

IMF Programs and Health Spending: Case Study of Zambia
By David Goldsbrough and Caesar Cheelo

Abstract

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The study concentrates on two recent periods:

- (i) 2003 and early 2004, after the earlier IMF-supported program had gone off-track and as the Government implemented an informal (“staff-monitored”) adjustment program in an effort to restore macroeconomic stability and qualify for full HIPC debt relief. It was during this period that explicit ceilings on the overall wage bill were first introduced into programs
- (ii) The period covered by the most recent set of programs under the Poverty Reduction and Growth Facility (PRGF), from mid-2004 to 2006. In this period, especially following the achievement of comprehensive debt relief, the main macroeconomic policy challenge shifted from addressing short-term macroeconomic instability to making good choices on how to utilize the potential for greater fiscal space created by additional external support. Key questions for this period are how well IMF policy advice and program design are adapting to these new challenges and how macro policy choices have interacted with a potential scaling-up of health spending.

The authors conclude with lessons for the IMF, the Government of Zambia, and donors.

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 case study examines the interaction between IMF program design and health spending in Zambia. Its aim is to investigate a number of potential criticisms of IMF-supported programs, including that (i) the macroeconomic frameworks underlying the programs take a too conservative view of what is needed for macroeconomic stability and on the prospects for aid flows, and (ii) some of the specific aspects of program design, notably the use of wage bill ceilings, have adverse consequences for the health sector. This study is not intended to be a comprehensive review of either macroeconomic and development policies or the health sector.

The study concentrates on two recent periods: (i) 2003 and early 2004, after the earlier IMF-supported program had gone off-track and as the Government implemented an informal (“staff-monitored”) adjustment program in an effort to restore macroeconomic stability and qualify for full HIPC debt relief. It was during this period that explicit ceilings on the overall wage bill were first introduced into programs. So an important reason for examining this period is to investigate the causes and consequences of such conditionality. (ii) The period covered by the most recent set of programs under the Poverty Reduction and Growth Facility (PRGF), from mid-2004 to 2006. In this period, especially following the achievement of comprehensive debt relief, the main macroeconomic policy challenge shifted from addressing short-term macroeconomic instability to making good choices on how to utilize the potential for greater fiscal space created by additional external support. Key questions for this period are how well IMF policy advice and program design are adapting to these new challenges and how macro policy choices have interacted with a potential scaling-up of health spending.

Section I gives a very brief overview of economic developments and overall health outcomes. Section II assesses the IMF-supported programs, and Section III discusses budgetary processes and their influences on priority-setting, in the context of what has actually happened to health spending. Section IV discusses the health sector strategy, especially the hiring and wage strategy. The concluding section identifies a number of lessons.

I. Overview of Key Economic Developments and Health Outcomes

For most of the period since the 1970s, economic developments were dominated by a large trend decline in the real price of copper, to which Zambia was highly vulnerable, and by a struggle of policies to respond adequately. The Government initially responded to the sharp deterioration in the terms of trade and loss of export earnings by heavy external borrowing to avoid restructuring, but growth remained weak and the fiscal position precarious. IMF (and World Bank) analyses highlighted a large and inefficient state sector and a poor resource allocation driven by extensive government intervention in the economy as the key reasons for the prolonged weak economic performance. These factors were undoubtedly important, but the fundamental causes of a country’s growth (or lack of growth) are always difficult to explain; Zambia is no exception.¹ In any event, by the early 1990s, Zambia was one of the most heavily indebted countries in Africa and had accumulated substantial external arrears, including to the IMF.² The most extensive economic reforms, including liberalization of most prices, trade and exchange controls and a program of privatization began in the 1990s under the Chiluba administration.³ However, heavy losses in the government-owned copper mines and a large contraction in mining output contributed to falling GDP and further macroeconomic instability in the first half of the 1990s.⁴ Growth picked up moderately in the second half of the decade and accelerated further during 2000-2005 (to an average of about 4 ½ percent annually), helped by a rebound in copper prices (Table 1). But this recovery was only sufficient to make a small reversal in the previous dramatic erosion of living standards. GDP per capita (in constant 2000 dollars) fell by almost half from \$613 in 1965 to a low of \$318 in 1995 before recovering moderately to \$354 in 2003. Inflation declined from an average of over 100 percent a year during 1992-95 to the 20- to 30-percent range in 1999-2003.

Table 1. Zambia Key Macroeconomics Indicators, 1999-2006								
	1999	2000	2001	2002	2003	2004	2005	2006 est.
Inflation (percent)	26.8	26.1	21.4	22.2	21.4	18.0	18.3	9.1
Real GDP growth (percent)	2.2	3.6	4.9	3.3	5.1	5.4	5.2	6.0
Fiscal (in percent of GDP)								
Grants	6.6	8.0	5.7	5.8	8.3	7.0	5.5	5.6
Revenues	18.8	17.7	19.4	19.2	17.9	18.0	18.3	17.4
Total expenditures	27.2	26.5	27.9	29.7	27.2	27.1	23.2	23.0
Overall balance, before grants	-14.6	-12.0	-12.7	-13.8	-14.6	-13.5	-7.2	-8.2
Overall balance, after grants	-8.0	-4.0	-7.0	-8.0	-6.3	-6.6	-1.7	-2.6
External								
Total net aid flows (US\$ million)	365	466	336	518	639	299	337	597
External current account balance, before grants (% of GDP)	-16.8	-19.2	-20.8	-17.3	-15.9	-12.2	-11.8	-2.3
Gross external reserves (in months of imports of goods and services)		0.9	1.0	2.2	1.3	1.2	1.6	
Source: IMF documents								

Zambia was granted provisional debt relief under the enhanced Initiative for Highly Indebted Poor Countries (HIPC) when the so-called decision point was reached at the end of 2000. However, reaching the completion point under the Initiative (and hence full debt relief) was delayed several times by problems in implementing various conditions set for the debt relief, including when IMF-supported and monitored programs went off-track in 2003 (see Section II). The completion point was finally reached in April 2005 (after a period of satisfactory performance under the new PRGF arrangement). Zambia was also eventually granted further debt relief from the IMF and the multilateral development banks in early 2006 under the Multilateral Debt Relief Initiative (MDRI). As a result, the face value of Zambia's external debt was reduced from over \$7 billion in 2004 to about \$500 million by mid-2006.

These economic developments, exacerbated by ineffective public spending, adversely affected Zambia's ability to improve the living conditions of its population and fight poverty. Through the 1990s, poverty rose and most MDG-related indicators deteriorated (Table 2). There has been some moderate improvement in recent years as growth began to recover, but Zambia remains a country with widespread poverty and weak health outcomes. The share of the population below the official poverty line increased from 70 percent in the early 1990s to 73 percent in 1998, but then fell to 67 percent by 2004.⁵ Infant and under-5 mortality rates both rose during 1992-96 but had declined moderately by 2002. Stunting rose by nearly 10 percentage points in the 1990s, with nearly half the under-5 population stunted by the end of the decade.⁶ The share of the adult (15-49) population infected by HIV had reached about 20 percent in the second half of the 1990s, although a recent survey suggests some tapering off (to 16 percent). The later status report suggests that Zambia is unlikely to meet the MDG target for reducing maternal mortality and that its progress toward other health-related MDGs has been mixed (see matrix).

Total spending on health fluctuated within a range of \$18-26 per person (at market exchange rates) during 1995-2002, but increased to an estimated \$34 per person by 2004, largely because of an increasing share of donor funding. By 2004, the last year for which National Health Account estimates

are available, more than 40 percent of total health spending was being financed from external sources. The share has almost certainly increased further since then, because of a large expansion in financing from disease-specific “vertical funds,” most notably PEPFAR. Government health spending per person showed little trend increase during 1995-2002, ranging around \$12 per person. It increased significantly in dollar terms in 2006, but this largely reflected a large recent appreciation of the exchange rate of the Zambian kwacha. (See Section III for further details.)

Zambia: Progress Toward Health-Related MDGs

Goal/Target	Will Target Be Met?*	Status of Supportive Environment**
<u>Child Mortality</u>		
Reduce by two-thirds between 1990 and 2015 the under-5 mortality rate	Potentially	Good
<u>Maternal Mortality</u>		
Reduce by three quarters between 1990 and 2015 the material mortality rates	Unlikely	Weak
<u>HIV/AIDS</u>		
Have halted by 2015 and begun to reverse the spread of HIV/AIDS	Likely	Good
<u>Malaria and Other Major Diseases</u>		
Have halted by 2015 and begun reducing the incidence of malaria and other major diseases	Potentially	No rating
<u>Water and Sanitation</u>		
Halve by 2015 the proportion without access to safe drinking water and sanitation	Potentially	Good

Source: United Nations: Zambia, Millennium Development Goals, Status Report 2005.

*Possible classifications are Likely, Potentially or Unlikely.

** Possible classifications are Strong, Good or Weak.

Table 2. Millennium Development Goals (Zambia)																	
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	
Goal 1: Eradicate extreme poverty and hunger																	
Poverty headcount ratio at national poverty line (% of population)	...	...	...	...	...	...	69.2	...	72.9	...	...	...	...	...	...	...	..
Share of population below \$1 per day (%)		64.6		73.6			72.6		64.8					75.8			
Prevalence of undernourishment (% of population)	...	48	...	...	...	...	48	...	...	...	...	...	47	...	...	...	..
Goal 4: Reduce child mortality																	
Immunization, measles (% of children ages 12-23 months)	90	80	85	91	96	86	86	86	85	85	85	84	84	84	84	...	..
Mortality rate, infant (per 1,000 live births)	101	...	...	...	...	102	...	...	...	...	102	...	...	...	102	...	..
Mortality rate, under-5 (per 1,000)	180	...	...	...	...	182	...	...	...	...	182	...	...	...	182	...	..
Goal 5: Improve maternal health																	
Births attended by skilled health staff (% of total)	...	...	50	...	...	...	46	...	...	47	...	...	43	...	...	...	..
Maternal mortality ratio (modeled estimate, per 100,000 live births)	940	...	...	...	...	870	...	...	...	...	750	...	...	...	...	...	..
Goal 6: Combat HIV/AIDS, malaria, and other diseases																	
Children orphaned by HIV/AIDS (thousands)	...	...	...	...	...	...	...	...	...	...	...	570	...	650	...	710	..
Prevalence of HIV, total (% of population ages 15-49)	...	...	...	...	...	...	...	...	...	...	...	16.7	...	16.9	...	17	..
Incidence of tuberculosis (per 100,000 people)	548	...	...	...	...	...	...	...	...	...	1025	1056	737	663	707	...	..
Tuberculosis cases detected under DOTS (%)	...	...	...	...	...	...	...	...	...	...	...	...	40.2	61.9	53.7	...	..
Tuberculosis death rate per 100,000 population	117	...	...	...	...	...	...	...	...	...	210	226	139	128	137	...	..
Children under 5 with fever being treated with anti-malarial drugs, percentage	...	...	...	...	...	...	...	...	...	58	...	...	51.9	...	...	...	..
Other																	
Life expectancy at birth, total (years)	46	...	43	...	...	41	...	39	...	...	38	...	37	38	38	...	..
*Source: UN Millennium Development Indicators and World Bank MDGs.																	

II. The IMF-Supported Programs, 2003-2006

Zambia has been involved in some form of IMF-supported or monitored program for most of the period since the mid-1970s, except when its access was interrupted by arrears to the IMF. Its debt to the IMF was large (over \$1 billion by the end of 2002) and the earlier refinancing of arrears had rolled forward much of this debt to fall due into a fairly narrow period through 2005. This created strong incentives, on both sides, to reach agreement on new programs to help refinance these payments, especially since donors were not enthusiastic about seeing any stepped-up aid being used to pay off debt to the IMF.⁷ An additional major motivation for continued program involvement was that satisfactory performance under an IMF arrangement was a pre-condition for debt relief. These circumstances formed the background to Zambia's experience of repeated and early derailments of programs, reflecting weak ownership. The IMF's own review of this earlier program involvement concluded that, in light of these ownership concerns, a greater front-loading of prior actions was needed.⁸ However, it is doubtful that a change in the modalities of conditionality alone would be sufficient to address issues of ownership, especially when the key challenges involved addressing deep-seated institutional weaknesses.

Zambia's earlier arrangement under the PRGF expired in early 2003, and the IMF Board concluded that large budget overruns threatened macroeconomic stability and precluded a new arrangement. An important factor behind this judgment was the Government's decision (in April 2003) to grant large unbudgeted increases in wages and housing allowances (discussed in more detail below). As an interim measure to establish a better track record, the authorities requested a staff-monitored program (SMP) covering the second half of 2003.⁹ Performance under this SMP was also judged to be not satisfactory by the IMF Board, largely because of fiscal slippages, and the SMP was extended to June 2004. Strong performance under this later SMP led to agreement in mid-2004 on a new 3-year arrangement under the PRGF, covering 2004-2006.¹⁰

a. Macroeconomic strategy

The Government's Poverty Reduction Strategy (PRSP), which was prepared in 2002, aimed to achieve poverty reduction through a combination of growth-promoting activities in key economic sectors (with a particular emphasis on rural-based economic activity) and supporting infrastructure; improved access and quality in the provision of social services; and improved governance. Macroeconomic stability was seen as an important component to stimulating stronger private-sector-led growth.¹¹ The macroeconomic framework underlying the PRSP had to be modified to take account of developments in 2003, including fiscal slippages. However, the macroeconomic strategy underlying both the staff-monitored programs of 2003-4 and the 2004-2006 PRGF contained similar core elements:

- Bringing the inflation rate down to about 10 percent within a 2-3 year period, with a further decline (to about 5 percent) envisaged beyond the program period.
- Relatively "conservative" assumptions of aid flows. For example, the original PRGF program assumed total external assistance would increase from 5.3 percent of GDP in 2003 (a year when donors had reduced support because of poor performance) to an average of 7.3 percent of GDP over 2004-2007—well below the average of 12 percent of GDP seen in 1999-2002.
- Substantial fiscal consolidation to prevent a further escalation of domestic debt and interest payments. For example, the original program under the PRGF targeted the deficit before grants to decline by more than 3 ½ percent of GDP. (Table 3)
- Only moderate increases in revenues. (The initial PRGF-supported program targeted revenues to rise from 18 percent to 18 ½ percent of GDP over the medium term).

