missed (see Box 2), but subsequent reviews did adapt substantially to the changing outlook.	Deficit widened by 2½% of GDP. Government spending increased by 5% of GDP. Too early to tell for new program.
Zambia	Substantial front-loaded reduction in deficit before grants (by 3.6% of GDP) to be achieved primarily by lower overall spending. Significant shift in composition of spending toward "priority" sectors, including health, targeted, but sources of spending cuts left vague.	Initial fiscal targets were largely based on debt sustainability analysis plus references to concerns about "crowding out" of private investment. In addition, a 2002 World Bank study analyzed the impact of additional domestically financed spending on growth and income distribution and concluded (based on historical data) that such spending would have no significant impact on growth. In 2005, IMF staff analyzed the consequences of a substantial scaling-up in aid and public spending.	Deficit reduced by 6.8 % of GDP (almost all in first year). Expenditures fell by 5.6 percentage points. Government health spending was broadly flat in real terms over 3-year period, until a big increase in the 2007 budget.

Source: Background papers on country case studies.

Table 6. Country Case Studies: What the Programs Assumed About Aid

Country	What did the original program assume about aid?	What rationale was given for the projection?	Were alternative scenarios considered?	What actually happened?
Mozambique	Original program assumed aid flat in dollar terms (at around US$700 million). Subsequent reviews projected a short-term increase in net aid but flat thereafter. The recently completed fifth review (December 2006) projects a sharp further increase in net aid (to US$1.3 billion a year over 2007-2009).	Short-term projections based on a donor-by-donor survey of intentions. Original emphasis of medium-term projections was on reducing aid dependence.	No discussion of alternative scenarios in the original program or early reviews. However, the latest review (Dec 2006) acknowledges explicitly that a major scaling-up of aid will be the key macroeconomic challenge, with the consequences depending critically on how the additional resources are used. A more comprehensive analysis of a scaling-up scenario is to be presented in the 2007 Article IV consultation.	Aid rose substantially (to about US$1 billion in 2006).
Rwanda	Original 2002-2004 program assumed declining aid flows, from about US$340 million in 2001 to US$257 million in 2004 (Chart 9) 2006-2008 program assumes aid broadly flat at around US$450 million.	Short-term projections based on donor-by-donor survey but with all but grant aid discouraged by debt sustainability assessment. Original medium-term projections skeptical about prospects for aid –financed scaling up, but subsequent reviews much more flexible.	Donor-sponsored attempt to explore alternative scenarios was stillborn (see Box 2).	Aid rose substantially to over US$400 million in 2004.
Zambia	Net aid flows in 2004-2006 projected to be broadly flat (at about US$500 million—the average level received in 1999-2002).	Ex-Post Assessment concluded that earlier program projections of aid had been too optimistic and that shortfalls were typically due to failure to observe policy objectives set by donors.	Yes—Alternative scenario in 2005 envisaged a higher level of aid (50% over the baseline) that was calibrated to broadly match the path implied by doubling of aid to Africa and no change in Zambia's share.	Net aid increased faster than programmed (to US$600 million a year in 2005-2006), but by less than implied by the alternative scenario.

Source: Background papers on country case studies.

Bibliography

ActionAid International USA. 2004. "Blocking Progress: How the Fight Against HIV/AIDS Is Being Undermined by the World Bank and International Monetary Fund." Washington, D.C. [http://www.actionaidusa.org/blockingprogress.pdf]

ActionAid International USA. 2005. "Changing Course: Alternative Approaches to Achieve the Millennium Development Goals and Fight HIV/AIDS." Washington, D.C. [http://www.actionaidusa.org/pdf/Changing%20Course%20Report.pdf]

ActionAid International USA. 2006. "Cancelling the Caps: Why the EFA movement must confront wage bill caps now." Washington, D.C. [http://www.campaignforeducation.org/resources/Nov2006/Cancelling%20the%20Caps.pdf]

ActionAid International USA. 2007. "Confronting the Contradictions: The IMF, wage bill caps, and the case for teachers." Washington, D.C. [http://www.actionaid.org/assets/pdf%5CAAConf_Contradictions_Final2.pdf]

Adam, Christoper, and David Bevan. 2001. "Fiscal Policy Design in Low-Income Countries." Paper prepared for the UNU/WIDER research project on "New Fiscal Policies for Poverty Reduction and Growth, Helsinki, November 2000. Oxford.

Adam, Christoper, and David Bevan. 2004. "Aid and the Supply Side: Public Investment, Export Performance and Dutch Disease in Low-Income Countries." Department of Economics Discussion Paper Number 201. Oxford University, Oxford. [http://www.economics.ox.ac.uk/Research/wp/pdf/paper201.pdf]

Adam, Christoper, and David Bevan. 2005. "Fiscal Deficits and Growth in Developing Countries." *Journal of Public Economics* 89 (2005): 571-597.

