

**What Has Happened to Health Spending and Fiscal Flexibility
in Low Income Countries with IMF Programs?**

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Abstract

This paper examines what has happened to health expenditures and to overall fiscal targets in low-income countries with programs supported by the IMF. The focus is on programs under the Poverty Reduction and Growth Facility (PRGF), which is the IMF low-interest lending facility for low-income countries.

The authors find that government health spending has increased moderately since the late 1990s but that this has only been sufficient to reverse an earlier decline that took place in the mid-1990s. They also find that there were no major differences between recent trends in health spending as a share of GDP or as a share of total government spending in the groups of program and non-program countries outside of Africa. In sub-Saharan Africa, total government spending increased more in the group of program countries, but the differences are not large, especially in light of the size of external resources directed toward the health sector. Finally, they find that estimates of the impact of IMF-supported programs on health spending are complicated by a number of econometric difficulties but available estimates suggest little overall impact; at best, programs may be associated with a small and relatively short-lived increase in health spending but in practice it is not possible to distinguish between the effects of the IMF program and other factors such as HIPC debt relief.

On fiscal targets, the authors find that there has been some shift toward more expansionary fiscal programs but even in the latest (2003-2006) period most programs targeted relatively small increases in the deficit that tapered off by the end of the 3-year periods. The same pattern occurred in projections of grants: a moderate increase in the first year of the program which disappears by the third year. Whether this represents sufficient fiscal flexibility depends on judgments regarding likely financing prospects as well as the uses and effects of additional government expenditures. These questions can only be answered taking into account the circumstances in each country. But the assumed rapid tapering of higher grant aid by the end of the 3-year program does seem to reflect a conservative approach to balancing risks in the current environment of international commitments to increase overall aid flows.

This paper informed the deliberations of the Center for Global Development's Working Group on IMF Programs and Health Expenditures.

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This paper examines what has happened to health expenditures and to overall fiscal targets in low-income countries with programs supported by the IMF. The focus is on programs under the Poverty Reduction and Growth Facility (PRGF), which is the IMF low-interest lending facility for low-income countries. The PRGF replaced the earlier Enhanced Structural Adjustment Facility (ESAF) in 1999 and was intended to give a more central role to pro-poor growth considerations in the design of programs, linked to country-driven Poverty Reduction Strategies. Box 1 summarizes seven key features that were intended to distinguish PRGF-supported programs. In particular, programs were intended to incorporate greater fiscal flexibility and to incorporate budgets that were more pro-poor and pro-growth. Of course, “pro-poor” and “pro-growth” are fairly general terms and do not necessarily imply higher spending in a specific area or any particular path for the fiscal deficit. However, the emphasis given to greater fiscal flexibility suggests that there could be less focus on fiscal consolidation, at least in countries that had already achieved a considerable measure of macroeconomic stability. Similarly, the emphasis given to channeling debt relief to increased poverty-reducing spending suggests that the share of social expenditures would increase.¹ It is useful to examine what actually happened to health spending and fiscal targets in IMF-supported programs under the PRGF in this light.

1. What Happened to Health Spending?

Information on health spending is weak in many low-income countries, with frequent gaps in coverage and changes in definitions, reflecting underlying problems with the national expenditure monitoring and statistical frameworks. However, the two main data sources, from the WHO and from the IMF Fiscal Affairs Department, show a similar picture with regard to overall developments in government health expenditures.² We begin with a brief summary of longer-term trends before turning to more recent developments. Since we are examining what has happened to health spending in countries with IMF-supported programs, the focus is on the group of countries that are eligible for the PRGF.³

a. Long-term trends

Available information on developments since 1985, taken from the IMF database, indicate that health spending in relation to GDP rose quite rapidly through the early-

¹ The debt relief initiative for Heavily Indebted Poor Countries (HIPC) was first introduced in 1996, with the aim of using savings from debt service reductions to increase government spending directed toward fighting poverty.

² See Appendix I for a description of the two data bases. A Working Group on Global Health Resource Tracking set up under CGD’s Global Health Resources Network has made a number of specific recommendations to improve information systems on financial flows to the health sector.

³ 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 \$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). See the IMF’s Fact sheet on the PRGF, available at www.imf.org, for further details.

Box 1. Key Features of PRGF-Supported Programs⁴

Broad participation and greater ownership

- The main elements of the PRGF are to be drawn from the country's Poverty Reduction Strategy paper (PRSP).
- PRSPs will be produced by country authorities in a transparent process with broad participation.

Embedding of the PRGF in the overall strategy for growth and poverty reduction

Budgets that are more pro-poor and pro-growth

- Government spending should be reoriented toward activities that benefit the poor.
- Efficiency and targeting of spending in key sectors relevant to growth and poverty reduction should be improved.
- Data and monitoring to track expenditures should be improved.

Appropriate flexibility in fiscal targets

- More normative macroeconomic projections to signal financing needs should be presented.
- Where warranted, commitments of higher aid flows should be sought and built into the program.
- The PSRP should be used to identify contingent expenditures that could be added if more aid were forthcoming.
- The program should indicate how fiscal targets would be modified in the event of key shocks.

More selective structural conditionality

Emphasis on measures to improve public resource management/accountability

- Fiscal policies and objectives should be open to public debate
- Transparent monitoring systems to improve efficient delivery of public services should be developed.