- A significant decline in overall government spending as a share of GDP but with a reorientation toward categories designated as poverty-reducing. Total government spending, excluding interest, was targeted to decline by 2 ½ percent of GDP under the PRGF with all of the adjustment front-loaded in 2004.
- Containing the overall wage bill at about 8 percent of GDP.

In assessing the macroeconomic strategy, it is important to recognize that the content of programs is the outcome of a negotiation process rather than a simple exercise in technical design. Ownership is a difficult concept to define and measure in concrete terms, and this paper does not attempt to do so. However, different domestic stakeholders—even within the Government—had different views on priorities and the appropriate balancing of risks (e.g., between macroeconomic stability and other objectives). Indeed, it was clear from our interviews that the Ministries of Health and Finance viewed these tradeoffs differently. So even if some stakeholders are dissatisfied with the choices that are made, this does not mean necessarily that the IMF has acted inappropriately. So the approach taken in the paper is not to try to establish whether there is some “better” set of policies that the IMF could have advocated, but to examine whether the IMF—by not considering some feasible policy options-- may have unduly narrowed the policy space for domestic political processes to make choices on tradeoffs.

Therefore, in what follows, two sets of questions are asked about this macroeconomic strategy: (i) what rationale was provided by the IMF for the approach taken and was there a sound analytical and evidentiary basis for it; and (ii) were alternative feasible policy options considered? To address these questions, all available IMF program documents for the period were reviewed and key stakeholders within the government, the IMF, the donor commitments and civil society were interviewed.¹² Table 4 summarizes the rationale and analytical basis (as discussed in IMF documents) provided for major components of the programs.

*b. Aid projections.*¹³

The initial programs were based on conservative assumptions about future net aid flows, once account is taken of the unusually low starting position following the 2003 slump in aid. Subsequent programs incorporated the rebound in aid that occurred in 2005 (helped by the finalization of HIPC debt relief), but still included rather conservative baseline assumptions about aid prospects for the medium term. In effect, these later programs assumed the level of aid would plateau at its existing level or would decline slightly, well short of donors’ global commitments for aid to Africa (see Chart 1 and Box 1).

**Table 3. Zambia: Key Macroeconomic Targets and Outcomes
Under IMF Programs, 2004-2006**

	Original Program Targets ¹⁴	Estimated Actual ¹⁵	Significant Modification at Program Reviews?
Inflation (percent)	From 17% in 2003 to 10% in 2006 and 5% in 2007	9% in 2006	Yes—to more gradual decline in inflation, but similar final target
Real GDP growth (percent)	Average of 4.3% per annum during 2004-2006	Average of 5.5%	Yes—raised to 6% in outer years
Total net aid flows (in US\$ Million) *	Total of \$1.5 billion over 3-year period 2004-2006	Latest estimate is \$1.54 billion	Yes—specific estimates heavily influenced by timing of debt relief
Change in overall fiscal balance, before grants (in percent of GDP) ¹⁶	Deficit to be reduced by 3.6 percentage points of GDP over 3-year period (2004-2006)	Deficit reduced by 6.8 percentage points (almost all in first year)	Not for 2004-2006. But Fourth Review envisaged a further substantial deficit reduction for later years
Net domestic financing of the deficit (in percent of GDP)	Domestic financing reduced by 3 percentage points in first program year and by over 4 percentage points in 3-year period (to under 1 percent of GDP by 2006)	Reduced by over 8 percentage points (i.e., its substantial surplus in 2006)	Not for 2004-2006
Change in total government expenditures (excluding interest) (in percent of GDP)	Reduced by 2.5 percentage points of GDP over 3-year period	Reduced by 5.6 percentage points	

* Net of amortization actually paid and including net IMF financing.

Source: Appendix Table 1.

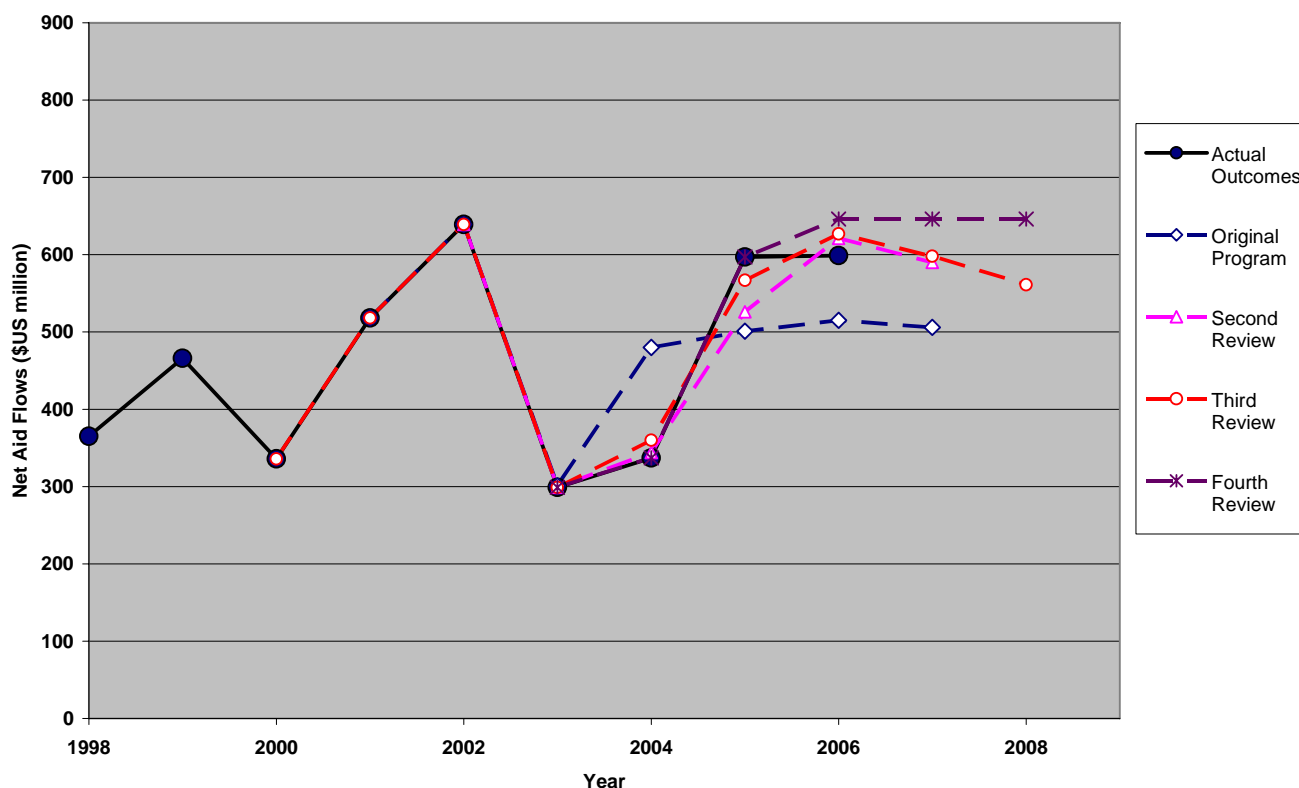
Table 4. Zambia: Rationale and Economic Analysis Underlying Program Content and IMF Policy Advice on Selected Issues, 2003-2006

Policy issue	Key program content/policy advice	Analytical basis provided in IMF documents¹⁷	Other analytical inputs drawn upon by program
Targeted inflation path	From about 20% to 10% by end of program period. Further reduction to 5% envisaged in 2007.	2003 Ex-Post Assessment concluded that targets in earlier programs (which had aimed to bring inflation down from around 30% to 4% over 3 years) were over-optimistic against the background of fiscal outcomes that were not strong enough to support such a disinflation path.	No other country-specific analysis. Target was in line with general IMF policy guidance (see IMF 2006).
Projected aid flows	Net aid flows in 2004-2006 projected to be broadly flat (at about 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.	None mentioned. (No analysis of projected net aid flows in comparison with expected global trends or of implications for Zambia's 'share' of aid.)
Path of fiscal deficit/ net domestic financing	Substantial front-loaded adjustment.	Initial fiscal targets were largely based on debt sustainability analysis plus references to concerns about "crowding out" of private investment.	World Bank study analyzing impact of additional domestically financed spending on growth and income distribution [Devarajan and Go (2002)].
Expenditure levels and composition	Substantial front-loaded reduction (2 ½ percent of GDP). Significant shift in composition of spending toward priority sectors.		See above. A later (2005) analysis did explore the consequences of a higher spending scenario with some sensitivity analysis of the macro consequences of different levels of effectiveness of the additional spending (see main text).
Wage bill ceilings	Total wage bill to be held at about 8 percent of GDP.	None, beyond general concern with macroeconomic stability.	None mentioned. (Some references to size of wage bill in other Sub-Saharan African countries.)

Source: IMF Documents.

Source: IMF documents. Net aid is measured as grants plus loans less amortization actually paid plus net IMF financing.

Chart 1. Projected and Actual Aid Flows



Source: IMF documents. Net aid is measured as grants plus loans less amortization actually paid plus net IMF financing.

Our review of the initial programs suggests the following:

- Unlike some other cases, the content and rationale of the aid forecasts were discussed explicitly in IMF program documents. The justification given for the cautious approach was to avoid a repeat of earlier shortfalls in external budget support, which had hindered implementation of past programs. IMF staff who were interviewed said that such shortfalls (and within-year volatility of aid) had greatly complicated implementation of earlier programs and exacerbated Zambia's cash flow management problems.
- Given this earlier history and the information available to the IMF staff at the time of the formulation of the original program, using a relatively cautious baseline for aid in the initial program design was justified. It was consistent with signals from donors, many of whom were awaiting evidence of better policy performance before committing higher aid.¹⁸
- Less justifiably, there was no substantive discussion in these earlier programs of the macroeconomic implications of a faster rebound in net aid. The original program stated that higher levels of concessional assistance could be incorporated over time to increase priority spending, but there was no analysis of what this might mean for the overall macroeconomic framework and key economic and social objectives. Moreover, as we will discuss later, the technical design of the program discouraged the spending of higher-than-projected aid inflows.

By 2005, circumstances had changed. Zambia's performance in implementing agreed policy measures had improved, leading to increased donor willingness to commit aid, while completion of debt relief had

largely eliminated external sustainability concerns. In this context, a review of these later programs indicates the following:

- The baseline projections for aid during these later programs (i.e., the third and fourth program reviews, completed in December 2005 and June 2006) were still quite conservative. For example, they implied aid to Zambia would grow more slowly than what donors were signaling they were prepared to do globally, especially after Gleneagles (i.e., implicitly assuming either that Zambia's share of aid would fall or that donors would not deliver on these global commitments.) (See Box 1.)
- However, the IMF staff did undertake a substantive analysis of the macroeconomic impact of scaling up donor assistance.¹⁹ The analysis focused on the impact of a 50 percent scaling up of aid by 2010 (compared to the baseline), with half of the additional aid devoted to rural infrastructure and the rest split equally between health and education services. The composition of additional expenditures was in line with alternative policy scenarios to achieve greater pro-poor growth set out in the National Development Plan (NDP), 2006-2010, which also serves as Zambia's new PRSP. This scaling-up scenario was broadly in line with donors' signals on their global intentions for increasing aid.

In interviews, IMF staff indicated that (i) the shift to assessing the impact of significant scaling-up partly reflected changes in Zambia's circumstances and in the attitude of donors and (ii) changing expectations within the IMF on the consideration of such scenarios. However, there still appears to be considerable ambiguity within the IMF concerning what is expected for the content of such scenarios and much seems to depend on the initiative of individual mission chiefs. But there is a clear understanding among IMF staff interviewed (not just those working on Zambia) that it is not their role to generate MDG "needs-based" scenarios if the projected aid requirements were out of line with any likely provision.

Box 1. How Optimistic Were the Projections of Aid Underlying the 2004-2006 IMF Programs?

To test the degree of optimism or pessimism of the aid assumptions, we compared the projections for net aid flows (grants plus net loans after debt relief) in the original program and subsequent reviews to several benchmarks: (i) previous trend growth in aid flows to Zambia; (ii) expected trends in global aid flows at the time each program was finalized (according to the OECD DAC);²⁰ and (iii) actual outcomes (to the extent the data is available). The results indicate the following:

- Compared to two of the benchmarks, the original program projections for net aid flows in 2004-2006 were not unduly pessimistic based on what was known at the time. The projected average annual growth in net aid over the 3-year period of the macroeconomic framework (8.2 percent) was faster than what Zambia had achieved in the preceding 5-year period and was about the same as concurrent OECD DAC projections of growth in global aid flows (Table 5). However, these projections were from a base year (2003) in which aid to Zambia was especially low because of performance problems. Actual aid flows were only slightly higher than the original program projections for the full 3-year period, but were substantially higher in 2005 and 2006 (Table 6).²¹
- The original program and subsequent reviews all assumed a sharp increase in net aid flows in 2005, reflecting a rebound from earlier lows and, especially, the expected timing of debt relief. Thereafter, the medium-term trend in net aid was assumed to be broadly flat or even declining slightly in the baseline projections (see Chart 1). This was still the case after the Gleneagles Summit and the undertaking to double aid to Africa.
- In 2005, the staff did analyze the macroeconomic implications of an alternative scenario incorporating a substantial growth in aid over the medium term (see main text). This alternative scenario assumed continued rapid growth in aid (by 11-12 percent per annum in dollar terms), which is broadly in line with donors' more recent global commitments on aid to Africa. However, this projection was not the basis of the agreed program.