Barder, Owen. 2006a. "A Policymakers' Guide to Dutch Disease." Working Paper Number 91. Center for Global Development, Washington, D.C. [http://www.cgdev.org/content/publications/detail/8709]

Barder, Owen. 2006b. "Are the planned increase in aid too much of a good thing?" Working Paper Number 90. Center for Global Development, Washington, D.C. [http://www.cgdev.org/content/publications/detail/8633]

Bevan, David. 2005. "An Analytical Overview of Aid Absorption: Recognizing and Avoiding Macroeconomic Hazards." Paper prepared for the Seminar on Foreign Aid and Macroeconomic Management. Maputo. [http://www.imf.org/external/np/seminars/eng/2005/famm/pdf/bevan.pdf]

Bevan , David. 2007. "Promoting and Protecting High-Priority Expenditures." Background Paper to the Working Group on IMF Programs and Health Expenditures. Oxford University, Oxford. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

Bourguignon, François and Mark Sundberg. 2006. "Constraints to Achieving the MDGs with Scaled-Up Aid." Working Paper Number 15. UN Department of Economic Affairs (DESA), New York. [http://www.un.org/esa/desa/papers/2006/wp15_2006.pdf]

Cabral, L, A Cumbi, S. Vinyals, et al. 2005. "Study of 'off-budget' in the health sector." Final Report. Government of Mozambique.

Celasun, Oya, and Jan Walliser. 2005. "Predictability of Budget Aid: Experiences in Eight African Countries." Paper prepared for the World Bank practitioners' forum on budget support. Cape Town.

Celasun, Oya and Jan Walliser. 2007. "Predictability and procyclicality of aid: Do fickle donors undermine economic development?" Preliminary version of a paper prepared for the 46th Panel Meeting of Economic Policy in Lisbon. International Monetary Fund and World Bank, Washington, D.C.

Chowdhury, Anis, and T. McKinley. 2006. "Gearing Macroeconomic Policies to Manage Large Inflows of ODA: The Implications for HIV/AIDS Programmes." Working Paper Number 17. UNDP International Poverty Center, New York. [http://www.undp-povertycentre.org/newsletters/WorkingPaper17.pdf]

Christiansen, Karin, David Goldsbrough, and Tom Leeming. 2007. "IMF Programs and Health Spending: Case Study of Rwanda." Background Paper to the Working Group on IMF Programs and Health Expenditures. Overseas Development Institute, London and the Center for Global Development, Washington, D.C. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

Clements, Benedict, Sanjeev Gupta Sanjeev, and Gabriela Inchauste. eds. 2004. *Helping Countries Develop: The Role of Fiscal Policy.* International Monetary Fund, Washington, D.C.

Commission on Macroeconomics and Health. 2001. *Macroeconomics and Health: Investing in Health for Economic Development.* Final Report. World Health Organization, Geneva. [http://www.cid.harvard.edu/cidcmh/CMHReport.pdf]

de Renzio, Paolo, and David Goldsbrough. 2007. "IMF Programs and Health Spending: Case Study of Mozambique." Background Paper to the Working Group on IMF Programs and Health Expenditures. Overseas Development Institute, London, Oxford University, Oxford, and the Center for Global Development, Washington, D.C. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

Devarajan, Shantayanan and Delvin S. Go. 2002. "A Macroeconomic Framework for Poverty Reduction Strategy Papers with an application to Zambia" in: Bourguignon, François and Luiz A. Pereira da Silva (eds.) 2002. *The Impact of Economic Policies on Poverty and Income Distribution*. World Bank, Washington, D.C. [http://www.csae.ox.ac.uk/conferences/2002-UPaGiSSA/papers/Devarajan-csae2002.pdf]

Dinh, Hinh T., Abebe Adunga, and C. Bernard Myers. 2002. "The Impact of Cash Budgets on Poverty Reduction in Zambia: a Case Study of the conflict between well-intentioned macroeconomic policy and service delivery to the poor." Policy Research Working Paper 2913. World Bank, Washington, D.C. [http://papers.ssrn.com/sol3/papers.cfm?abstract_id=636276]

Easterly, William. 2005. "How to assess the needs for aid? The answer: Don't ask." Paper prepared for Third AFD/EUDN Conference: Financing Development: What Are the Challenges in Expanding Aid Flows? Paris.

Eifert, Benn and Alan Gelb. 2005. "Improving the Dynamics of Aid: Toward More Predictable Budget Support." Policy Research Working Paper 3732. World Bank, Washington, D.C.

Evans, Alison, Laure-Hélène Piron, Zaza Curran, et. al. 2006. "Independent Evaluation of Rwanda's Poverty Reduction Strategy 2002-2005 (PRSP1): Final Report February 2006." Overseas Development Institute and Institute of Development Studies, London. [http://www.odi.org.uk/PPPG/cape/publications/ae_Independent_Evaluation_Rwanda_PRS.pdf]

Evans, David B, Ajay Tandon, Christopher J L Murray, et. al. "Comparative efficiency of national health systems: cross national econometric analysis." *British Medical Journal* 323 (2001): 307-310.

Fiess, Norbert. 2005. "Chile's Fiscal Rule" in: Burnside, Craig (ed.) *Fiscal Sustainability in Theory and Practice: A Handbook*. World Bank, Washington, D.C.

Fedelino, Annalisa, Gerd Schwartz, and Marijn Verhoeven. "Aid Scaling Up: Do Wage Bill Ceilings Stand in the Way?." Working Paper 06/106. International Monetary Fund, Washington, D.C. [http://www.internationalmonetaryfund.org/external/pubs/ft/wp/2006/wp06106.pdf]

Foster, Mick. 2002. "Direct Budget Support to Mozambique: Report to the Department for International Development." Mick Foster Economics, Ltd, Essex, England.