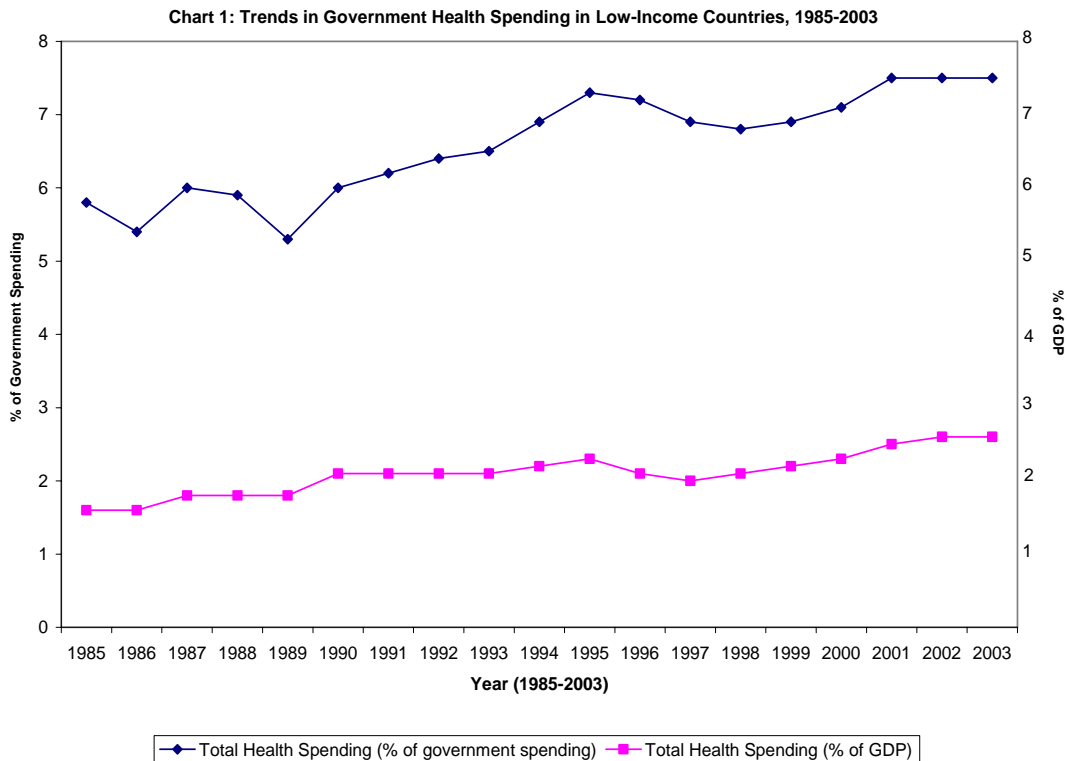
Social impact analysis of major macroeconomic adjustments and structural reforms

- The distributional effects of substantial macroeconomic adjustments or structural reforms should be considered.
- Countervailing measures to offset temporary adverse effects on the poor should be highlighted.
- The World Bank takes the lead if technical impact analysis is needed, but PRGF documents should indicate what work was done and how it influenced policies

1990s but then dropped in the mid-1990s (Chart 1).⁵ 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 2 ½ percent of GDP, in 2000-2001 and has not risen much above these levels subsequently. 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.

⁴ Derived from IMF (2000a) and IEO (2004).

⁵ 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 (see Thomas, 2006).



b. Developments during 1998-2005

We examine in more depth what has happened to health spending in the most recent period, from 1998 (the year prior to the introduction of the PRGF) to 2005, the most recent year for which data is available. We use here the information reported in the WHO database since it also includes estimates for total (public plus private) health spending. There are weaknesses in this database as well as in others so estimates for individual countries often vary depending on which source is used.⁶ The key trends were as follows:

- Average total health spending (public plus private) as a share of GDP in the group of all PRGF-eligible countries increased by about ½ percentage point over the period, reaching 5.5 percent of GDP (Chart 2 and Table 1). Average public spending on health, as a share of GDP, also increased moderately (from 2.5 percent to 2.9 percent).
- Private spending on health, primarily own-account spending by households, still accounts for about one half of total health spending in both groups.
- The average share of spending on health in total public expenditure rose, but only moderately, to a little over 9.6 percent in 2005 for the group of low-income countries and

⁶ The WHO database also includes more complete data for 2004-2005, although some of this is based on extrapolations from overall trends in government spending. The broad conclusions do not change if the IMF database had been used, although the ratios differ somewhat because of some differences in country coverage of the two databases and because of differences in definitions for individual countries. The WHO database attempts to maintain a common definition across countries, if necessary by estimating missing components whereas the IMF data omits some components (e.g., externally financed government health spending) if the data is not available. See Appendix 1 for a more detailed discussion of the two databases.

to 10.1 percent for Sub-Saharan Africa. Very few countries in Africa spend 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 (Chart 3).

- Average public spending per head on health for the low-income (i.e., PRGF-eligible) group of countries rose from \$28 in 1998 to \$44 in 2005 (at market exchange rates), but varies widely across countries (Chart 4). In most countries, public spending per capita is still far below levels estimated to be required to reach the health MDGs or even to ensure broad delivery of a basic package of health interventions.