Table 5. IMF Program Projections for Aid Compared to Past Trends and Global Commitments
(In percent; based on US\$ values)

	Original Program (2004- 2006)	Second Review (2005- 2007)	Third Review (2006- 2008)	Zambian Aid Scale Up Scenario (2006-2008) ^a	Fourth Review (2006- 2008)
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Projected Annual Change in Aid in IMF Programs	22%	24.2%	-0.8%	15.2%	2.5%
Trend Change in Aid Over Previous 5 Years	-1.8%	-4.0%	2.9%	2.9%	-4.2%
Projected Annual Percent Change in Global Aid ^b	9.9%	9.2%	6.8%	6.8%	11.3% ^c

Source: Authors' calculations based on data in IMF documents and OECD-DAC.

Notes:

a. Zambian Aid Scale Up Scenario refers to Box 4, "Macroeconomic Effects of Scaling Up of Donor Assistance," in the IMF's Third Review of Zambia's PRGF Program

b. Based upon most recent OECD DAC global aid projections available at the time of program negotiation or review.

c. Based on OECD DAC Secretariat projections of Gleneagles commitments. Authors' calculations use 2004 as the base year and interpolate yearly aid flows assuming linear increases.

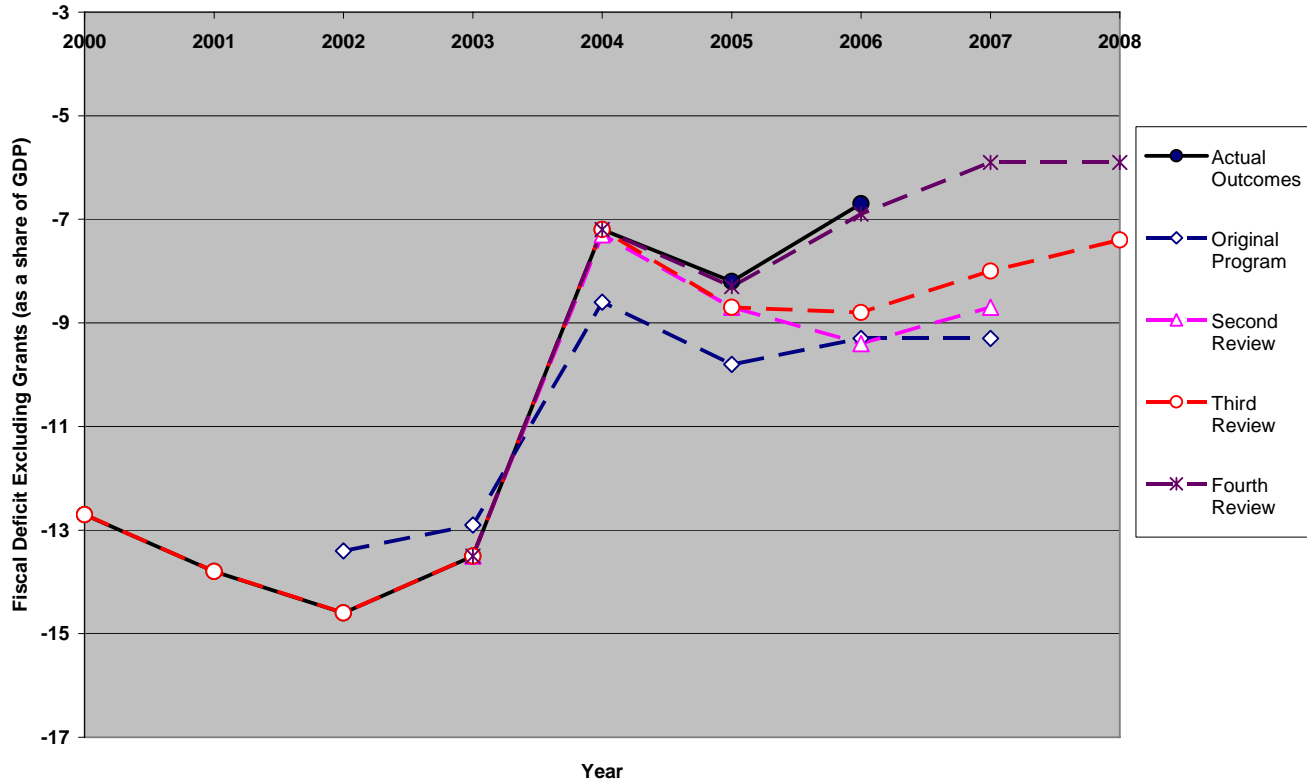
Table 6. Program Projections vs. Actual Outcomes in Original Program, 2004-2006 (in US\$ millions)

Program Projections				Actual Outcomes			
2004	2005	2006	Total 2004-2006	2004	2005	2006	Total 2004-2006
480	501	515	1496	337	597	604	1538

c. The fiscal adjustment path and its rationale.

The initial programs targeted a large reduction in the fiscal deficit, with most of the reduction concentrated in the first year (2004). Thereafter, the programs generally targeted moderate further reductions in the fiscal deficits before and after grants (Charts 2 and 3). Actual outcomes were quite close to the program targets; indeed, the initial deficit reduction was actually higher than targeted.

Chart 2. Programmed and Actual Fiscal Adjustments

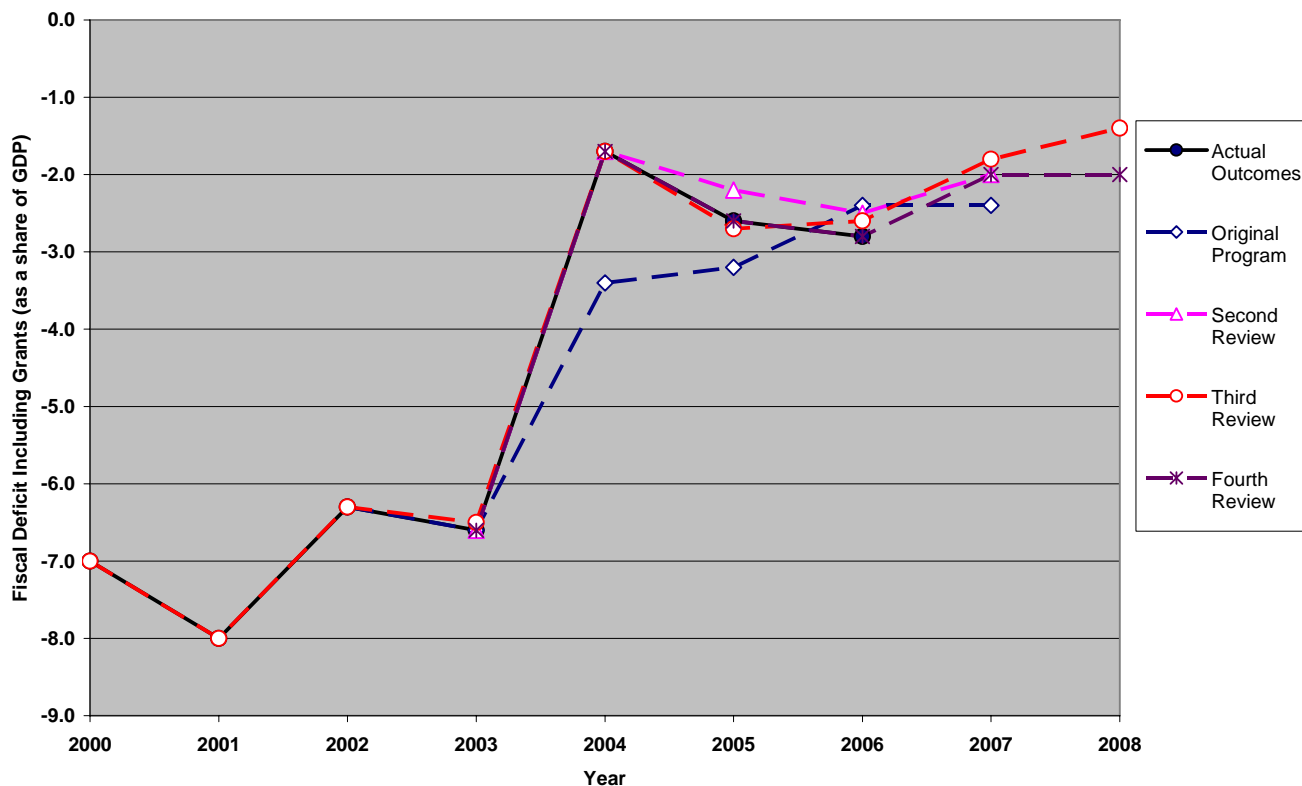


Was the rationale for this fiscal path reasonable and were alternative feasible policy options considered? To address these questions, the remainder of this section discusses in some detail the analytical basis given for the proposed fiscal path in the various IMF program documents. The nature of this analysis, which is explored in depth in the rest of this section, can be summarized as follows:

- Initially, the focus of the analysis underlying the derivation of the fiscal targets was on what would be required to maintain a stable public debt dynamics—especially domestic financing of the deficit--given conservative assumptions about aid. However, the underlying analysis was less effective at exploring different policy options to bring about this reduced domestic financing. The potential tradeoffs involved in creating additional fiscal space for high-priority expenditures were not explored in any depth.
- Following substantial debt relief, debt sustainability considerations were no longer a sufficient benchmark for the fiscal path. Recognizing that macroeconomic judgments about this path depended in large part on the composition and effectiveness of expenditures, the IMF staff did explore the potential tradeoffs implied by alternative aid-financed expenditure paths, although

the results were not fully integrated into the design of the actual program. One of the greatest difficulties encountered was the lack of sector-level information on the costs and likely impact of expanded public sector activities.

Chart 3. Programmed and Actual Fiscal Adjustments

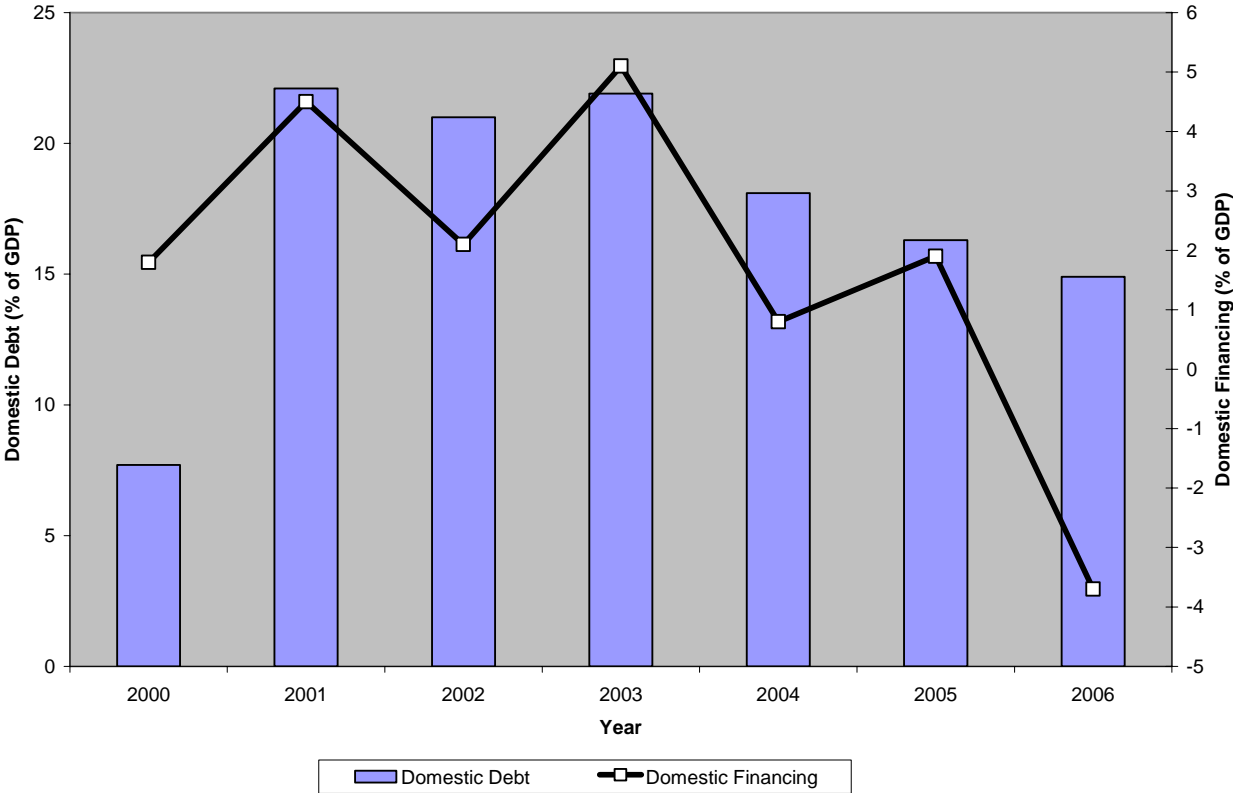


The principal rationale given for fiscal consolidation in the Staff-Monitored programs and the initial PRGF-supported program was to preserve domestic debt sustainability.²² Expenditure overruns had led to a surge in domestic financing during 2000-2003 and a domestic debt burden of over 20 percent of GDP (Chart 4).²³ Moreover, the increased domestic financing in this period had not been used to protect (let alone expand) designated “poverty-reducing” spending. The result was very high real domestic interest rates and surging domestic interest payments. The bill for the latter doubled in only three years to 2.8 percent of GDP by 2003, as large as total government spending on health.

Consistent with the focus on debt sustainability, the IMF staff undertook an analysis of government debt dynamics and expenditure composition in 2003.²⁴ The aim was to assess how medium term fiscal adjustment could be consistent with higher “poverty-reducing” spending by lowering domestic interest payments and reducing the “mandatory” share of non-interest, non-poverty reducing spending (defined in the analysis to include all wage payments). The analysis concluded that since revenues were already relatively high by regional standards and the “mandatory” share of non-poverty spending was high, the only substantial scope for increasing fiscal space for poverty-reducing spending was through expenditure reforms to reduce non-poverty spending so as to both reverse the adverse domestic debt dynamics by reducing the fiscal deficit and shift resources to poverty-reducing activities. Under the “baseline” scenario, which incorporated HIPC debt relief, non-poverty spending was targeted to decline from 18 percent of GDP to 13 percent over the period 2003-2008. This would make possible a gradual

phasing out of domestic financing of the deficit and put domestic debt/GDP on a declining path. Resources freed by expenditure reform and declining domestic interest payments would allow poverty-reducing spending to rise by 3 percentage points of GDP (i.e. from US\$10 to US\$22 per person per year). The analysis concluded that such an adjustment path, while desirable, would still not be adequate to provide the additional resources to put Zambia on a path to reach the MDGs, suggesting that additional donor finance would be necessary for such an objective. However, it did not include any analysis of the macroeconomic implications of a scenario incorporating such higher aid.