Goldsbrough, David. 2006. "The Nature of the Debate Between the IMF and its Critics." Background Paper to the Working Group on IMF Programs and Health Expenditures. Center for Global Development, Washington, D.C. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

Goldsbrough, David. 2007. "The IMF and Constraints on Spending Aid." One Pager Number 35. International Poverty Centre, UNDP, Brasilia. [http://www.undp-povertycentre.org/pub/IPCOnePager35.pdf]

Goldsbrough, David and Ben Elberger. 2007. "What Have IMF Programs With Low-Income Countries Assumed About Aid Flows?" Working Paper 116 and Background Paper to the Working Group on IMF Programs and Health Expenditures. Center for Global Development, Washington, D.C. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

Goldsbrough, David and Caesar Cheelo. 2007. "IMF Programs and Health Spending: Case Study of Zambia." Background Paper to the Working Group on IMF Programs and Health Expenditures. Center for Global Development, Washington, D.C. and University of Zambia, Lusaka. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

Goldsbrough, David, Ehui Adovor, and Ben Elberger. 2007a. "Inflation Targets in IMF-Supported Programs." Background Paper to the Working Group on IMF Programs and Health Expenditures. Center for Global Development, Washington, D.C. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

————. 2007b. "What Has Happened to Health Spending and Fiscal Flexibility in Low-income Countries with IMF Programs?" Background Paper to the Working Group on IMF Programs and Health Expenditures. Center for Global Development, Washington, D.C. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

Gupta, Sanjeev, Robert Powell, and Yongzheng Yang. 2006. "Macroeconomic Challenges of Scaling Up Aid to Africa: A Checklist for Practitioners." Handbook prepared by the Policy Wing of the IMF's African Department. International Monetary Fund, Washington, D.C. [http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf]

Heller, Peter. "Back to Basics: Pedantry or Prudence: How Does the IMF Account for Fiscal Space?" *Finance & Development* 41 (2004): 28-29.

Heller, Peter. 2005. "Understanding Fiscal Space." Policy Discussion Paper 05/4. International Monetary Fund, Washington, D.C. [http://www.imf.org/external/pubs/ft/pdp/2005/pdp04.pdf]

Hanson, Kara, M. Kent Ranson, Valeria Oliviera-Cruz, et al. "Expanding access to priority health interventions: a framework for understanding the constraints to scaling up." *Journal of International Development* 15 (2003): 41-65.

High-Level Forum on the Health MDGs. 2005. "Fiscal Space and Sustainability From the Perspective of the Health Sector." Background Paper for the November 2005 Meeting of the High Level Forum. Paris. [http://www.hlfhealthmdgs.org/Documents/FiscalSpacePerspective.pdf]

————. 2005b. "Fiscal Space and Sustainability: Towards a Solution for the Health Sector, Background Paper for the November 2005 Meeting." Paris. [http://www.hlfhealthmdgs.org/Documents/FiscalSpaceTowardsSolution.pdf]

Hudson, Alan and Claire Wren. 2007. "Parliamentary strengthening in developing countries." Report for DfiD. Overseas Development Institute and One World Trust, London.

Independent Evaluation Office, International Monetary Fund. 2003. *Evaluation Report: Fiscal Adjustment in IMF-Supported Programs.* Washington, D.C. [http://www.ieo-imf.org/eval/complete/pdf/09092003/all.pdf]

————. 2004. *Evaluation of the IMF's Role in Poverty Reduction Strategy Papers and the Poverty Reduction and Growth Facility.* Washington, D.C.

————. 2007. *An Evaluation of the IMF and Aid to Sub-Saharan Africa*. Washington, D.C. [http://www.imf.org/external/np/ieo/2007/ssa/eng/pdf/report.pdf]

Independent Evaluation Office, International Monetary Fund and Operations Evaluation Department, World Bank. 2004. *Republic of Mozambique: Evaluation of the Poverty Reduction Strategy Paper (PRSP) Process and Arrangements Under the Poverty Reduction and Growth Facility (PRGF).* Washington, D.C. [https://www.imf.org/External/NP/ieo/2004/prspprgf/eng/moz2.pdf]

International Monetary Fund (IMF). 1996. *Reinvigorating Growth in Developing Countries: Lessons from Adjustment Policies in Eight Economies.* Occasional Paper 139. Washington, D.C.

————. 2004a. "A Response to ActionAid International and Other Organizations." Washington, D.C. [www.imf.org/external/np/vc/2004/093004.htm].

————. 2004b. *Operational Framework for Debt Sustainability in Low-Income Countries—Implications for Fund Program Design.* Washington, D.C. [http://www.imf.org/external/np/pdr/sustain/2004/091304.pdf]

————. 2005a. *The Federal Democratic Republic of Ethiopia: 2004 Article IV Consultation and Sixth Review Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility—Staff Report; Staff Statement; and Public Information Notice and Press Release on the Executive Board Discussion.* Washington, D.C. [http://www.imf.org/external/pubs/ft/scr/2005/cr0525.pdf]

————. 2005b. "Mali—Staff Report for the 2005 Article IV Consultation, Second and Third Review Under the Poverty Reduction and Growth Facility, and Request for Waiver of Nonobservance of Performance Criteria." Washington, D.C. [www.imf.org/external/pubs/scr/2006/cr0673.pdf]

————. 2005c. *Monetary and Fiscal Policy Design Issues in Low-Income Countries*. Washington, D.C.