Chart 2. Low Income Countries - Total and Government Health Expenditures (as a percent of GDP)

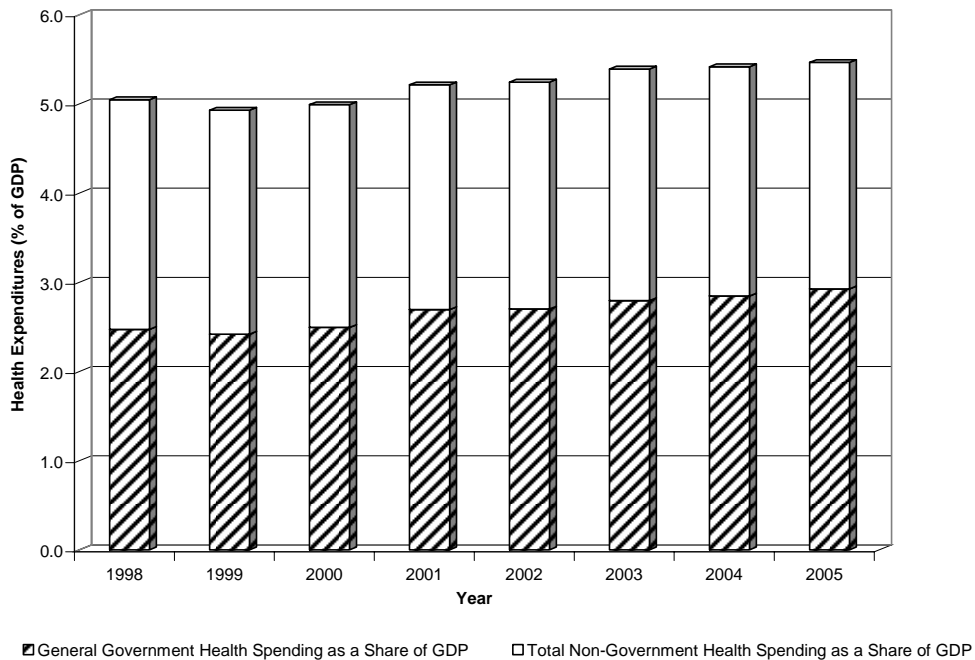
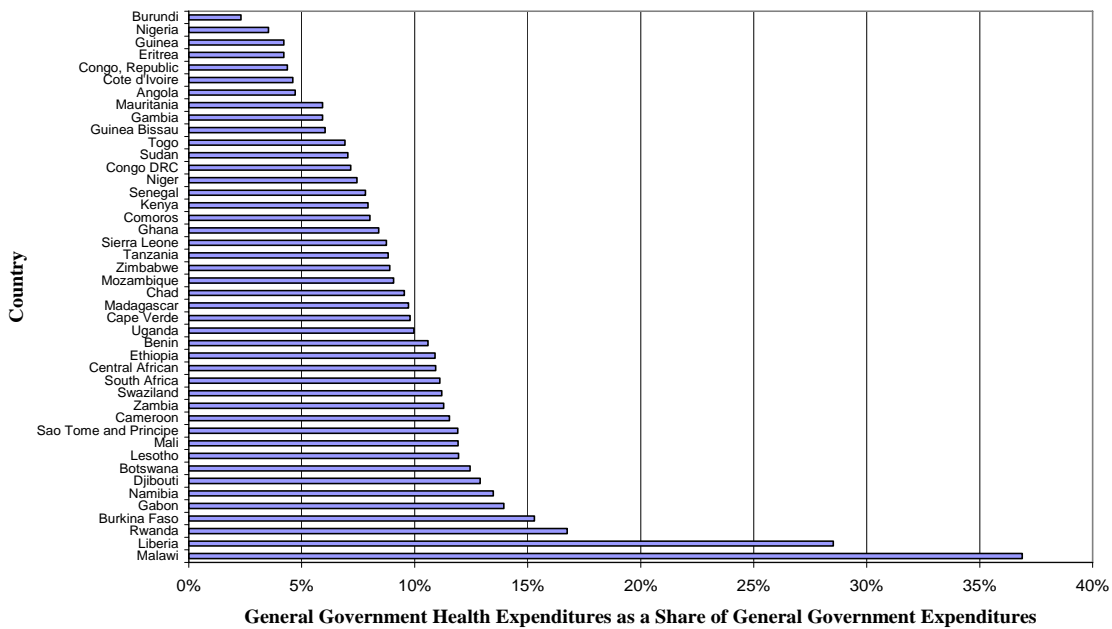