Chart 4. Zambia: Domestic Financing of Fiscal Deficit and Domestic Public Debt, 2000-2006



The fiscal strategy eventually adopted in the 2004-2006 PRGF was very similar to that set out in this analysis. As already noted, a front-loaded reduction in the overall fiscal deficit and its domestic financing was programmed to halt the cycle of rising domestic debt and interest payments. All of the fiscal adjustment was to come from expenditure reduction, along with a gradual increase in higher spending on (non-wage) priority poverty-reducing activities.

To undertake a macroeconomic assessment that goes beyond a narrow debt sustainability exercise, there has to be some way of analyzing the consequences of particular paths of the fiscal deficit and public expenditures for the real economy—especially for growth and for key relative prices that influence the distribution of real incomes. In designing the initial program, the IMF staff also drew upon the results of a 2002 World Bank study that examined the consequences of different paths for domestic financing of the deficit—with aid levels assumed constant—for income distribution and growth.²⁵ Based on the estimated relationships between public expenditures and growth during previous decades, the study concluded that any positive impact on poverty reduction from increases in government spending

financed by domestic borrowing was likely to be offset by the adverse effect on growth of crowding out of private sector activity and investment.

Was such an approach justified? Given Zambia's history of poor use of public sector resources, an approach that involved extrapolating on the basis of past relationships between public expenditures and growth was bound to give a pessimistic answer. Indeed, skepticism was justified given this history, calling for an examination of whether governance systems and expenditure choices have changed sufficiently to make better outcomes likely. But such reforms—and changes in expenditure composition—*were* a key part of the fiscal strategy; extrapolating past relationships could not give any insight into the likely impact of such changes.²⁶ (For example, judgments on the likely effectiveness of HIV/AIDS spending -- which is a relatively new phenomenon -- cannot be made by extrapolating past relationships for total public spending.)

How did the IMF analyze the wider range of potentially feasible fiscal policy options available for Zambia following debt relief? A late 2005 assessment concluded that, with attainment of the completion point under the HIPC (and even before MDRI debt relief), Zambia's external debt and debt service indicators would remain quite low over the long term compared with the various threshold indicators of potential debt distress.^{27 28} Debt relief was estimated to lower the net present value of total public sector debt from 132 percent of GDP in 2003 to a projected 20 percent by end-2006. The assessment noted that, if the only objective were to stabilize public debt relative to GDP, significant additional public borrowing would be possible but concluded that in practice the scope for using this room was limited. Two reasons were given for this conclusion. The first was that a reduction in domestic borrowing was needed to anchor the stabilization effort and give the macro framework (specifically, the inflation objective) credibility in light of entrenched expectations of high inflation. But it is hard to believe that such effects (referred to as "fiscal dominance" in the economic literature) would be so paramount when debt relief has just reduced the overall public debt burden so dramatically.

The second argument was that higher domestic financing would crowd out credit to the private sector and private investment. There was probably greater justification for this argument, especially since Zambia's domestic financial markets are not well-integrated with international markets. However, it has proven to be extremely difficult – not just in Zambia, but elsewhere – to identify strong evidence on the size and precise channels of such effects.²⁹ The most that can probably be said is that there was a reasonable case for not expanding substantially domestic financing of the deficit even in the absence of a sustainability constraint; however, the nature of the evidence does not allow for strong judgments about the exact path of domestic financing. (For instance, once it was down to about 1 percent of GDP, it is hard to make a case that a further decline was necessary.) Moreover, as in all discussions over "optimal" fiscal paths, much depends on the efficiency with which the additional resources are used.³⁰

The IMF staff analysis of the macroeconomic effects of an alternative scenario involving a 50-percent scaling up of donor assistance included a number of features of particular relevance for the health sector:

- (i) The impact of the composition of additional public spending on demand: infrastructure investment (mainly road building) was assumed to have a high import component while health and education spending was largely on salaries.
- (ii) Potential supply constraints, especially for scarce personnel, were taken into account. In particular, the short supply of health workers in Zambia was assumed to result in 75 percent of the additional domestic spending on health going to higher wages and the transfer of skilled labor from other sectors. However, there was no discussion of what these constraints might imply for other aspects of program design. In particular, there was no discussion of what the effects on wages and employment in health

and education might mean for the overall ceiling on public sector wages (which remained unchanged at about 8 percent of GDP).

(iii) Perhaps most crucially, the analysis assumed that government spending would be used effectively, with positive impacts on productivity and real growth over the medium term.³¹ The analysis assumed that the different types of public spending affected productivity with different lags but that all had the same overall rate of return. Infrastructure spending was assumed to come on stream with a 2-year lag while lags for health and education spending were assumed to be 5 and 10 years, respectively. (The shorter lag for health spending reflected the potential impact on labor supply of programs such as anti-retroviral treatment for HIV/AIDS.)

The simulation results suggested that: (i) the scaling-up of donor assistance would have a positive effect on growth even after the pick-up in aid tapers off but the estimated sustained impact on growth was relatively modest (0.3 percent); (ii) some real exchange rate appreciation and dampening of exports occurs during the period of aid scaling up; however, export growth picks up after 2010 reflecting the productivity effects of government spending (suggesting that “Dutch Disease” effects are not a major concern); (iii) the overall fiscal deficit before grants widens substantially but the increase in deficit after grants is modest and sustainable; (iv) the positive effects of scaling up are very sensitive to the effectiveness of government spending; and (v) capacity constraints limit the positive effects of the stimulus provided by higher government spending. This latter result implies that aid effectiveness could be enhanced significantly by directing the additional resources to ease key supply constraints. In particular for Zambia, the conclusion suggests that, given the severe shortages of health workers, an expansion of training facilities could be highly productive (see Section IV).

In terms of the tests set out at the beginning of this section, our conclusions on the rationale underlying the fiscal paths in the IMF programs are as follows:

- *There was a reasonable basis for the focus on reducing domestic financing of the deficit. It is impossible to say whether the precise path chosen (including the heavy front-loading 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 the earlier analysis was a misleading one since it included all spending on wages as not reducing poverty. Since a large proportion of health (and education) spending is on wages this classification obscured the critical tradeoffs. More generally, there was insufficient discussion of how the reduction of 5 percentage points of GDP in “non-poverty” reducing spending would be achieved.*
 - *While it is true that Zambia’s revenue/GDP ratio was already relatively high for Sub-Saharan Africa, Zambia’s economic structure was also different, with a smaller proportion accounted for by the (hard to tax) agricultural sector. This is not to say that more of a “tax and spend” strategy was necessarily desirable, but simply that there were probably more feasible policy choices on the revenue side than the initial analysis undertaken by the IMF suggested.³²*
- *Subsequent analysis did explore alternative options for expenditures—including by trying to take account of some of the supply side constraints that were likely to be of most importance for Zambia (including for the health sector). But, as will be discussed later, the fiscal*

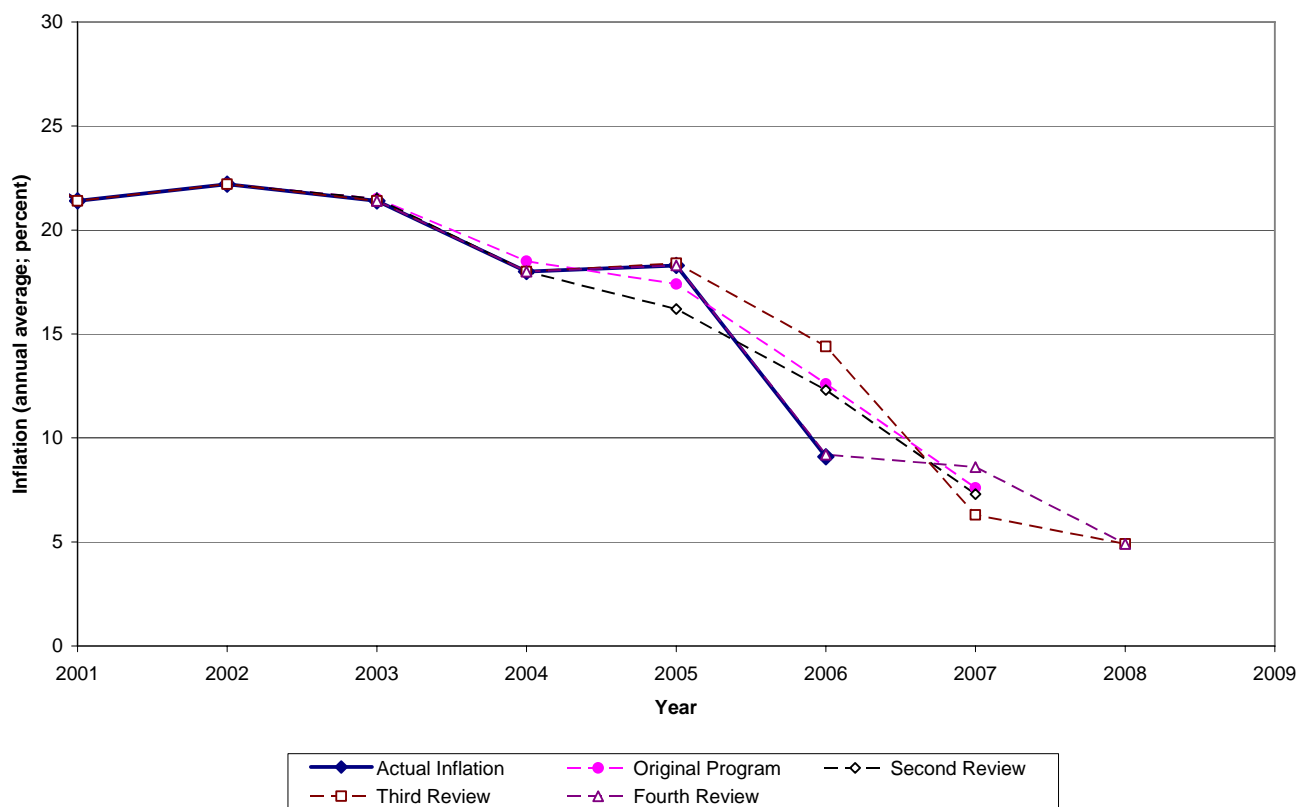
implications of key strategic choices for longer term recurrent spending (especially for wages) remain largely unexplored.

- *Zambia’s case illustrates the difficulties of integrating sector –level expenditure analysis into the macro assessment.³³ IMF staff working on Zambia took two very different approaches at different points: (i) the initial analysis extrapolated on the basis of past experience of links between public spending and growth/poverty outcomes; (ii) a later analysis assumed that the additional resources would be used effectively and analyzed the macro consequences. In practice, there is little that macroeconomic analysis by itself can say on this issue. But it is important to avoid presenting what are essentially judgments on absorptive capacity (i.e., that additional public expenditures will or will not be used efficiently) as macroeconomic assessments.*

d. Inflation targets

Zambia has a history of high inflation—averaging almost 100 percent annually during 1992-1995 before slowing to a rate of 20-30 percent during the period 1996-2002. Earlier IMF arrangements (i.e., covering the periods 1995-98 and 1999-2002) had both targeted sharp declines in inflation to 4 percent annually during their respective 3-year periods. The IMF staff’s subsequent ex-post assessment of these programs concluded that these targets had been overoptimistic, largely because fiscal outcomes were not strong enough to support the programmed disinflation. The IMF’s analysis emphasized the argument of ‘fiscal dominance’ (i.e., that persistent budget deficits were forcing the monetary authorities to monetize the public sector debt so that monetary policy was largely driven by the government’s budget constraint and *seigniorage* to determine inflation). Whatever the merits of such arguments (and they probably had considerable validity during earlier periods of fiscal stress, but much less so following debt relief), they say little about the desirable pace of disinflation. In fact, subsequent IMF programs all consistently targeted a decline in inflation to an end-point of 5 percent, albeit slightly more gradually than the earlier arrangements (Chart 5). (For example, the initial program approved in June 2004 targeted inflation to decline to 15 percent by end-2005, 10 percent by end-2006, and 5 percent by end-2007.)

Chart 5. Targeted and Actual Inflation



Was this targeted path too ambitious? It is very difficult to say, because although there is considerable evidence that high inflation is harmful to growth, the effect on growth of continued moderate inflation is ambiguous.³⁴ The IMF’s own general policy advice for low income countries (see IMF, 2006) is that (i) the balance of considerations generally support the use of single-digit inflation targets; (ii) however pushing inflation too low, say below 5 percent, may entail a loss of output, suggesting the need for caution in setting very low targets; and (iii) program targets should take into account the fact that low-income countries tend to be subject to more output volatility and more vulnerable to price shocks (such as adverse weather conditions, whose effects are exacerbated by weak transportation links and generally undiversified production—both factors present in Zambia). In the latter circumstances, programs are expected to be flexible in accommodating at least the first-round effects of such shocks. Judged by these guidelines (which, of course, some critics would say are too tight), the program targets for inflation in Zambia went to the edge of, but not beyond, the desirable disinflation path. In practice, a detailed review of the IMF program documents for Zambia suggests that the 3-year targeted path for inflation has limited operational significance, with specific monetary targets actually determined on a much shorter (6- to 12-month) period that does take account of supply shocks and other developments, albeit with a goal of keeping inflation on a declining trend.

e. Short-term program design – response to aid shocks and expenditure smoothing

The technical design of the recent IMF programs with Zambia reflects a consistent—and somewhat surprising—bias in favor of “saving” any higher-than-projected aid in the short term. This part of program design is set out in the technical adjustments that are made to a program’s fiscal and monetary targets in the event of shocks to aid in the intervals between program reviews.³⁵ (Table 7.)