————. 2006a. *Republic of Madagascar: Request for a Three-Year Arrangement Under the Poverty Reduction and Growth Facility and Activation of the Trade Integration Mechanism - Staff Report; Staff Statement; Press Release on the Executive Board Discussion; and Statement by the Executive Director for Republic of Madagascar.* Washington, D.C. [http://www.imf.org/external/pubs/ft/scr/2006/cr06306.pdf]

————. 2006b. *Zambia: 2005 Article IV Consultation, Third Review Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility, Request for Waiver and Modification of Performance Criterion, and Financing Assurances Review— Staff Report; Public Information Notice and Press Release on the Executive Board Discussion; and Statement by the Executive Director for Zambia.* Washington, D.C. [http://www.imf.org/external/pubs/ft/scr/2006/cr0639.pdf]

————. 2006c. *Ghana: Fourth and Fifth Reviews Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility and Request for Waiver of Nonobservance of Performance Criteria—Staff Report; and Press Release on the Executive Board Discussion for Ghana*. Washington, D.C. [http://imf.org/external/pubs/ft/scr/2006/cr06228.pdf]

————. 2006d. *Designing Monetary and Fiscal Policy in Low-Income Countries*. Occasional Paper 250. Washington, D.C.

————. 2006e. *Federal Democratic Republic of Ethiopia: Selected Issues and Statistical Appendix.* Washington, D.C. [http://www.imf.org/external/pubs/ft/scr/2006/cr06122.pdf]

International Monetary Fund and World Bank. 2004. *Debt Sustainability in Low-Income Countries—Proposal for an Operational Framework and Policy Implications.* Washington, D.C. [http://www.imf.org/external/np/pdr/sustain/2004/020304.pdf]

Isard Peter, Leslie Lipschitz, Alexandros Mourmouras, et al. eds. 2006. *The Macroeconomic Management of Foreign Aid*. Papers presented at a high-level seminar on Foreign Aid and Macroeconomic Management held in, Maputo. International Monetary Fund, Washington, D.C. [http://www.imf.org/External/Pubs/NFT/2006/mmfa/eng/mmfa.pdf]

Lawson, Andrew, Paolo de Renzio, and Miriam Umarji. 2006b. "Assessment of Public Finance Management in Mozambique 2004/2005: Based on PEFA methodology." Overseas Development Institute, London and SAL Consultoria e Investimentos Lda, Maputo. [http://www.pap.org.mz/downloads/pefa_final_report2006_eng.pdf]

Lewis, Maureen. 2005. "Addressing the Challenge of HIV/AIDS: Macroeconomic, Fiscal, and Institutional Issues." Working Paper 58. Center for Global Development, Washington, D.C. [http://www.cgdev.org/content/publications/detail/2730]

Mackinnon, John, Anne Thomson, Ida Hakizinka, et. al. 2003. "Poverty and Social Impact Assessment: The impact of increases in public expenditure in Rwanda." Powerpoint Presentation. [http://www.prspsynthesis.org/rwandapresentation.ppt]

Martin, Ricardo, and Alex Segura-Ubiergo. 2004. "Social Spending in IMF-Supported Programs." IEO Background Paper 04/1. Independent Evaluation Office, IMF, Washington, D.C. [http://www.ieo-imf.org/pub/background/pdf/BP041.pdf]

Medecins Sans Frontieres. 2007. "Help Wanted: Confronting the health care worker crisis to expand access to HIV/AIDS treatment: MSF experience in southern Africa." Johannesburg. [http://www.msf.org/source/countries/africa/southafrica/2007/Help_wanted.pdf]

Mishra, Prachi and David Newhouse. 2007. "Health Aid and Infant Mortality." Working Paper 07/100. International Monetary Fund, Washington, D.C. [http://www.imf.org/external/pubs/ft/wp/2007/wp07100.pdf]

Ooms, Gorik, Wim van Damme, and Marlene Temmerman. "Medicines without Doctors: Why the Global Fund Must Fund Salaries of Health Workers to Expand AIDS Treatment." *PLoS Medicine* 4 (2007): 605-608. [http://medicine.plosjournals.org/archive/1549-1676/4/4/pdf/10.1371_journal.pmed.0040128-L.pdf]

Oxfam International. 2003. "The IMF and the Millennium Development Goals: Failing to deliver for low-income countries." Briefing Paper 54. Oxford. [http://www.oxfam.org.uk/what_we_do/issues/debt_aid/downloads/ bp54_imfmdgs.pdf]

Oxfam International. 2007. "Paying for People: Financing the skilled workers needed to deliver health and education services for all." Briefing Paper 98. Oxford. [http://oxfam.intelli-direct.com/e/d.dll?m=235&url=http://www.oxfam.org/en/files/bp98_paying_for_people.pdf/download]

Pollin, Robert, and Andong Zhu. "Inflation and economic growth: a cross-country non-linear analysis." *Journal of Post Keynesian Economics* 28 (2006): 593-614.