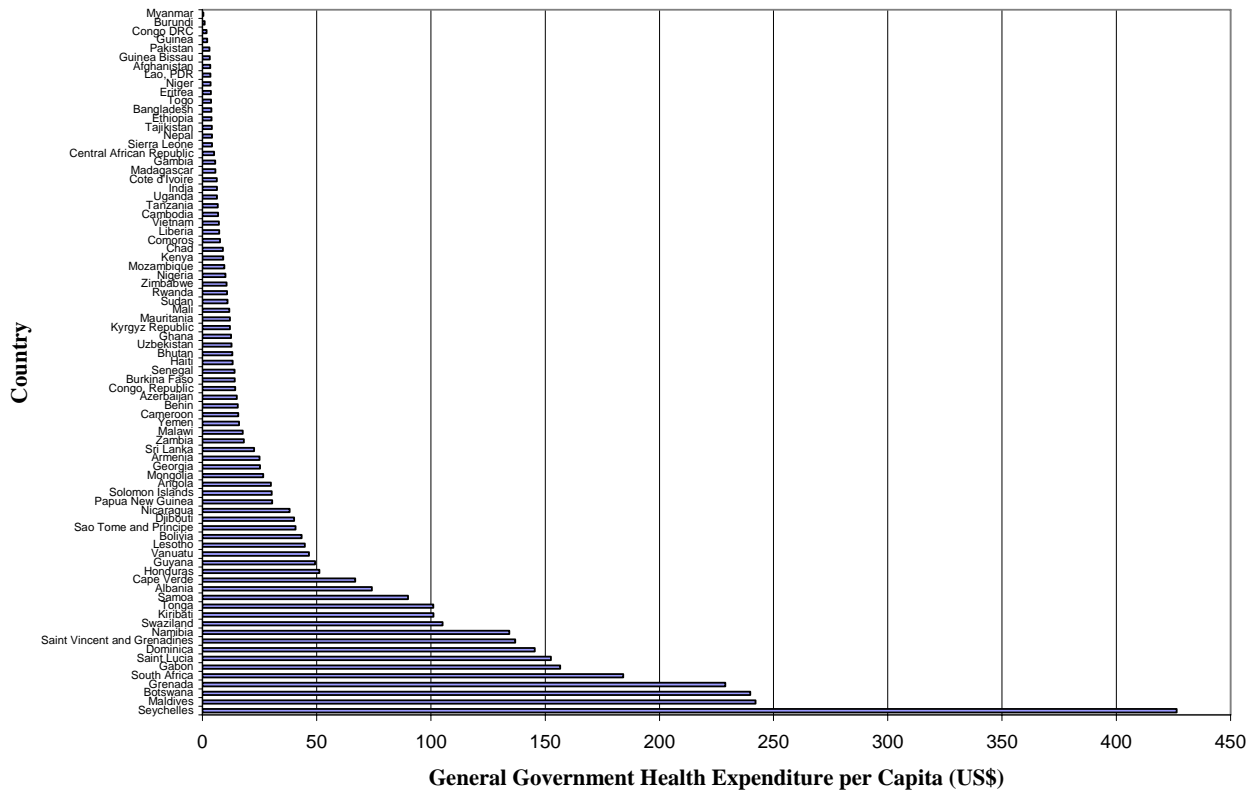
Chart 3. Government Health Spending as a Share of Total Government Expenditures in Selected African Countries, 2005



* 15 percent target is that adopted by African Heads of state at Abuja in 2001

Source: WHO

Chart 4. General Government Health Expenditure per Capita, 2005



Source: WHO

To examine whether there are any differences in trends between program and non-program countries, countries were divided into groups according to whether they had, or had not, been in an IMF-supported program under the PRGF at some point during this period⁷. There were no major differences in trends in health spending as a share of GDP between the two groups (Table 1). The non-program group generally started out with somewhat higher average levels of health spending (both government *and* total) in relation to GDP, but the changes over the period were not markedly different. For Sub-Saharan Africa, public spending on health as a share of GDP appears to have fared somewhat better in the program countries than in the non-program group, although the differences are not large and the improvement appears to have tapered off in the last few years. The changes in health spending varied substantially from country to country (Chart 5), but there were no statistically significant differences between program and non-program countries. As we will discuss later, there are considerable methodological problems with using such simple comparisons to infer any causal impact. Thus, the results should be interpreted only as indicating broad trends.

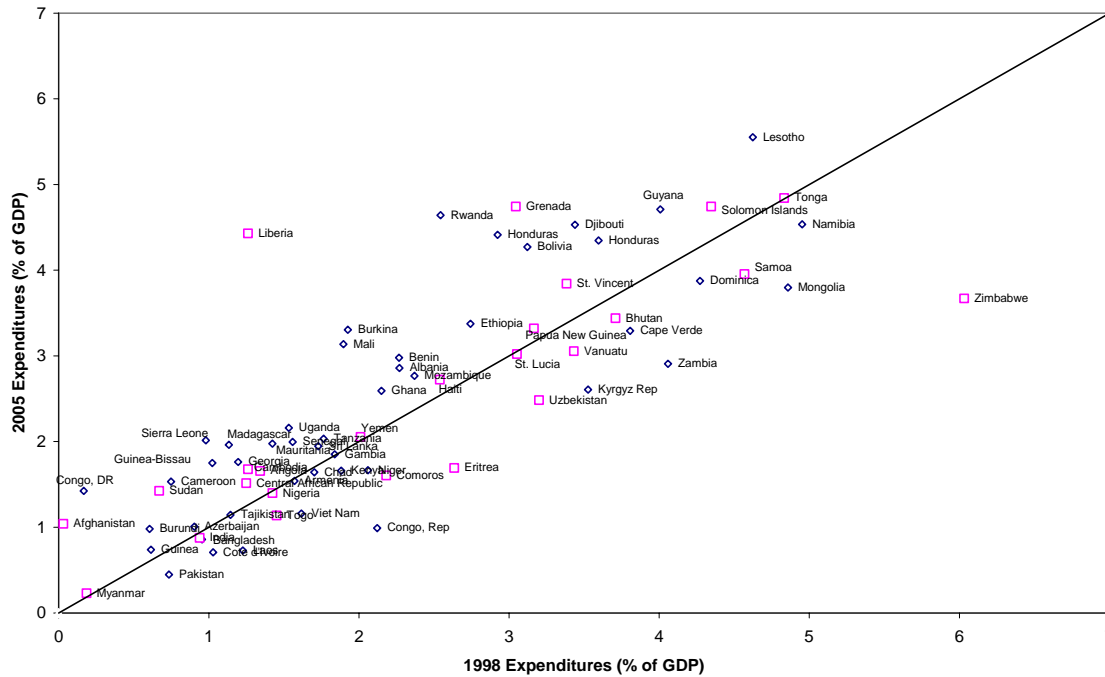
Table 1. Health Spending in Countries With and Without IMF-Supported Programs
(Group means in percent of GDP)