The programs called for any excess external support not linked to specific project spending to be offset by lower domestic financing of the fiscal deficit. Shortfalls in aid could be offset by higher domestic financing but only up to a relatively low ceiling (\$20 million in later programs). In effect, the program design reflected a balancing of risks that, in the short-term, favored accumulating reserves over additional expenditures in response to aid shocks. This may have been justified at the time of the initial program design, in light of the experience in 2003 (when aid shortfalls had seriously complicated macroeconomic management). However, it became less and less justified over time as the balance of payments and overall macroeconomic situation eased. In practice, the combination of a conservative aid assumption (discussed above) and an asymmetric response to aid shocks created incentives not to release aid-financed budgetary resources until the aid was actually in hand. As a result, the program design was likely to exacerbate any adverse effects resulting from short-term volatility in donors' disbursements of program aid. As will be discussed in Section III, Zambia has a history of cash flow budget squeezes falling unduly on sectors such as health and there are several reasons why financing for district-level health spending may be especially vulnerable to shocks at the present time. Therefore, a shift in program design in favor of greater expenditure smoothing would be desirable.

Table 7. How Zambia's IMF Programs Adjusted to Aid Shocks

	Nature of adjustment*	Implications
Original program (July 2004)	Ceilings on net domestic financing of the deficit (and NDA) adjusted downward by 100% of higher- than-projected balance of payments support net of debt service. Ceilings adjusted upwards for any shortfall but only up to a limit of \$14 million.	Asymmetric adjustment. Program requires any excess program support to be "saved" while any shortfalls (beyond a narrow limit) require fiscal adjustment.
Second review (March 2005)	As above, except ceiling on upward adjustments in the event of a shortfall in BoP support raised to \$20 million for 2005.	Asymmetric adjustment.
Third review (Dec. 2005)	As above. Ceiling on upward adjustments in the event of a shortfall in BoP support maintained at \$20 million for 2006.	Asymmetric adjustment.
Fourth review (June 2006)	As above	Asymmetric adjustment.

* The focus here is on the program adjustments to the fiscal targets and to net domestic assets (NDA) of the banking system; typically, there was a corresponding adjustment to the target for net international reserves.

Source: Technical Memoranda of Understanding in IMF program documents.

f. Wage bill ceilings

The use of wage bill ceilings is probably the most controversial aspect of IMF arrangements with Zambia. The ceilings have been heavily criticized by a number of civil society groups as unduly constraining the expansion of personnel in health and education needed to attain the MDGs (see, for example, ActionAid (2004), Global Campaign for Education (2004) and Mukosha (2005).) The IMF response to these criticisms has been that surges in the wage bill threatened macroeconomic stability and that the overall ceiling did not prevent the government from hiring new staff in priority areas.³⁶ This section addresses these issues by clarifying the evidence on what the IMF actually did with regard to the wage bill; assessing the rationale underlying the ceilings; and examining the actual outcomes, especially for the health sector. Box 2 identifies some of the key events and Box 3 describes what the IMF programs targeted.

The context in which the wage bill ceilings were introduced was one of fundamental structural weaknesses in Zambia's budgetary systems and public sector pay policies. The payroll and

establishment control 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.³⁷ According to Lewis (2005), government bodies hired with impunity, without reference to the Ministry of Finance or payroll regulations. 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, instead keeping 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; as will be discussed in Section IV, this was 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.³⁸ Previous attempts to address these structural weaknesses had largely failed. Pay reform initiatives launched in 2001 (with World Bank support) focused on decompressing the wage structure, but progress was disappointing, especially in implementing a wage reform strategy.

As will be discussed more extensively in the next section, the health sector in particular had also suffered as a result of earlier stillborn attempts at reform. 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 payroll and wage system in the health sector that was especially fragmented.

The overall wage bill began to increase sharply in 2000, rising from 5.3 percent of GDP to 8 percent by 2002 (Chart 7). IMF programs during this period discussed the need for controlling the wage bill as an important component 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 from the freeze).³⁹ Many of those interviewed in Zambia still have the impression that the IMF had imposed a freeze on health (and education) recruitment at this time. This is not the case. But it does appear that the Government’s own policy choice at the time was to restrict hiring in these areas as well, with the IMF program used as a convenient scapegoat.

The shift to explicit IMF conditionality on the wage bill was triggered by events in 2003 that threatened a major disruption to the macroeconomic program. 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 10 ½ 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 to planned recruitment and ad hoc hiring freezes. The 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 modified the macroeconomic framework to accommodate part of the higher payments. The SMP also included monthly ceilings on overall wage payments (equivalent to an overall wage bill of 8.7 percent of GDP). The Government subsequently reached agreement with some unions to reduce the awarded housing allowances by two thirds, albeit not without considerable disruptions (see Box 2).⁴⁰ 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 (see Box 3 for details).

Box 2. Zambia: Key Events Related to the Wage Bill Ceiling

2000	In a Letter of Intent to the IMF (June 2000), the Government says that the wage bill for 2000 will be limited to 5.2 percent of GDP, but the program does not include any conditionality on the wage bill. The Government also says that it intends to reduce the share of wage bill in domestic non-interest expenditures over the medium term.
2001	Public sector workers strike in May 2001 to demand higher wage increases. Presidential elections in December contribute to substantial budgetary overruns, including substantial wage award to defense and security forces. Wage bill for 2001 reaches 6.8 percent of GDP.
2002	Following further large overruns in the wage bill, the Government announces a hiring freeze [effective August 2002] The hiring freeze is a structural benchmark under the IMF program, but doctors, nurses and teachers are explicitly excluded. The Government announces that its medium-term pay reform strategy aims to consolidate all allowances into basic salaries and undertakes to complete a comprehensive audit of all payrolls. Performance related pay enhancements are to be funded out of resulting payroll savings.
January 2003	Approved budget for 2003 includes an overall wage bill of K 1,520 billion (about 8 percent of GDP).
April 2003	<p>Increases in wages and housing allowances are granted by government that exceed budgetary provisions by an estimated K 500 million on a full-year basis (about 2.5 percent of GDP).</p> <p>Government announces a hiring freeze in light of widespread reports of difficulties by spending ministries in keeping within their budgeted allocations. In practice, a number of Ministries, including Health, had already been forced to constrain any new hiring because budgetary releases were insufficient to meet wage costs that were much higher than originally budgeted.</p> <p>Government opens negotiations with trade unions to discuss reducing increases in housing allowances to more affordable levels. Strike action follows, but the government reaches agreement with some unions to reduce the housing allowances awarded earlier by about two thirds.</p>
July 2003	IMF mission agrees with the Government on a Staff-monitored program (SMP) covering the second half of 2003. The SMP includes monthly indicative ceilings on the wage bill.
Early 2004	<p>A new SMP covering first half of 2004 is agreed upon between the government and IMF mission. This SMP also includes monthly indicative ceilings on the wage bill as well as an undertaking by the Government that the total headcount for the core civil service would not exceed the October 2003 level .</p> <p>Government introduces new procedures to centralize wage negotiations, ensure their consistency with the approved budget (requiring approval by Ministry of Finance and Planning), and require that their implications are set before the Cabinet before final approval.</p>
May 2004	New PRGF arrangement negotiated covering 2004-2006. Program includes quarterly indicative ceilings on the wage bill.
2004	Netherlands provides a grant to finance unpaid termination benefits of an estimated 7,000 non-working but not formally retired teachers to allow them to leave the service, thereby creating room for the hiring of replacements. (A subsequent audit discovered fewer such “non-working” teachers.)
2005	Basic salaries increased by 25 percent.
August 2006	Unionized health workers and Ministry of Health medical staff embark on a strike to demand better pay and working conditions and payment of outstanding allowances owed to them. (Basic salaries were eventually increased by 13 percent and on-call allowances for doctors were about doubled.

Box 3. Wage Ceilings: What Did the IMF Programs Target?

Explicit ceilings on the government wage bill were first introduced in the staff-monitored program (SMP) that covered the second half of 2003 and have been a feature of IMF arrangements with Zambia since then. This box summarizes how the ceilings operated, drawing on a detailed review of IMF program documents.

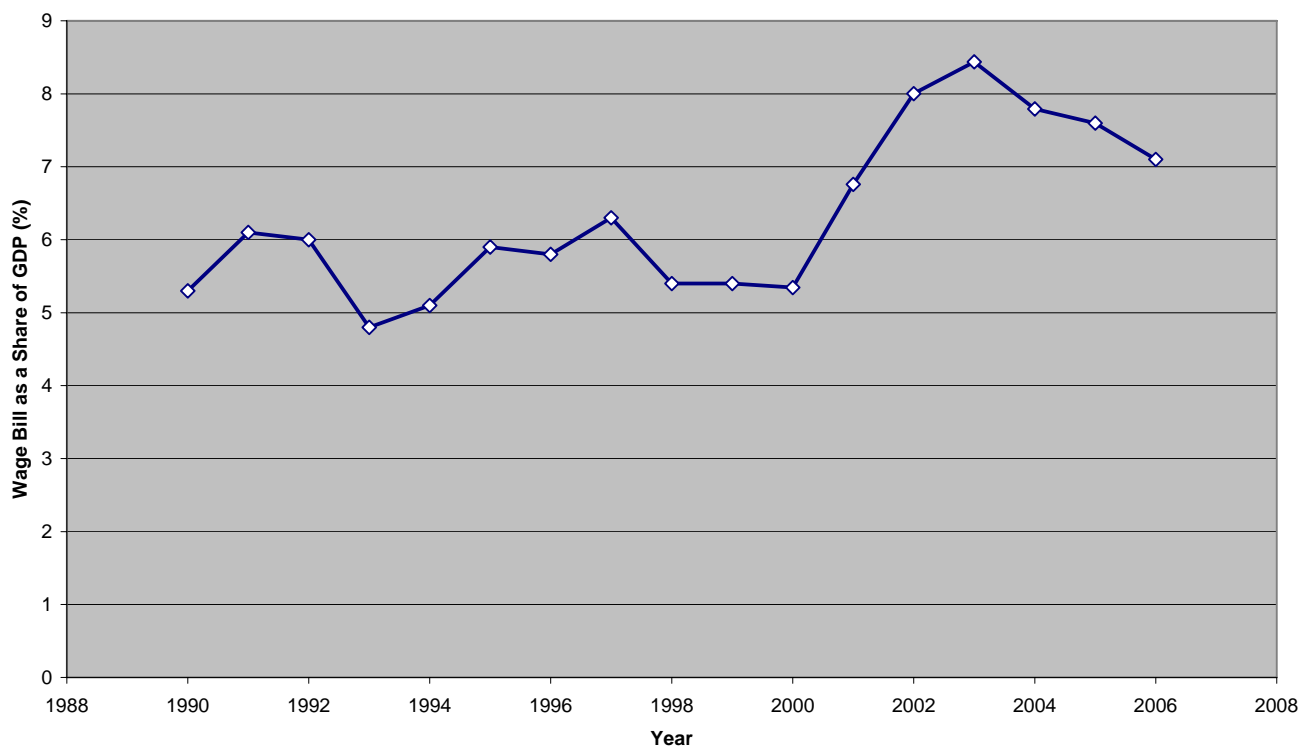
What was targeted? The ceiling covered the Central Government's total wage bill including wages, salaries, allowances and other items specified as personal emoluments in the Government's budget (Yellow Book). There were no exclusions for particular "priority" categories of expenditures (e.g., in health or education), although the setting of the ceilings was meant to allow for additional identified recruitment needs in these areas. Indeed, IMF documents typically include specific statements about the number of additional health service staff and teachers that are assumed to be provided for under the ceilings.⁴¹ In practice, however, there was no way in which the programs could ensure (or even monitor) that any space under the ceilings was actually allocated to such areas.

What was the nature of the conditionality? The ceiling was always an indicative benchmark (monthly under the two SMPs; quarterly under the PRGF). In other words, it was never a formal performance criterion (i.e., a condition that, if not met, automatically interrupts the program, unless the IMF Board grants a waiver). In interviews, the IMF staff emphasized this distinction, but its practical implication may not be very great. It should not be interpreted as meaning that the ceiling was not treated seriously in tracking performance. In practice, the ceilings were generally met (with the exception of some small overshooting during July-September 2003).

What were the quantitative targets? The ceilings were set in kwacha, cumulatively from the beginning of each year. In terms of GDP, they were equivalent to the following:

Program (and year covered by ceiling)	Targeted wage bill (percent of GDP)
First SMP (2003)	8.7
Second SMP (2004)	7.9
Original PRGF (2004)	7.9
Second review (2005)	8.1
Third review (2006)	7.9
Fourth review (2006)	7.5 ⁴²

Chart 7. Government Wage Bill as a Share of GDP



Source: Appendix Table 1.

The rationale underlying the use of such ceilings in Zambia appears to have 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. Under these circumstances, they saw it as a useful supplement to the normal macroeconomic policy instruments that are typically the focus of IMF targets and conditionality. However, once any threats to macroeconomic stability had receded (which most would agree had occurred by 2005) two other purposes appear to have played a role: (i) as a proxy for or incentive to encourage broader civil service reform; and (ii) as a rough benchmark for medium-term resource allocation goals.

The program conditionality on the wage bill was a blanket one, covering all sectors whether they were judged as priorities or not. Interviews with IMF staff indicate that this was because the monitoring systems for payroll expenditures 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. Indeed, program documents generally identified specific numbers for recruitment in these two sectors that were said to be included in the ceilings.⁴³ In practice, however, there was no way to enforce or even systematically monitor whether such priority uses of the ceilings were implemented. The remaining weaknesses in the payroll and establishment systems for the health sector would have made such monitoring difficult: it was 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 on the government payroll. Not surprisingly, therefore, subsequent program documents said very little about what had actually happened to recruitment and employment in health

(or education). Interviews with Ministry of Health officials indicate that, in practice, part of the hiring room was taken up by Ministries that were politically more powerful than health.