Sachs, Jeffrey, John W. McArthur, Guido Schmidt-Traub, et. al. 2004. "Ending Africa's Poverty Trap." Brookings Papers on Economic Activity 1:2004. Brookings Institution, Washington, D.C. [http://www.unmillenniumproject.org/documents/BPEAEndingAfricasPoverty TrapFINAL.pdf]

Thomas, Alun. 2006. "Do Debt-Service Savings and Grants Boost Social Expenditures?" Working Paper 06/180. International Monetary Fund, Washington, D.C. [http://www.imf.org/external/pubs/ft/wp/2006/wp06180.pdf]

Walters, Bernard. 2007. "The Fiscal Implications of Scaling Up ODA to Deal with the HIV/AIDS Epidemic." International Poverty Centre, Conference Paper Number 3. Brasilia. [http://www.undp-povertycentre.org/pub/IPCConferencePape003.pdf]

Wemos. 2006. "IMF Macroeconomic Policies and Health Sector Budgets." Amsterdam. [http://www.wemos.nl/Documents/wemos_synthesis_report_final.pdf]

World Bank. 2006. *World Development Report 2006: Equity and Development.* Washington, D.C. [http://go.worldbank.org/XP2234QDV0]

World Health Organization. 2000. *The World Health Report 2000: Health Systems: Improving Performance.* Geneva. [http://www.who.int/whr/2000/en/whr00_en.pdf]

World Health Organization. 2006. *The World Health Report 2006: Working Together for Health*. Geneva. [http://www.who.int/whr/2006/whr06_en.pdf]

Appendix 2. Working Group Members

K.Y. Amoako was until recently a Distinguished Africa Policy Scholar for the Global Health Initiative at the Woodrow Wilson International Center for Scholars. He was the former Executive Secretary of the United Nations Economic Commission for Africa (ECA). He led the organization, the regional arm of the United Nations in Africa at the rank of Under-Secretary-General of the United Nations since 1995. Prior to that, he held a number of senior positions in the World Bank, including as Director of the Education and Social Policy Department. He has a PhD in economics from the University of California at Berkeley.

Anupam Basu recently retired as Deputy Director of the African Department of the IMF where he was responsible for the supervision of the department's policy wing and work on countries of Eastern and Southern Africa. Since joining the Fund in 1971, Mr. Basu has worked extensively on African countries and has also held senior positions in the Fund's Policy Development and Review Department, where he was involved in the review of ESAF programs.

Lola Daré is a community physician and medical epidemiologist. She is also the founding member and current executive secretary of the African Council for Sustainable Health Development (ACOSHED), a unique partnership between governments, civil society, and development partners. Working with the tools of advocacy, information dissemination and operations research, ACOSHED works through country chapters to hold governments to their commitments to health and sustainable development. Dr. Daré is also chief executive officer for the Center for Health Sciences Training and Research and Development (CHESTRAD), and has been involved in research design, implementation, and evaluation in the field of reproductive health.

Alan Gelb is the Director, Development Policy, Development Economics at the Vice President's Office of the World Bank. Before assuming his current position in July 2004, he was the Bank's Chief Economist for Africa. Prior to that, he was staff director of the 1996 World Development Report, *From Plan to Market*, and chief of the transition division in the Bank's policy research department. He is a specialist on transition economies, financial systems, macroeconomic management, commodity prices, and the economics and political economy of oil-exporting countries. He has published several books and scholarly articles on these and related subjects, and co-authored an authoritative study on African development *Can Africa Claim the 21st Century?*

David Goldsbrough joined CGD as a Visiting Fellow in April 2006. He was Deputy Director of the Independent Evaluation Office (IEO) of the IMF from its foundation in August 2001 until March 2006. During this period, he was the project leader and principal author of evaluations of the Prolonged Use of IMF Resources; the IMF Role in Poverty Reduction Strategy Papers (PRSP) and the Poverty Reduction and Growth Facility (PRGF); and Financial Sector Assessment Programs . Before joining the IEO, Mr. Goldsbrough was Deputy Director of the IMF Western Hemisphere Department, in charge of IMF work on the U.S. and Canada and a number of countries in Latin America and the Caribbean. Prior to that, he held senior positions in the Asian Department, heading missions to Japan, India, and Indochina. He has also worked in the IMF African department and, prior to joining the IMF, was an Overseas Development Institute (ODI) fellow in Swaziland. He is the author of a number of articles on macroeconomic policy, IMF program design, and the role of foreign direct investment. He has a PhD in economics from Harvard University

Jo Marie Griesgraber is Director of the New Rules for Global Finance Coalition. Previously, she served as the Policy Director at Oxfam America. Prior to that, Dr. Griesgraber directed the Rethinking Bretton Woods Project at the Center of Concern, a Jesuit-related social justice research center. There she worked on reform of the World Bank, regional development banks, and the IMF in part by disseminating information to Lead Regional Partners (LRP) in Latin America, Africa, and South Asia. She also chaired Jubilee 2000/USA's Executive Committee. Dr. Griesgraber received her PhD in Political Science from Georgetown University.

Kara Hanson is a Senior Lecturer in Health Economics and a health economist with the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine. She has worked on health

systems organization and financing as well as the economics of delivering mlaria control interventions since 1988, mostly in sub-Saharan Africa. She has been involved in research on hospital sector reforms in Zambia and Uganda. Dr. Hanson is also interested in the role of the private sector in health systems, and identifying the opportunities and limitations of the private sector in improving the efficiency, quality, and responsiveness of health systems. She was recently appointed Director of the DFID-sponsored Consortium for Research on Equity and Health Systems.

Peter Heller is a long-standing expert on fiscal policy issues and recently retired from the position of Deputy Director of the Fiscal Affairs Department of the IMF. He is a former member of the WHO's Commission for Macroeconomics and Health and a current member of the Task Force on Poverty and Economic Growth of the UN Millennium Project. Dr. Heller is the author of numerous articles on fiscal policy issues, including on the health sector. He is a former Professor of Economics at the University of Michigan.