	1998	1999	2000	2001	2002	2003	2004	2005	Change 1998-2005
<i>Total health expenditures (public and private)</i>									
Low income countries	5.1	4.9	5.0	5.2	5.2	5.4	5.4	5.5	0.4
--program	4.9	4.9	5.0	5.1	5.2	5.3	5.3	5.3	0.5
--non-program	5.4	5.0	5.0	5.4	5.3	5.6	5.6	5.7	0.3
Sub-Saharan Africa	5.1	4.9	4.8	5.0	5.1	5.3	5.4	5.4	0.3
--program	4.8	4.9	4.9	5.0	5.1	5.3	5.3	5.4	0.5
--non-program	5.6	5.0	4.7	5.0	4.9	5.3	5.6	5.5	-0.1
<i>General government health expenditures</i>									
Low income countries	2.5	2.4	2.5	2.7	2.7	2.8	2.9	2.9	0.4
--program	2.2	2.2	2.3	2.4	2.5	2.5	2.6	2.6	0.5
--non-program	3.0	2.8	2.9	3.2	3.0	3.3	3.3	3.5	0.4
Sub-Saharan Africa	2.3	2.2	2.3	2.4	2.5	2.7	2.8	2.8	0.5
--program	2.1	2.1	2.2	2.4	2.5	2.6	2.7	2.7	0.7
--non-program	2.9	2.5	2.4	2.6	2.4	2.8	3.0	3.0	0.1

Source: Authors' calculations based on WHO data.

⁷ Countries were divided into groups according to whether or not they had a program supported by the PRGF at any time during the period. Since programs under the PRGF are intended to take a longer term perspective and discussions on policies continue with the IMF even if a program is interrupted, a classification like this, based on longer-term program involvement, addresses best the question of whether countries involved in IMF-supported programs over the period have had a different history with regard to trends in health spending than those countries without programs.

Chart 5. General Government Health Expenditures (1998 & 2005)



◆ - individual countries that had a program supported by PRGF during the period
 ■ - individual countries that did not have a program under the PRGF during the period
 Note: Malawi (1998: 3.2% of GDP, 2005: 11.1% of GDP) and Maldives (1998: 4.6% of GDP, 2005: 10.9% of GDP) are not pictured

Outside of Africa, there are no major differences between the broad trends in the groups of program and non-program countries. Average government health spending rose moderately in both groups, both as a share of GDP (by about ½ percent of GDP) and as a share of overall government spending (by about 1 percentage point). (See Table 1). For Sub-Saharan Africa, average changes for the two group are different: the average increase in health spending over the period was larger for the group of program countries, both as a share of GDP and as a share of total government spending, albeit from a smaller base (Tables 1 and 2).

However, these differences are not large, especially in light of the significant amount of resources that donors have channeled toward health, either through earmarked HIPC debt relief or aid. Indeed, there is evidence to suggest that governments tend to adjust the allocation of resources so as to reflect their own, not donor, objectives. For example, the analysis in the background note 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 relatively small—much smaller than notional earmarking.⁸

⁸ Comparing net changes in public expenditure on health to changes in net aid disbursements during 1998-2002, they find a statistically significant relationship between changes in aid and changes in public health spending, although the coefficient is quite small, implying that only 3.6 percent of additional aid is used to finance health expenditures. (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

Table 2. Share of General Government Expenditures going to Health in Countries with and without IMF-Supported Programs, 1998-2004

(Group means, in percent)

	1998	2005	Change 1998-2005
Low-income countries	8.7	9.6	.9
--program	8.6	9.4	.8
--non-program	8.8	9.9	1.1
Sub-Saharan Africa	8.5	10.1	1.6
--program	8.6	10.0	1.4
--non-program	8.1	10.2	2.1

Source: *Authors' calculations based on WHO data.*

Finally, available information on externally-funded expenditures on health suggests that such financing rose moderately in the group of low-income program countries from 1998 to 2005 (0.7 to 1.2 percent of GDP). A similar change in Sub-Saharan Africa is notable with financing rising from .8 percent of GDP to 1.5 percent of GDP. However, underlying uncertainties in the data make it sufficiently unreliable to draw strong conclusions.⁹

c. Econometric evidence

These simple statistical associations prove nothing about causation. Isolating the impact of IMF programs on health spending is subject to many statistical complications, especially since whether or not a country has a program is likely to be influenced by its initial fiscal position, which in turn influences health spending. Consequently, simple comparisons of health spending in countries with and without programs (or before and after a program in the same country) are subject to various statistical biases. The direction of these biases is not obvious and will depend on the factors that influenced countries to enter into IMF-supported programs. For example, if a country had encountered significant macroeconomic problems, it might well have been forced to squeeze spending sharply in the absence of a program and the associated financing. In these circumstances, relatively flat health spending could be the sign of a positive impact of the program (at least compared to the counterfactual of disorderly adjustment that fell heavily on social spending). But if a country had already achieved macroeconomic stability and negotiated a program with the IMF largely because this is the “price of entry” for access to scaled-up aid

earmarked for the health sector, which, according to estimates by the High Level Forum, rose from 9 percent in 1990 to 17 percent in 2003.