So efforts to implement strategic expenditure priorities in Zambia face a complicated interaction of mechanisms that has not worked well in practice:

- Expenditure planning and implementation systems are weak, making it difficult to enforce strategic priorities. The first-best solution is obviously to strengthen the budgeting and expenditure framework, including for payrolls.⁴⁴ But in the interim various second-best devices are being used.
- The most important device, discussed in the next section, is to designate priority spending categories that will be protected from short-term pressures during budget implementation and will receive more resources over the medium term.
- But these priority designations fit awkwardly with the use of a wage bill ceiling, especially for the health sector, where about half of total spending is on personnel emoluments. There are two reasons for this awkward fit. First, there does not appear to have been a practical way of “ring-fencing” the health wage bill from short-term political pressures within the overall ceiling. Second, medium-term choices on how much money to spend on health (or education) are, to a significant extent, choices about employment and compensation. Therefore, it is not possible to judge an appropriate level for the overall wage bill for the medium term without analyzing the fiscal consequences and tradeoffs implied by these choices. As will be seen from the discussion in Section IV, this is a debate that is still underway in Zambia, and is complicated by the lack of concrete operational plans to translate the longer term human resources strategy for the health sector into concrete operational plans for the next several years. But it is not a policy choice the IMF can usefully contribute to through using an overall wage bill ceiling in its programs.

Our overall assessment of the use of wage bill ceilings in the IMF arrangements with Zambia is as follows:

- 1. The initial use of the wage bill ceiling in 2003/2004 was justified. There was a major problem that had to be addressed. In the context of the loss of control over payrolls, the ceilings probably helped to avoid a significant deterioration in macroeconomic conditions.***
- 2. However, the ceiling is a blunt instrument and inevitably involved distortions. The IMF did make efforts to protect hiring in priority sectors, but in practice there was no way of ensuring that any room allowed under the ceiling was not used up by politically powerful agencies, potentially crowding out designated priorities. In practice, the health sector does appear to have been adversely affected. As will be discussed below, the influences on what priority to give to the health sector are complex and ultimately are the responsibility of domestic political choices. But the wage bill ceiling represented one more “head wind” with which the health sector had to struggle in its battle for such political priorities.***
- 3. The ceilings are only suited to short-term emergency situations and that they are not a good vehicle to promote broader civil service reform, which is still urgently needed.***
- 4. There are still major unanswered questions about the longer term fiscal tradeoffs between scaling up employment in the health (and education) versus other claims on scarce resources. However, these are not questions the IMF can answer and they cannot be addressed using a short-term conditionality instrument. Therefore, the wage bill ceiling has outlived its usefulness in Zambia.***

g. Process of program negotiation

Our discussions in Zambia and with IMF staff suggested several messages about the process in which the macroeconomic programs are formulated:

- “Ownership” is hard to define and measure, but our interviews suggested that the key objectives and overall macroeconomic strategy was fully shared at least within the relatively narrow confines of those directly involved with such policies; in that sense, they were not “imposed” by the IMF.⁴⁵
- However, the discussions over macroeconomic policy take place within a relatively small circle. There was a strong sense among many we interviewed that the debate was too closed, with two adverse consequences. First, it weakens political support for key policy choices. As already noted, we were struck by the extent to which certain decisions, including some affecting the health sector, were wrongly attributed to the “IMF program.” This is not healthy because it undermines what should be a robust domestic debate about priorities. Second, it aggravates the lack of integration between discussions about sector-level policies (specifically, choices on the level and composition of expenditures and what needs to be done to improve their effectiveness) and the overall macroeconomic framework. While such a 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 goal should be to encourage a stronger domestic capacity to undertake such analysis.
- The IMF should do more to integrate itself into the broader framework for strengthened mutual accountability that is slowly being developed between the Government and donors. Those interviewed, including donor representatives, generally thought that the IMF’s Zambia team had been effective in their efforts to communicate and coordinate (e.g., about likely aid levels; exploring the consequences of a scaling-up scenario). However, the IMF “way of doing business” needs to adapt further to (i) the longer timeframe involved in the dialogue about policies; (ii) the changing nature of performance assessment frameworks, which de-emphasized explicit conditionality; and (iii) greater emphasis on what is expected of cooperating partners (i.e., donors or the IMF), not just of Government. But these issues go well beyond Zambia since they involve the overall architecture of the IMF’s role in aid-dependent countries.

h. User fees

User fees in the health sector were introduced in 1993, along with a system of exemptions for targeted segments of the population (children under 5, extreme poor, “disease-based” exemptions for those with chronic conditions like TB). Usage of health services fell after introduction of the fees but then recovered. However, the eventual overall conclusion (stated in the First National Development Plan) was that the user fee exemption system had proved ineffective and that such fees had served as a barrier to accessing health services especially by the poor and vulnerable.⁴⁶ An assessment of healthcare financing options conducted by the University of Zambia’s Health Economics Project (2005) concluded that cost recovery had a minimal impact on the overall resource envelope of the public health system. At the district level, however, the fees had represented a useful source of supplemental income, typically being more predictable and stable than government funding. In 2006, the government abolished user fees for primary health care services and also abolished fees for medical services in rural areas.

There was no conditionality on user fees in any of the IMF-supported programs reviewed.

III Budgetary Processes and Priority-Setting

a. *Planning and budgeting processes*

Zambia's budgeting and public expenditure management systems have been historically weak. As recently as 2004, the World Bank concluded that a lack of effective and realistic budget preparation led to absence of a credible budget, with adverse implications for budget execution and service delivery. As a result, public resources were often not well spent and had less impact on poverty than they should:⁴⁷

- The budget process had almost broken down: budget outcomes varied widely from intended plans and political engagement in budget preparation had been ineffective.
- Significant budgetary arrears had built up prior to 2003 due to weaknesses in commitment control.
- There was too little debate over key strategic tradeoffs. A medium-term expenditure format (MTEF) was introduced in 2004 but was yet to be integrated into the budgetary process to allow for closer alignment of policies and resources and a better delineation of priorities in line with the NDP.
- Accountability and transparency in use of public funds was inadequate.

Zambia began a comprehensive Public Expenditure and Financial Accountability (PEMFA) reform program in June 2005 aimed at strengthening existing expenditure management systems and implementing an integrated financial management and information system (IFMIS).

An evaluation of Zambia's public financial management (PFM) system, completed in December 2005, noted some improvements but concluded that effective PFM was still challenged by a number of institutional and capacity constraints, which potentially undermine the effectiveness of the systems:

- There was now greater Cabinet-level involvement earlier in the budget process to discuss priority tradeoffs and set overall ministry ceilings
- Budget presentation was clearer with the advent of activity-based budgets.
- But poorly integrated databases and weak capacity lead to poor predictability/credibility of the budget, which is still not a good predictor of actual expenditures.
- Further moves to strategic budgeting will require significantly greater analytical capacities, particularly in the line ministries. Most of those interviewed agreed with this conclusion. (One person said the MTEF was "just 3 years of numbers," with little integration into operational plans and annual budgeting.) Ministry of Finance officials said that it was often difficult to engage sector Ministries in a substantive discussion at early stages of the budgetary process about short- to medium-term priorities with clear indications of what additional priorities would be funded at different levels of budgetary provision. This lack of a clear indication of what additional interventions could be "bought" with different budgetary choices made it harder to make sharp choices among priorities.
- Multi-year budget planning is still in its infancy. While sector strategies, including for health, prepared as part of the national planning process and investment expenditures in the MTEF come broadly from the sector strategies, the ongoing recurrent costs of many of these decisions have not yet been calculated and included in the forward estimates. As already noted, the overall wage bill ceiling is not, in practice, linked to such forward-looking estimates.

b. Treatment of priority spending under the IMF-supported programs

Zambia entered the most recent set of IMF-supported programs with a history of public financial management that had done a poor job of protecting budget execution decisions from short-term political pressures. A so-called “cash budgeting” system had been in place since 1993 in an effort to control runaway inflation by keeping actual spending in line with revenues, but in practice, after some initial successes, the system was not successful in restoring fiscal discipline. The Government often took on additional expenditure commitments during the year, resulting in large budget overruns and payments arrears. Typically, the planned budget went off track early in the year so that the cash budget system led to ad hoc expenditure squeezes that fell most heavily on the ministries delivering social and economic services.⁴⁸ The unpredictability of monthly cash releases also made the efficient planning and use of budgetary resources very difficult. As might be expected in such circumstances, the burden fell most heavily on non-wage and capital spending, with the health sector among the most affected.⁴⁹

The recent assessment of Zambia’s PFM system noted similar issues. The current system, in effective operation since 2005, is built around estimated quarterly funding profiles submitted by the spending Ministries that are the basis upon which resources are released by the Treasury. The Ministry of Finance and National Planning aggregates these funding profiles and then has to adjust them to match projections of revenue and available external financing, but does not communicate the revised quarterly ceilings back to the implementing ministries. Consequently, actual budget releases may not match the funding profiles and spending ministries cannot reliably predict what resources they will receive.⁵⁰ How much of a problem this creates for the Ministry of Health depends largely on the size of any unanticipated shocks to overall revenues and expenditures. Both Ministry of Health and Ministry of Finance officials report that the system worked well in 2005, but that there were greater problems in 2006 when adverse shocks (e.g., shortfalls in kwacha-denominated donor support because of the exchange rate appreciation, election-related spending not included in the original budget) disrupted budgetary releases; the Ministry of Health was adversely affected.

Reforming public financial management and budgetary processes along the lines discussed above is obviously the first-best solution to these problems. In the interim, however, the way in which IMF-supported programs were designed to protect high-priority expenditures during budget implementation was likely to be of considerable practical importance. A review of the programs and interviews in the field indicate the following:

- The initial definition of “priority poverty-reducing spending” adopted by the authorities was too narrow. Presumably the rationales behind the creation of such priority categories is that they (i) help to protect politically “weak” sectors with potentially high social returns from being unduly squeezed during budget implementation: and (ii) encourage a shift in resources toward these sectors over the medium term. The initial priority category, which included only a fairly narrow group of capital spending items, did not seem to match well with either of these rationales. In particular, it excluded all recurrent spending for health (and education)—even though non-wage health spending had been one of the major casualties of the cash budgeting system.⁵¹ But the IMF was not significantly involved in deriving the priority categories; it essentially took what was agreed between the Government and donors in the context of the HIPC debt relief discussions.⁵²
- The conditionality used in the program to support the floor on such priority spending was a benchmark on payments into the HIPC Initiative account in the Bank of Zambia which was used to fund these expenditures. But in practice, this mechanism was not sufficient to protect

such spending from cash flow pressures. For example, in 2004, the government formally met this benchmark, but many of the commitment authorizations were only made in December, reflecting the late arrival of a large part of donors’ budget support. As a result, a significant part of the spending did not take place.

- A revised and much broader definition of poverty-reducing spending was agreed in time for the 2005 budget and includes a wide range of recurrent costs directly and indirectly related to poverty reducing programs, including wages of health workers. Actual outcomes have been close to or above the targets for such spending in 2005 and 2006 (see Table 8).
- There is no formal budgetary mechanism for protecting specific expenditures (such as ring-fencing or a virtual poverty fund like that used in Uganda) linked to this designation of priority categories, although Ministry of Finance officials said there was an effort to avoid compromising the programmed monthly “profiles” of expenditure releases for health (and education) in the event of revenue shortfalls.⁵³ Moreover, there is no clear relationship between these priority designations – which include health and education spending with heavy wage components – and the overall wage bill ceiling.

Table 8. Priority Poverty-Reducing Spending*
(In percent of GDP)

	2001	2002	2003		2004		2005		2006		2007
			Budget	SMP Act	PRGF Act	PRGF Act	PRGF Act	PRGF Prel.	PRGF		
Priority poverty-reducing spending (Original definition)	1.4	0.9	2.2	1.4	1.0	2.1	2.6		2.9		3.7
Poverty-reducing spending (Expanded Definition)	...	...	...	...	...	...	10.0	13.0	10.7	10.2	10.5

* The original classification of poverty-reducing expenditures covered only specific capital-related items. The revised, and much broader definition, includes a range of recurrent costs both directly related to poverty-reducing programs (e.g., wages of government staff such as health workers, teachers, agricultural extension workers etc.) as well as indirect costs (training, monitoring, maintenance, etc.) related to those activities. See Appendix II to the Addendum to the Second PRSP Progress Report (February 2005) for a detailed classification.

Source: IMF documents.

c. What has happened to government health spending?

Any discussion of government health spending needs to pay careful attention to the particular measure being used especially what types of donor-financed spending is included (see Appendix 1 for a detailed discussion). But the following trends are evident (Table 9):

- Real government spending on health increased moderately in the period 1999-2003, but declined thereafter as fiscal consolidation took place. By 2006, real government spending on health (excluding the vertical funds and donor-funded capital projects) was below the level of 2001 (see Chart 8).⁵⁴ In U.S. dollar terms, per capita spending reached \$17 in 2006, but this recent increase reflected the appreciation of the kwacha. The 2007 budget, if fully implemented, would represent a significant increase in real health spending.
- As a share of GDP, government health spending has declined significantly in recent years, although the 2007 budget implies a reversal of this trend.

- As a share of total health spending, government spending was declining through 2004 (the last year for which National Health Accounts estimates are available), in part because of the increasing importance of external financing channeled through non-government agents. This trend has almost certainly continued in the past two years. For example, the total amount budgeted for Zambia in the U.S. FY 2005 under PEPFAR was \$130 million, about the same size as all government spending on health. In contrast, the total Ministry of Health budget in 2005, including financing by donors under SWAP arrangements, was the equivalent of \$141 million. Of course, not all of the PEPFAR funding is spent in Zambia: part is spent by the various U.S. partners (mainly NGOs) that are responsible for implementation of the various programs.
- As a share of total government expenditures, health spending (excluding that financed by the vertical funds and donor-funded capital projects) has been around 10-11 percent in recent years, still well below the Abuja target. The share is targeted to increase under the 2007 budget, but the targeted increase is less impressive once account is taken of the sharp decline in statutory spending associated with debt relief.