Maureen Lewis is Advisor to the Senior Vice President for Human Development at the World Bank and a Non-resident Fellow at the Center for Global Development, where she was recently a Senior Fellow for two years. She specializes in the economics of health and education. Much of her research, publications, and policy work examine governance and corruption concerns in the health sector. She was formerly Chief Economist of the Human Development Network of the World Bank and, prior to that, managed a unit in the Bank dedicated to economic policy and human development research and programs in Eastern Europe and Central Asia. Before joining the World Bank, she established and directed the International Health and Demographic Policy Unit at the Urban Institute. An Adjunct Professor in the George Washington University Graduate Program, she has published dozens of articles in peer-reviewed journals on health and population. She earned her PhD at Johns Hopkins University.

Nora Lustig is currently the Director of the Institute of Studies on Sustainable Development and Social Equity and Professor of Economics at the Universidad Iberoamericana in Mexico City. Previously she was Director of the Poverty Group at UNDP in New York; President of the Universidad de les Americas, Puebla; Professor of Economics at the Universidad de les Americas; and Senior Advisor on Poverty and Chief of the Poverty and Inequality Unit at the Inter-American Development Bank. She co-directed the World Bank's World Development Report 2000/2001 *Attacking Poverty*. Dr. Lustig has published extensively in the fields of economic development and determinants of poverty and inequality.

Maurice Middleberg is the Vice President for Public Policy at the Global Health Council. He is responsible for ensuring that the Council is an effective advocate for improved global health by increasing decision-makers' access to the best available evidence and providing a platform for dialogue. Mr. Middleberg has been working in the field of global health for more than 23 years as an executive, program manager, analyst, advocate, teacher, and writer. Prior to coming to the Global Health Council, Mr. Middleberg served as Executive Vice President of EngenderHealth, Director of Health for CARE, Director of the Options for Population Policy Program, Population Program Coordinator for USAID/Niger, and Senior Research Associate at The Futures Group. He has also held academic appointments at the Columbia University Mailman School of Public Health and the Emory University Rollins School of Public Health.

Mary Muduuli is currently the Operations Officer at the World Bank Country Office in Uganda. She is the former Deputy Secretary to the Treasury at the Ministry of Finance, Planning and Economic Development, Uganda.

Anthony Akoto Osei is currently the Deputy Minister for Finance and Economic Planning in Ghana, as well as the Member of Parliament for Tafo**.**

Sara Sievers is the Senior Program Officer, Developing Country Advocacy, at the Bill and Melinda Gates Foundation**.** Before taking up her present position, Ms. Sievers directed policy, research, and advocacy for the Association Francois-Xavier Bagnoud (FXB), a global voice for children living with HIV/AIDS. Previously, Ms Sievers served as founding Executive Director of both the Center for Globalization and Sustainable

Development at Columbia University and the Center for International Development at Harvard University. She is a former U.S. Foreign Service Officer and has an MBA from MIT.

Ellen Verheul is the Team Manager for Advocacy at Wemos, a Dutch NGO focused on health and development issues. She is the author of numerous articles on health and poverty issues and was the project manager of reviews of Health and Poverty Reduction Strategies and IMF macroeconomic policies and health sector budgets, and supporting health budget advocacy initiatives in developing countries.

Endnotes

[1] See, for example, ActionAid (2004, 2005, and 2007) and Oxfam (2003 and 2007) and the response by the Director of External Relations of the IMF to ActionAid (IMF, 2004a).
[2] The only exception is when programs include minimum targets for spending in some priority areas.
[3] The judgments expressed in the background papers are the responsibility of the authors of those papers.
[4] For a more detailed description of the nature of IMF-supported programs, see IMF (2006).
[5] If any performance criterion is missed, the program is automatically interrupted unless the IMF Board gives a waiver. Programs also contain "benchmarks", which are targets that are monitored to see if the program is on track but do not lead to automatic program interruption if missed.
[6] For example, the World Development Report (2004) did not find a statistically significant relationship between total government health spending and various health outcomes, after controlling for the effects of per capita income. In contrast, Mishra and Newhouse (2007) concluded that health aid had a statistically significant positive effect on infant mortality rates. They estimated that a doubling of health aid would lower infant mortality rates by 2 percent, which is small relative to the goals of the MDGs.
[7] See World Health Report 2000: Health Systems: Improving Performance. Evans et al (2001) suggest that performance of health systems increased substantially as per capita spending rose to about US$80 per capita.
[8] The original estimates by the UN Commission on Macroeconomics and Health of the minimum level of spending to support a basic health package was US$34 per head, which would be the equivalent of about US$40 per head at today's prices (personal communication with Jeffrey Sachs).
[9] Moreover, many different concepts of government health spending are in use, even within the same country, and different commentators often have different measures in mind. See, for example, the detailed discussion of the different measures of government health spending in Zambia in the background paper on the case study.
[10] The definition of "low-income countries" used here includes those that are eligible to use the IMF concessional (PRGF) resources.
[11] Surprisingly, the decline in government health spending in the mid-1990s did not coincide with the peak period of fiscal consolidation in low-income countries which occurred in the early 1990s, at the same time that social spending was reaching its peak (Thomas, 2006).
[12] At the 2001 African Summit on HIV/AIDS, tuberculosis and other related infectious diseases, member governments of the Organization of African Unity set a target of allocating at least 15 percent of their annual budget to the improvement of the health sector.
[13] PRGF eligibility is based primarily on the IMF assessment of a country's per capita income, drawing on the cut-off point for eligibility to World Bank concessional lending (currently a 2003 per capita gross national income of US$895). As of September 2005, 78 countries were PRGF-eligible. Coverage is similar to the World Bank classification of Low-Income Countries but also includes some countries classified by the World Bank as Lower Middle Income (e.g., Bolivia and Lesotho). For further details, see the IMF's Factsheet on the PRGF, available at www.imf.org.
[14] Weighted by population; excludes India.
[15] Excluding India. The results are very similar if weighted by GDP.
[16] See Section 3.5 of High Level Forum, 2005a. Since, as Table 1 shows, low-income countries typically spend about 2.5 percent of GDP on government health spending, this implies that higher aid does increase the total share of spending going to health, but by much less than the share of development aid commitments earmarked for the health sector.
[17] See also Walters (2007) and Gupta et al. (2005) for recent reviews of many of the issues.
[18] One reason why the positive effects of fiscal consolidation on private investment are often weaker than anticipated is that it can take the private sector and domestic credit markets considerable time to recover in "post-stabilization" phases. This can have major implications for the conduct of fiscal policy during such periods:

> "Realistically there is likely to be a recovery phase in which the private sector occupies less 'economic space' than it would in a more equilibrium configuration. The balance between government expenditures and any associated deficit financing may be struck differently during such a phase than they will subsequently" (Adam and Bevan, 2001).

[19] Others include Ghana (IMF, 2006c) and Mali (IMF, 2005b). We were also told that such an analysis for Mozambique is now in the pipeline.

[20] The IEO used the inflation rate as a proxy for the test of domestic macro stability because data on domestic debt levels were not available on a consistent basis for all of the program countries investigated. However, the level of domestic debt was probably the critical determinant of choices on the fiscal path.
[21] The data used by the IEO does not include domestic debt, so the inflation rate was used as the main indicator for full macroeconomic stability.
[22] The six countries with large targeted increase in spending were the Democratic Republic of Congo, Guinea, Guinea-Bissau, Guyana, Madagascar, and Sierra Leone. The seven countries where large declines in spending were targeted were Ethiopia, Kyrgyz Republic, Lesotho, Macedonia, Malawi (2001 program), Nicaragua and Sao Tome and Principe.
[23] Rwanda had qualified for interim debt relief when it reached the "decision point" under the Enhanced HIPC Initiative in December 2000, but continuation of an IMF arrangement in good standing was one of the conditions for such relief and for progressing to the "completion point."
[24] MINECOFIN officials acknowledge that several of the issues raised in the IMF's rejection of the PRSP costing scenarios (Dutch Disease, domestic demand impact, etc.) were not previously discussed. The PSIA was therefore seen as an opportunity for the government to develop better and more realistic macroeconomic scenarios.
[25] The UK Department for International Development (DfID) supported demonstration studies in six countries to provide *ex ante* analysis of the likely poverty and social impact of particular policies. The Rwanda PSIA was one of these studies.
[26] As discussed in the background paper on "The Nature of the Debate between the IMF and Its Critics," the strength of "crowding out" effects as higher deficits displace private investment through higher interest rates can vary substantially depending on country circumstances. IMF programs tend to overestimate the speed at which a reverse "crowding in" will take place as deficits are reduced. In particular, it can take private demand for domestic credit considerable time to recover in "post-stabilization" phases, which has important consequences for the conduct of fiscal policy.
[27] In interviews, IMF staff indicated that, drawing on World Bank analysis, they had also been concerned that a potential failure of a state-owned bank would entail significant quasi-fiscal costs requiring additional domestic debt to be issued.
[28] A recent IMF technical assistance report made a number of suggestions for broadening the tax base but some have proved controversial.
[29] In interviews, many senior IMF staff said that they regarded the challenge of integrating such information as the most difficult problem they faced in undertaking assessments of various scaling-up options, especially if the necessary information was lacking or incomplete, as it usually was, including in Zambia.
[30] Net aid is defined as grants plus loans minus amortization actually paid. For further details, see the background paper "What Have IMF Programs With Low-Incomes Countries Assumed About Aid Flows?" The paper is also available as a CGD Working Paper at www.cgdev.org
[31] These conclusions are based on regression results that are explained more fully in the background paper.
[32] The outcomes data is partially estimated, i.e., based on the latest updates in IMF program documents.
[33] For example, a report by a consultant commissioned by the UK's DfID concluded that, "If additional external support could be made available on acceptable terms, Mozambique could in principle make good use of it, either to accelerate expenditure growth if absorptive capacity permits, or to increase reserves or reduce taxation if it does not" Foster (2002). The report went on to call for a "high case" aid scenario on the grounds that, "donors will react to bids which the Government develops for their support. The PARPA sends the message that donors are neither expected nor invited to even maintain existing levels of support in real terms, let alone increase them. In these circumstances, donors can be expected to commit their resources elsewhere."
[34] Part of the recorded increase in aid reflected more aid-related activities being brought on budget.
[35] These adjustors are most important in the period between reviews of the program, which typically take place every six months. However, given the need for long lead times to commit certain types of expenditures, their effects can be significant.
[36] See the background paper on "Inflation Targets in IMF-Supported Programs" for a brief review of the evidence. Pollin and Zhu (2006) give some recent cross-country estimates and discuss the arguments in favor of somewhat higher inflation targets in low-income countries.
[37] For example, the small size of the so-called inflation tax in low-income countries is recognized by both the IMF and its critics (e.g., ActionAid, 2005 and 2006) and does not seem to be the main source of disagreements over the appropriate level of inflation targets. The revenue generated by money creation—called *seigniorage*—comes from the fact that those who hold currency or similar domestic claims on the central bank are giving an interest-free loan

to the bank. This is transferred to the government as central bank profits or below-market loans. Total *seigniorage* earnings have typically been in the range of 1 to 1½ percent of GDP for low-income countries not experiencing very rapid inflation. Adam and Bevan (2005) identify a "threshold" effect beyond which higher *seigniorage* tends to have a negative effect on growth, at about 1¼ percent of GDP, but note that these effects depend on how the resources are used.