⁹ In principle, the external resources are those entering the recipient country’s health system as a financing source, i.e., all external resources (grants and loans) whether passing through governments or private entities are included. See the explanatory notes to the Statistical Annex to the 2006 World Health Report and the discussion of methodology available at <http://www.who.int/nha/en/>. However, this is an area where data coverage is likely to be especially weak.

and debt relief, one might expect to see rising levels of spending on core social sectors, including health. Compared with such a counterfactual, a small increase in health spending as a share of GDP following the program could be a sign of relative failure.¹⁰

A recent exercise (Martin and Segura-Ubiergo, 2004) that attempted to take account of such potential biases concluded that (i) for most countries, there was no preponderance of evidence to conclude that levels of health (or education) spending were systematically higher or lower during periods with IMF-supported programs; and (ii) an examination of panel data (i.e., combined cross-country and time series data) controlling for other influences on social spending suggested that the presence of an IMF program tends either 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 (e.g., around 0.3 percent of GDP) and relatively short-lived.

Two other studies have tried to measure the impact of debt service relief on social (health plus education) expenditures. Chauvin and Kraay (2005) measure the impact of debt relief in successive 5-year periods on the share of health and education spending in the subsequent 5-year period. They conclude that debt relief in the earliest period (1989-1993) had no significant effect whatsoever on social spending. Debt relief obtained in 1994-98 did have a significant positive association with the share of social spending in the subsequent five-year period but the effect was due entirely to two outliers (Mozambique and Yemen). They conclude that there is little empirical evidence that debt relief has affected the composition of public spending in recipient countries. However, these results may be influenced by the way in which debt relief is measured in the study, since a comprehensive data series on debt relief among low-income countries does not exist. Thomas (2006) does not attempt to measure debt relief directly but looks at the effect of changes in debt service ratios (which could be due to debt relief or to changes in borrowing strategies). He concludes that the impact on total social expenditures of a decline in debt service was significant and was stronger than the impact of a similar increase in grants.¹¹ However, he concludes that although debt service savings for the HIPC countries are likely to boost social expenditures, the size of these effects is dwarfed by the financial resources needed to reach the MDGs.

d. Conclusions

This discussion suggests the following key messages. First, government health spending (either in relation to GDP or as a share of total government spending) has been increasing moderately since the late 1990s. But this has only been sufficient to reverse an earlier decline that took place in the mid-1990s. Second, there were no major differences between recent trends in health spending as a share of GDP or as a share of total government spending in the groups of program and non-program countries outside of Africa. In sub-Saharan Africa, total government spending increased more in the group of program countries, but the differences are not large, especially in

¹⁰ In practice, dividing the group of program countries into those that had already achieved a substantial measure of macroeconomic stability (referred to as “mature stabilizers” by the IMF) by early in the period and countries that had not yet reached this threshold did not make much difference. Changes in the share of government spending on health were similar for both sub-groups.

¹¹ He also concludes that fiscal consolidation, as measured by positive changes in the overall budget balance, did not have a significant impact on the social expenditure ration in low-income countries.

light of the size of external resources directed toward the health sector. Third, estimates of the impact of IMF-supported programs on health spending are complicated by a number of econometric difficulties, but available estimates suggest little overall impact; at best, programs may be associated with a small and relatively short-lived increase in health spending but in practice it is not possible to distinguish between the effects of the IMF program and other factors such as HIPC debt relief.

2. What Has Happened to Fiscal Flexibility in Programs?

Critics of the IMF argue that it presses for reducing fiscal deficits and government expenditures to levels that are not justified by requirements of macroeconomic stability or expectations of aid flows and that, therefore, its programs do not show the greater fiscal flexibility called for under the PRGF (see, for example, Oxfam, 2003). The background to this debate, including the factors influencing the appropriateness of a particular fiscal path, is discussed in a companion paper on *The Nature of the Debate Between the IMF and its Critics*.¹² Here the focus is on investigating what programs actually did target. We also examine whether there has been any change in the nature of program design between those cases negotiated in the ‘early’ PRGF period of 2000-2002 and those formulated in the 2003-2006 period (referred to here for convenience as the ‘late’ PRGF period).

a. Fiscal targets

We examined targets for fiscal deficits before and after grants and for total government expenditures in all ESAF or PRGF-supported programs approved during 1995-2006.¹³ The results are summarized in Table 3 and indicate the following:

- There has been a gradual shift toward less contractionary/more expansionary fiscal programs, but even recent programs typically did not incorporate substantial aid-financed fiscal expansions. The most marked change occurred in programs formulated during the 2003-2006 period, but even then the average targeted expansion was relatively small. For example, the average government deficit before grants, which is the most aid-exclusive measure of the deficit, was targeted to decline sharply (by about 3 percent of GDP) over the 3-year program period under the ESAF and more moderately (1-1/2 percent of GDP) under “early” PRGF arrangements. In contrast, later PRGF programs targeted a significant (1.0 percent of GDP) increase in the deficit in the first program year, although this expansion was projected to disappear by the third year.
- “Late” PRGF programs also targeted a moderate increase in government expenditure ratios (by ½-1 percent of GDP during the 3-year life of the program), compared to a targeted decline under the ESAF and no significant change in “early” PRGF programs.