Table 9. Trends in Health Spending, 1995-2005

	Total health expenditures (percent of GDP)	Total health expenditures (US\$ per capita)*	Donor-funded share of total health spending (percent)	Government health expenditures (Kwacha billion)		Government health expenditures (percent of GDP)		Government health expenditures (US\$ per capita)*	
				NHA Concept**	Narrower concept***	NHA Concept**	Narrower concept***	NHA concept**	Narrower concept***
1995	5.7	22	11	96.0		3.2		13	
1996	6.2	21	18	113.7		2.9		10	
1997	6.4	26	22	154.2		3.0		13	
1998	6.9	22	23	214.0		3.6		12	
1999	5.7	18	9	205.7		2.8		8	
2000	5.6	18	18	282.7		2.8		8	
2001	5.5	19	15	386.4	318.4	2.9		10	8
2002	6.7	23	31	545.6	408.9	3.4	2.5	11	8
2003	6.8	27	38	654.6	597.0	3.2	2.9	12	11
2004	7.2	34	43	770.0	579.4	3.0	2.2	14	11
2005	...	...	...	...	629.3	...	1.9	...	12
2006 est.	...	...	...	...	682.3	...	1.7	...	17
2007 budget	...	...			977.5****	...	2.2	...	19

* At market exchange rates.

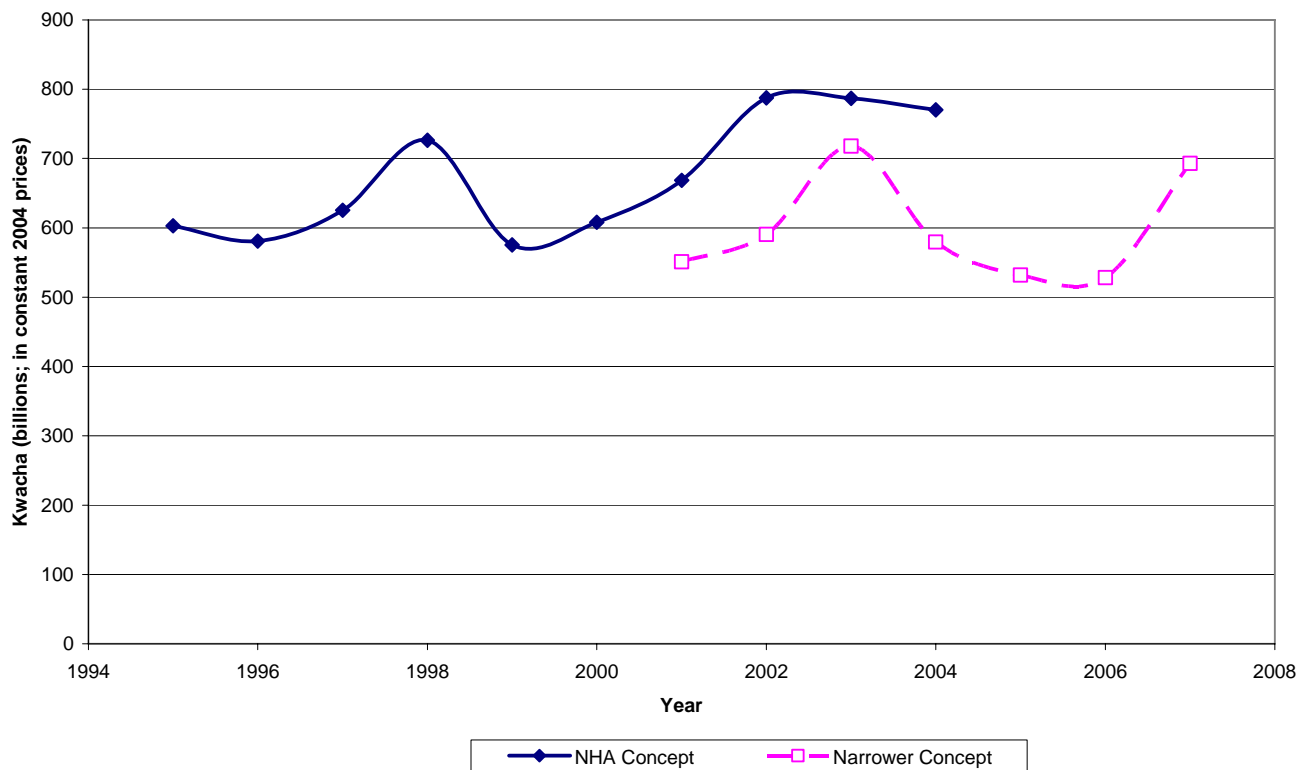
**The underlying data is taken from the Zambia NHA accounts, but the particular definition of government health spending used here differs from that discussed in the main text of those documents. We follow the concept of government health spending that is generally used by the WHO (i.e., all spending, for which the government is the "financing agent." (See Appendix I for details.)

*** Spending by Ministry of Health from budgetary resources plus donor basket funds.⁵⁵

**** K830 billion from central budget plus assumed donor basket support of \$35.1 million at average exchange rate of K4,200=US\$1. (2007 GDP is assumed to be K45,283 billion; and 2007 population at 12.07 million.)

Source: National Health Accounts for Zambia 2002-2004 (Draft, July 2006), Zambia National Health Accounts, 1999-2002, and authors' estimates based on data provided by Zambian officials.

Chart 8. Trends in Real Government Health Spending (1995-2007)
(in constant 2004 prices*)



Source: Table 9

* Average inflation in 2006 and 2007 is assumed to be 9.1 and 8.7 percent, respectively.

d. What influenced the priority given to health spending?

Of course, the final choice on what share of resources to devote to health has to be made by Zambia’s political system. There are many competing demands on the resources, so the question “Is the health sector given sufficient priority?” has no easy answer. Clearly, the needs are enormous and (as will be discussed further in the next section) current spending on health falls well short of several “benchmarks” of requirements to meet such needs. In particular, Zambia’s own agreed upon Basic Health Care Package (BHCP) – discussed in the next section – was substantially under-funded (Health Economics Project, 2005). Much will depend on the capacity of the sector to absorb effectively additional resources. This is not an issue on which an institution like the IMF can judge, but it could, at the very least, be careful to “do no harm” by actions that may inadvertently interfere in a complex set of political economy influences on the priority given to health.

In Zambia, these influences involve a number of actors:

- a) *The various Ministries (and ultimately Cabinet and Parliament) involved in the budgetary process.* Many of those interviewed, both within and outside the Government, said that—despite some undoubted improvements in recent years—the political system was still not very effective at making clear choices between competing priorities in a manner that would lead to decisive

strategic reallocations of resources. Three main reasons were identified. (i) As already noted, the budgetary process did not generate the type of information that would allow clear choices among outputs. Line ministries (including health and education) lacked sufficient technical capacity to generate a clear operational case for greater priority in budgetary discussions, so such choices were made using various rules of thumb. (Some noted that the Ministry of Health was improving in this respect, since there was at least a long-term strategy—including for human resources—to anchor their case.) (ii) The debate over budgetary priorities was fragmented, with some spending Ministries (including health) devoting much of their attention to the dialogue with donors who were funding their sector rather than to the discussion with the Ministry of Finance. This situation was changing, as more donors shifted to general budgetary support, but the period of transition could be a dangerous one for health sector priorities. (iii) Parliament did not play an effective role in the debate over priorities. It discussed and approved the annual budget but not in a manner that provided any serious challenge or input to strategic expenditure choices.

- b) *Donors (referred to as “cooperating partners” in Zambia).* Donors have influenced the share of government resources going to health as well as allocations *within* the health sector through various channels: sector-specific financing, explicit conditionality (e.g., in the context of HIPC debt relief⁵⁶); as well as the overall dialogue with the Government in the context of various sector working groups. The sector-specific funding has grown into a rather complex series of “basket funds” through which various donors provide support for specific activities.⁵⁷ The most important is the District basket, which channels support to the decentralized district-level activities for everything other than personnel expenditures. But, there are also specific ring-fenced funds for provincial hospitals, training schools, human resource retention, as well as a drug supply line and others. There is also an “expanded basket,” usable for broader activities in the health sector. Many of those interviewed agreed that this attempt to influence domestic priorities had grown overly detailed and could hamper the longer term development of stronger domestic budgetary institutions capable of setting and enforcing clear priorities.⁵⁸ For example, it led to some game-playing about what was designated as a “district” expenditure, as the Government attempted to shift funds to offset donor-imposed priorities. However, there was broad agreement that the mechanisms had helped to (i) channel more resources to the district level in a context where they would otherwise have been even more starved of resources; and (ii) improved overall budget predictability at this level. As one commentator put it, the decentralized system had “grown up” with the basket funds and there was a significant risk that, during the transition to a different financing modality, health expenditures would be adversely affected. This is especially the case at present because district-level health finances have been subject to additional shocks—the loss of revenue from user fees (no matter how desirable on other grounds)—and the appreciation of the exchange rate, which has lowered the kwacha equivalent of the remaining basket funds.

In addition, many of those interviewed noted that the large off-budget expansion of the various disease-based vertical funds (especially PEPFAR) had created a perception that there was plenty of money available for health initiatives in Zambia. They thought that this perception weakened the Ministry of Health’s case for greater budgetary priority, although Ministry of Finance officials said this was not the case.

- c) *Civil society.* Our interviews in Zambia indicated several messages about the role of civil society in the debate over priorities:
- Civil society has been more heavily involved at the stage of formulating and costing the broad strategies (e.g., the National Development Plan and the Health Sector Strategic Plan) 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 technical support from donors and northern NGOs to strengthen their capacity to participate at the planning stages; and inadequate access to information.
- Civil society representatives thought they had too little “space” in the debate over budgetary priorities in the medium-term expenditure frameworks and annual budgets.⁵⁹ They saw this debate as largely a dialogue between the Government and donors, although they had more input to sector-level working groups. Interestingly, this was **not** the perception of some of those we interviewed within the Government. They agreed that civil society input had been limited, but thought that this was because 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.⁶⁰
- d. *The IMF*. While the IMF has no direct involvement in choices on expenditure allocation, its actions can have an indirect influence through three possible channels, where it is important to avoid unintended adverse consequences:
- It is important that the IMF macroeconomic assessments about the consequences of scaling up health spending be explicit about what they are assuming about the effectiveness of such spending. Clearly, the capacity to use such resources efficiently is the key test for Zambia’s health system, but it is not an issue on which IMF macroeconomists can say much. The way the IMF dealt with this issue in its analysis of a scaling up scenario for Zambia (discussed in Section II) was reasonable.
 - 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. The decisions made on such priorities reflected domestic political choices. But, 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 such choices, even if that had not been the IMF’s intention.
 - The earlier discussion suggests that district-level non-wage health spending can be especially vulnerable to budgetary shocks in the period ahead. This argues for greater emphasis on expenditure smoothing when designing how Zambia’s fiscal programs respond to short-term shocks (see Section II).

IV The Health Sector Strategy and Links to the Macroeconomic Program and Budgetary Process

a. *Health sector strategy*

Health challenges in Zambia are immense, augmented by weak institutional capacity as well as low and ineffective spending that undermined the overall effectiveness of the health system. The main challenges include:

- A persistently high disease burden with: HIV/AIDS prevalence rate of 16 percent; a high incidence rate of malaria, estimated at 320 diagnoses per 1,000 population; widespread malnutrition with about 47 and 22 percent of under-five Zambian children being stunted and severely stunted, respectively; and a high poverty level.

- A human resource crisis with a large health worker hemorrhage from the public health system due to uncompetitive incentives as well as poor (and deteriorating) conditions of service.
- Inadequate (i.e., sparsely distributed and dilapidating) infrastructure and equipment, significantly limiting the populations access to health services, particularly in rural areas where only 50 percent of the population are within a 5-kilometer radius of a health facility.
- Erratic supply of drugs and other medical supplies, partly due to perennial under-funding and disbursement delays, which severely disrupted supply chains, particularly in the context of international drug procurement procedures.
- An inadequate logistics management system for health service delivery, including poor transport and communication systems.

Since the introduction of a number of health reforms in 1992, Zambia's health system has in principle emphasized the decentralization of health services planning and provision to the district level. The focus was on an "essential health care package" (or so-called the Basic Health Care Package (BHCP), which defined key health interventions that the public health system should provide within the available resources.⁶¹ Although the BHCP has been defined at all level and implemented at some, in practice, little progress has been made in using the packages for actual decision making in the allocation of resources to priority areas. And though a costing of the BHCP has been done, this costing has not been used effectively to inform the health sector about where resources should be prioritized. Further work is needed at the policy and planning level to refine the basic package and use it in the manner for which it was intended.

The priorities in the health sector are to deliver the BHP, control communicable diseases, address human resource constraints facing the sector and improve efficiency of resource mobilization and allocation. The human resource situation in health is particularly critical. According to the Fifth National Development Plan (FNDP) and many other accounts, the health sector is experiencing a human resource crisis that is undermining the capacity to provide basic health care services. In 2004 the Government set up a Human Resource Task Force to identify key human resource constraints and strategies to address those constraints. The recommendations of the Task Force were included in the recently approved Human Resource for Health (HRH) Strategic Plan (2006-2010). Specifically, human resource shortages in health were said to be caused by several factors including:

- Inadequate conditions of service such as low pay, uneconomical housing allowance, lack of medical scheme for health workers, unrevised and discriminatory allowances, limited access to loan facilities and lack of provision of uniforms for nurses.
- Poor working environment in terms of inadequate medical and surgical supplies, inadequate and sometime outdate medical equipment, and dilapidated work infrastructure.
- Weak human resources management systems resulting in delays in processing appointment, promotion, confirmation, transfer, payments of salaries and other conditions of service to health workers.
- Inadequate education and (pre- and in-service) training systems.
- Inadequate funding for the health sector.

The HRH Plan suggests several specific solutions for addressing the human resource crisis, the broad essence of which are: (i) making jobs in health more attractive through improving conditions of service and workplace environments; and (ii) using staff more effectively and efficiently through improved

human resource management and practices; and (iii) a substantial increase in overall staffing (establishment).