[38] Among the case studies, the coordination of monetary, exchange rate, and fiscal policy has been especially problematic in Rwanda. In light of the authorities' reluctance to allow a nominal appreciation of the exchange rate, the IMF program has used a reserve monetary ceiling to guide monetary policy, which tends to give too much weight to the inflation target in the event that some of the program assumptions turn out to be wrong.

[39] Zambia is one of the few cases in which IMF macroeconomic assessments attempted to estimate the likely magnitude of such effects. See the background paper on the Zambia case study, Section IIc.

[40] Staffing figures are taken from IEO (2004), page 73. Including staff from non-area departments regularly assigned to a country, but excluding resident representatives, average full time equivalent staff-years for a PRGF country in Africa was 2¾ and for a non-African country 3¼. IMF staff said that the number of staff working on Africa had increased moderately since then.

[41] The MTEF started to be presented to the Cabinet in Mozambique in 2007.

[42] Later in 2007, CGD's HIV/AIDS Monitor will be publishing a four-country study examining the degree to which three of the biggest AIDS donors—PEPFAR, the Global Fund, and the World Bank—fund programs through existing health sector systems or use new, parallel systems.

[43] See also the background paper by David Bevan, "Promoting and Protecting High-Priority Public Expenditures." Not all conclusions in the background paper were endorsed by the Working Group.

[44] The issue implies some form of system failure and gives rise to what economists refer to as a "second best" problem—i.e., how to mitigate the consequences of the failure. The general approach to second-best issues includes three precepts. First, it is preferable, if possible, to remove the original failure, as opposed to designing responses to it. Second, if that is not feasible, the designed response should generally be as "close" to the original failure as possible. Third, the nature of the original failure should be analyzed carefully to ensure that the response is appropriate to that failure.

[45] The background paper by Professor Bevan provides a taxonomy of the various possible mechanisms and discusses their potential advantages and disadvantages.

[46] For example, the fiscal rule adopted by Chile in 2000 was successful in stabilizing public expenditure as a whole, and, within this, social expenditure in aggregate. However, this reduced volatility in the aggregate did not translate to reduced volatility for all disaggregated, sector-level spending, such as on housing or health. See Fiess (2005) in Burnside (2005).

[47] For a discussion of these characteristics and a proposal for using them to help support spending on health sector wages, see Ooms, Van Damme, and Temmerman (2007).

[48] For the viewpoint of various critics of IMF wage bill ceilings, see ActionAid (2004 and 2007), Wemos (2004), and Medecins Sans Frontieres (2007). See also the response of the Director of the IMF's External Relations Department to the 2004 ActionAid report (IMF, 2004a).

[49] The 2005 assessment of Zambia's Public Financial Management system rated the effectiveness of its payroll controls at only a "D+."

[50] For example, (i) the increase in the wage bill by 0.2 percent of GDP in 2005 was to allow for the hiring of an additional 1,455 frontline health workers, to provide for a retention scheme for nurses and clinical staff, and some additional teacher hiring. (ii) The third review said the ceiling would allow for net recruitment of 2000 teachers and "retention of core health workers." (iii) The fourth review said the ceiling allowed for recruitment of an additional 4,578 teachers and 800 medical personnel that were included in the targets for overall poverty-reducing priority expenditures. In interviews, IMF staff said that the specific recruitment numbers in the health sector had typically been derived following discussions with the Ministry of Health to estimate the numbers graduating from medical training facilities.

[51] The wage bill ceilings for 2004-2005 incorporated an increase of 7,200 in the number of permanent positions in priority sectors (including about 1800 health care workers) out of a total increase for priority and non-priority sectors of 10,000. Program documents for the third and fourth reviews refer to the hiring of about 10,000 teachers and 2,000 additional health workers in 2006, justifying the revised projection of the wage bill rising from 7 to 7½ percent of GDP.

[52] Some payments of wages and allowances are included under other expenditure categories, which makes a full accounting, and any cross-country comparison, extremely difficult. The 2006 World Health Report suggests that the

average share of health spending on wages and salaries relative to general government expenditures in Africa was 29.4 percent (WHO, 2006).

[53] This is what the current Medium-Term Strategy of the IMF seems to suggest: in future, staff papers will not only assess whether macroeconomic policies support the MDGs, but will also frankly report the assessment of the World Bank and donors on the achievability of the MDGs under what the Fund would consider to be realistic macroeconomic scenarios and financing envelopes.

[54] For a recent review of external support for parliamentary strengthening and a summary of factors that are likely to influence the effectiveness of such support, see Hudson and Wren (2007). They emphasize the importance of external support that (i) responds to domestic demand; (ii) addresses specific causes of poor parliamentary performance; (iii) involves the recipients; (iv) focuses on particular issues, not just parliamentary procedures; and (v) provides long term sustainable support.