¹² A separate background note documents what programs targeted for inflation. See *Inflation Targets in IMF-Supported Programs in Low-Income Countries*, March 2007.

¹³ 52 arrangements in total. The following programs were not included in the summary results presented in Table 4 because three-year program targets were not set or are not publicly available: Georgia (2003), Kyrgyz Republic (2001), and Pakistan (2002).

- Within these averages, however, the fiscal strategies incorporated in program targets for individual countries varied substantially. For example, in the 52 PRGF arrangements analyzed, government expenditures as a share of GDP were targeted to rise by 3 percentage points or more in 7 countries and were targeted to decline by 3 percentage points or more in 7 countries (Chart 6).

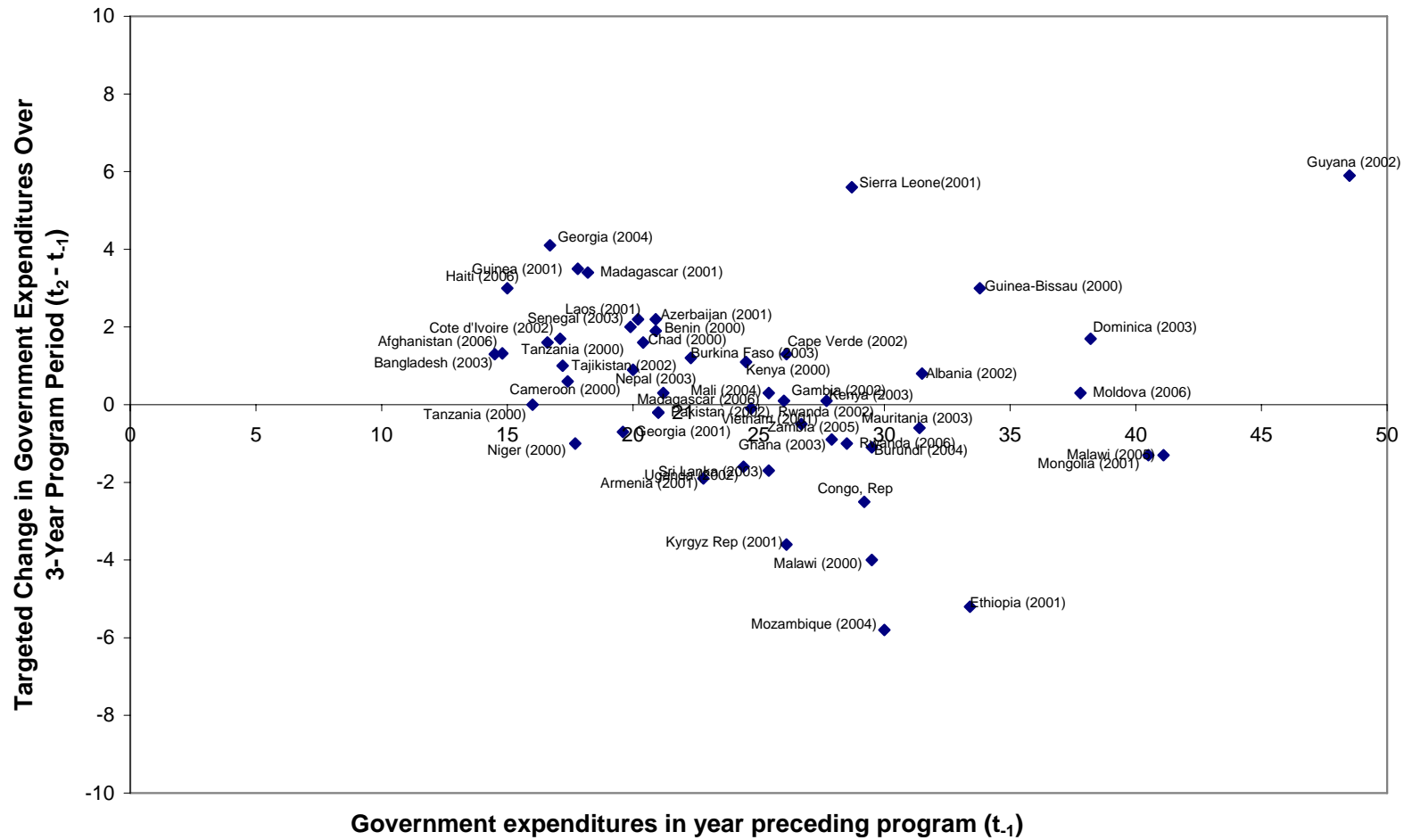
Table 3. Fiscal Targets in IMF-Supported Programs, 1995-2006
(Group Means, in Percent of GDP)

	Level at t_{-1}	Change*	
		$t_0 - t_{-1}$	$t_{+2} - t_{-1}$
General government balance, after grants**			
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	-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 6: Targeted Changes in Total Government Expenditures in PRGF-Supported Programs, 2000-2005 (In percent of GDP)



*b. External targets and projections*¹⁴

An analysis of external targets in programs over the same period indicates the following (Table 4):

- Whereas earlier programs under the ESAF had, on average, assumed a gradual decline in grant aid, programs under the PRGF were formulated on the basis of a moderate increase in grants in the first program year. However, this increase was assumed to taper off and disappear by the third program year.
- Targeted changes in the external current account deficit (excluding grants) have shifted moderately in favor of a widening of deficits during the first year of the program for “late” PRGF programs, but there is no such change over the 3-year program period.¹⁵

Table 4. Projections for Grants and External Current Account Balance in IMF-Supported Programs, 1995-2006
(Group Means, in Percent of GDP)

	Level at t_1	Change	
		$t_0 - t_{-1}$	$t_{+2} - t_{-1}$
Grants			
ESAF (1995-1999)	3.9	-0.2	-0.9
“early” PRGF (2000-2002)	3.9	0.8	0.1
“late” PRGF (2003-2005)	3.6	0.4	-0.5
External current account balance, excluding grants*			
ESAF (1995-1999)	-11.2	-0.3	0.3
“early” PRGF (2000-2002)	-15.7	-0.3	1.6
“late” PRGF (2003-2005)	-11.5	-0.8	0.2

**Positive change implies decline in deficit.*

¹⁴ A separate background paper discusses in more detail what the IMF has assumed about overall net aid flows. See *What the IMF Programs With Low-Income Countries Assumed About Aid Flows*.

¹⁵ See the companion paper on *The Nature of the Debate between the IMF and its Critics* for a discussion of the distinction between (fiscal) spending and (macroeconomic) absorption of aid. As discussed in that paper, there is considerable evidence that many countries tend to spend the fiscal proceeds of aid but do not fully absorb the corresponding foreign exchange resources by allowing a widening of the external current account deficit. A recent paper by the Independent Evaluation Office of the IMF (IEO, 2007) indicates that programs target relatively little “spending” of additional aid, except in countries with strong macroeconomic conditions (where almost all of the aid is targeted to be absorbed and spent). For example, in programs where external reserve levels were already comfortable, on average only 27 percent of additional aid was programmed to lead to a fiscal expansion.

c. Conclusions

What do these results suggest for the macroeconomic design and “fiscal flexibility” of programs? There has been some shift toward more expansionary fiscal programs, but even in the latest (2003-2006) period most programs targeted relatively small increases in the deficit that tapered off by the end of the 3-year periods. The same pattern occurred in projections of grants: a moderate increase in the first year of the program which disappears by the third year. Whether this represents sufficient fiscal flexibility depends on judgments regarding the likely financing prospects as well as the uses and effects of additional government expenditures. These questions can only be answered taking into account the circumstances in each country. But the assumed rapid tapering of higher grant aid by the end of the 3-year program does seem to reflect a conservative approach to balancing risks in the current environment of international commitments to increase overall aid flows. This is especially so in those cases where the achievement of macroeconomic stability offers some scope for changing the balance of risks implicit in program design to give greater weight to the potential benefits of higher aid financed expenditures.

Data on health expenditures used in this report

Information on health spending in low-income countries is often weak, with many gaps in coverage, reflecting underlying weaknesses in national public expenditure tracking systems.¹⁶ For example, the degree to which externally-funded public spending on health is captured in government finance statistics varies significantly from country to country. With this caveat in mind, the two main sources of data on health expenditures used in this report are from the IMF and the World Health Organization (WHO).

The IMF has an internal database, largely drawn from its country reports, on spending on health and education that covers the period 1985-2003, albeit with many gaps, especially for earlier years. There are significant variations in cross-country definitions. For example, the coverage of the government sector is for the general government (i.e., central plus state or local governments plus health spending by social security agencies) in some countries, but in many others the data only covers the central government. In some cases, the data excludes capital expenditures in the health sector and the coverage of donor-funded government spending varies, reflecting the weaknesses in coverage of this item in the underlying government accounts. The series has been updated for 2004 for the purposes of this report wherever additional information was available from IMF country reports.

The WHO compiles a five-year series on estimated health expenditures based on the framework of national health accounts. The estimates cover total national health expenditures and its main components (i.e., the sum of general government health spending and private health expenditures, including by commercial insurers, non-profit institutions, and households' own-account spending). The WHO database also includes estimates, drawn largely from OECD (DAC) sources, of the share of total funding of expenditures from external (donor) sources, whether channeled through government or non-government (e.g., NGO) spending. In practice, coverage of some of these components is limited in many low-income countries but an effort is made to maintain a consistent series for the five-year rolling period. The latest period for which consistent estimates are available is 1998-2005. See <http://www.who.int/nha/en/> for a description of the methodology and access to the database.

In practice, the estimates of government health spending in the two databases show similar patterns for most countries. This is not surprising since both are ultimately based on the same national statistical frameworks. Indeed, in a number of cases, the WHO database draws explicitly on IMF country reports for some of its information on government expenditures.

¹⁶ See the Executive Summary of the Report of the Global Health Resource Tracking Working Group (at http://www.cgdev.org/section/initiatives/_active/ghprm/workinggroups/rtrwg) for a more detailed discussion of the problems with existing information systems on resources going to the health sector. The Working Group makes specific recommendations to enhance the timeliness, comprehensiveness, and access to information on public and private financial flows in the health sector in developing countries.

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