In practical terms, the following progress in enhancing human resource sustenance in the first year of implementing the human resources plan in the health sector (or so-called “quick wins in the first 12 months of implementing the HRH Plan”) was reported:

- Health worker basic salaries were increased by 13 percent in 2006.
- On-call allowances were increased from K1.2 million to K2.6 million for junior doctors and from K1.5 million to K3 million for senior doctors.
- Various other initiatives were implemented with support from donors, including a doctor retention scheme, renovation of housing in rural areas, a car-loan scheme, hiring of retired health workers on contract and strengthening of in-service training systems.

b. Health costs and financing, and integration with overall budgetary processes

A number of efforts have been made to determine the “true” costs of health sector strategies, with some of these specifically relating the costs to meeting the health MDGs (e.g., Mphuka, 2005). Table 10 presents the cost estimates of health interventions, as estimated by different observers (indicated at the bottom of the table). In some cases, we have modified the original estimates (e.g, to present all projections in terms of the same baseline total GDP and GDP growth used in the FNDP).⁶²

Table 10: Range of Cost Estimates of Health MDGs

<i>Goal/Target Definition</i>	<i>Total cost (2005-2015) (\$ million)</i>	<i>Average. annual cost (\$ million)</i>	<i>Per capita annual cost (\$)</i>	<i>% of Average Annual GDP (FNDP projections)</i>
(I)	(II)	(III)	(IV)	(V)
Total Health est.:				
a) Health (incl. Child Mortality exc. Malaria, HIV/AIDS & Maternal Mort.) (<u>Mphuka</u>)*	2,512.90	228.4	16.6	1.7
b) <i>Alternative Health cost (CBOH)**</i>	2,684.5	244	22.7	1.8
Components of Health est.				
c) Child Mortality (minimum costs) (<u>Mphuka</u>)*	127.7	11.6	n.a	0.1
d) Maternal Mortality (<u>Mphuka</u>)*	167.4	15.2	1.3	0.1
e) Malaria only (<u>Mphuka</u>)*	630.7	57.3	4.8	0.4
f) HIV/AIDS costs (<u>Mphuka</u>)*	1,092.6	99.4	7.4	0.7
g) <i>Alt. HIV costs 1 (NAC)***</i>	2,684	244	18.5	1.8
h) <i>Alt. HIV costs 2 (Kombe & Smith)****</i>	1,760	160	15	1.2
Total Health Cost ests., recalculated:				
j) Total Health (CBoH + Kombe & Smith): (b)+(h)	4,444.9	404	31.1	2.9
k) Total Health Cost (<u>Mphuka</u>): (a)+(d)+(e)+(f)	4,403.6	400.3	30.8	2.9
l) Total BHCP Costs (CBoH + NAC): (b)+(g)	5,369.1	488	37.5	3.5
Total Health Cost est. in FNDP:				
m) Total Health Costs based on Core Costs	4,578.8	416.2	32.0	3.0

Notes:

*Mphuka (2005) "The Cost of Meeting the MDGs in Zambia". Research commissioned by CSPR, JCTR and CCJDP; Lusaka: October. The study costs all the MDGs, but only the health MDGs are reflected here.

**CBoH, UNZA and IHE (2004) "Costs of a Basic Health Care Package for 1st, 2nd and 3rd Levels of Referral in Zambia", Lusaka: November. The total (2005-2015) cost projection and health-to-GDP ratio calculation are innovations that were not in the study.

*** NAC (2006) "The Zambia HIV and AIDS Strategic Framework 2006-2010", Lusaka: February. Only costs of treatment were extracted and used, and total (2005-2015) cost projection and health-to-GDP ratio calculation are innovations.

****Kombe, G., and O. Smith (2003) "The Costs of Anti-Retroviral Treatment in Zambia", PHRplus, Abt Associates, October. The total (2005-2015) cost projection and health to GDP ratio calculation are authors' estimates based on the study.

Source: Authors' calculations based on cost data from various sources (see table notes).

Focusing on Column (V) and Total cost items (j)-to-(m), most estimates of the total annual costs of providing the desirable health interventions package are around 3 percent of GDP (i.e., in the range of \$30-32 per capita). However, the cost rises to 3 ½ percent of GDP if the estimates of the National Aids Commission (NAC) for HIV-AIDS interventions are used. Several points are worth noting about these estimates:

- Even the lower estimate is still significantly higher than the allocation to health in the 2007 Budget (2.2 percent of GDP) or the Medium-Term Expenditure Framework (MTEF). This raises critical questions about priority-setting for the years ahead.⁶³ There is still a notable divide between what the health sector sees as the actual costs and resource requirements and what the MTEF and national annual budget allocate to the sector.

- None of the cost estimates given in Table 10 take full account of the likely costs of addressing the human resource crisis, including through real wage increases.⁶⁴ [The FNDP and NAC (2006) estimates take partial account of steps to address the human resource crisis.]

c. Problems of planning and budgeting in health sector

The various stakeholder interviews (supplemented with reviews of relevant documents), suggest that many of the general problems with planning and budgetary processes discussed earlier were especially marked in the health sector:

- Ministry of Finance officials indicated that the budgetary process was weakened at the sector Ministry level because line Ministries, including Health, often found it difficult to present *substantive cases*⁶⁵ about their priority budgetary requirements. For example, Ministries such as Health were often in the process of lobbying for additional resources for human resource recruitment when information on the numbers and types of personnel that were hired in previous years was still not available.
- Related to the above, the timing of information provision was also said to weaken the negotiation position of sector Ministries, including the Ministry of Health. Since accountability information was generated with substantial lags, instead of the Ministry of Health and the Ministry of Finance engaging in a substantive discussion on priorities at early stages of the budgetary process, engagement often only happened at the internal “budget hearings” stage. Some changes in allocations could still be made at this stage, but it was more difficult to build a strong case for substantial shifts in priorities, especially when information still incomplete.
- Part of the problem was caused by severe bottlenecks in the process for implementing and monitoring recruitment. The failed attempt to de-link health workers from the civil service wage structure introduced a dual employment situation in the sector. This dual employment system meant that there were significant differences in pay and benefits between the “proper” civil service worker in the sector and the health workers (mainly medical personnel) that were being de-linked. When the effort was discontinued in 2004, many “de-linked” workers were reluctant to be “re-linked” to the civil service proper. During the transition – which arguably is still on-going – this has contributed to greater recruitment inertia and consequently, weakened the reliability of information about who is part of the Ministry of Health establishment.
- The Ministry of Health has been slow to respond to the shift in donor financing away from sector-specific support toward general budgetary support. This shift reinforces the central importance of making an effective case for budgetary priority as part of the centralized national negotiations on the overall budget. Like other sector ministries, the Ministry of Health prefers the sector-specific approach, which guarantees it a certain level of financing modalities.
- Another issue related to planning and budgeting concerns the unprecedented amounts of external resource inflows into the sector. This has raised questions about whether the sector is able to effectively absorb and utilize aid resources. A 2004 review of the World Bank-supported Zambia National Response to HIV/AIDS (ZANARA) Project showed that, out of the project’s four components, the public sector agents experienced the most notable problems with resource absorption and utilization. It was reported that continued delays by implementing agents [particularly the former Central Board of Health on behalf of Ministry

of Health] in submitting specifications to be used in the procurement of various items slowed down the releases of funds to them. More generally, the rapid growth of the various vertical projects and interventions has created multi-faceted pressures as (i) the population's expectations about what the health system should be delivering are reshaped (upwards) following exposure to new vertical interventions; (ii) the health system was disrupted since although vertical projects come with substantial financial resources, they come with limited human resources so that the resource gaps in the well paying and well equipped vertical projects are filled through human resource deflection from the public health system; and (iii) the timing of receipts and the volume of external resources going to health through the vertical projects are not incorporated into national medium-term planning and budget processes increasing the possibility of duplication of efforts.

d. Hiring and wage strategy in the health sector

The overall wage bill for the Ministry of Health has been about 1 percent of GDP in recent years and has generally accounted for a little under half of all health spending (including the basket funds) (Table 11).

Table 11. Personnel Expenditures (PE) in the Health Budget*

	2000	2001	2002	2003	2004	2005	2006 est.	2007 budget
PE (in billions of kwacha)	75.2	139.5	175.9	236.5	265.2	244.1	340.9	382.3
PE/ total Ministry of Health expenditures ** (in percent)		44	43	40	46	39	50	
PE/GDP (in percent)					1.0			

*Ministry of Health spending only.

** Including basket funds. Except for 2007, data is for budgetary releases (which typically exceeds initial budget allocation for P.E. expenditures).

The Government has recently approved the health worker establishment proposed in the Human Resources for Health (HRH) 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 (MTEF). The aim would be to begin by increasing the staffing levels of the most critical and essential 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 the annual budget discussions.⁶⁶ An indicative figure of 1,700 gross recruitments has been accommodated in the 2007 Budget (up from 700 gross recruitments in 2006). At such a rate, it would take a long time to reach the approved establishment.

There is an on-going debate about the medium- to long-term solutions to the incentives structure problems in the health sector. As implemented, the earlier efforts to de-link medical staff from the civil service wage structure created the problems discussed earlier, and was eventually abandoned, leaving a dual employment system with significant disparities in pay and benefits. Weeks et al (2006), quoting Dagdeviren, say the overall approach was a mistake. While many of the commentators interviewed agreed that a dual employment system was created, some do not agree that the basic idea underlying the reform was a mistake. One argument that emphasized was that – as coined by one commentator – a

system of “positive discrimination” was and is still necessary in the health sector. The idea should be to relate pay and other incentives more closely to the jobs people are doing and the skills they possess to perform them. The idea of the original de-linking was to positively discriminate in favor of core health workers, particularly those involved in service delivery.

The difficulties in the de-linking processes reportedly happened because of poor management of the process. The incentives discrimination that ensued was not positive, in the sense of being designed to influence the supply and distribution of skilled staff, since it was not done by type and rank of cadre (along the line described above), but rather by institutions where the cadre were employed with the health systems. Thus, for instance it is reported that posts in the former Central Board of Health attracted better overall incentives packages than counterpart or similar position in the Ministry of Health. This was irrespective of whether the post was in management/administration or closely related to service delivery. The lack of political will to discriminate positively within institutions weakened the reform element of the de-linking process, and the pay divergences that did result were unproductive.

The problem of how to create an effective incentive structure and how to fit that structure within overall resource constraints continue to this day. As noted earlier, salary levels are not the only – or even the most important – factor influencing the recruitment and retention of health professionals, they are one important consideration. While salaries in the health sector are comparable to those of other public sector professionals, the private sector and various NGOs pay significantly more than the Government.⁶⁷ In this context, the efforts to consolidate allowances, as part of the broader Public Sector Reform Process (PRSP) pay reforms, while desirable from many perspectives, needs to be implemented in a manner that fosters flexibility to recruit scarce staff and motivate them to move to areas where the needs are greatest.⁶⁸ More fundamentally, an overall wage strategy for the sector is still needed.

V Lessons

The case study suggests lessons for the IMF, the Government of Zambia, donors and civil society.

a) *The IMF.*

1. *The IMF has made important efforts to assess the macroeconomic implications of alternative scenarios for scaling-up aid in Zambia—more so than in many other countries. However, greater clarity is needed on how such assessments are incorporated into its programs.* Baseline projections for net aid flows over the medium term remain quite conservative in Zambia’s IMF-supported programs. This reflects earlier experience when performance-related disruptions to aid complicated macroeconomic policy, but is less justified now that the environment for greater aid is more favorable. For example, recent program projections are for aid to remain flat in dollar terms, implying a declining share of total aid to Africa if donors come anywhere close to their post-Gleneagles announcements.
2. *The IMF should do more to explore alternative feasible fiscal options.* There was a reasonable basis for the initial focus in the IMF programs on reducing the domestic financing of the fiscal deficit. However, following the extensive debt-relief that Zambia has received, there are many fiscal paths that are consistent with avoiding renewed risk of debt distress. The IMF should do more to help Zambia’s policy-makers explore the macroeconomic consequences of various feasible paths. The key question in such assessments is how effective any additional spending will be, which requires integrating the macroeconomic analysis with a consideration of sector-specific plans. For example, the longer-term fiscal implications of key choices involving recurrent spending for health and education have not been sufficiently investigated. There are major information gaps—stemming from the lack of sufficiently concrete operational plans in these areas—which the IMF cannot fill alone. Given these gaps, the initial approach the IMF took to explore a scaling-up scenario for Zambia (i.e., to assume the additional resources would be used effectively in each sector and to examine the resulting macroeconomic consequences) was a reasonable first step. But the IMF should be more proactive in identifying what information is needed to improve such assessments, in the context of a broader dialogue with Government and donors. Many IMF staff are unclear as to how far they are expected to be involved in such exercises. In Zambia, much depended on the initiative of individual mission chiefs.
3. *The treatment of priority spending categories in IMF programs with Zambia has little operational significance.* Earlier programs incorporated an inappropriately narrow definition of priority spending (e.g. excluding all recurrent spending on health and education)). The current categories of priority poverty-reducing expenditures are so wide as to provide limited guidance on actual priority-setting. Moreover, there are no specific budgetary mechanisms to enforce such “priorities”, other than ‘ring-fencing’ of some donor funds. Realistically, there is not much the IMF can do by itself to influence priority-setting mechanisms; in practice, it has just incorporated the definitions and targets for broad priority categories agreed between the Government and donors. We do not think such targets should be made subject to explicit IMF conditionality. However, as a minimum, the IMF should ensure that its programs do not inadvertently make it harder for some sectors, such as health, to obtain budgetary priority. The programs in Zambia may well have had such an adverse, although unintended, impact on the health sector, mainly because of the way the wage bill ceilings were implemented in practice.

4. *The wage bill ceilings in Zambia's programs have outlived their usefulness and should be dropped.* The initial use of the wage bill ceiling in 2003/2004 was justified because a widespread loss of control over payrolls had to be addressed. However, the ceiling is a blunt instrument and inevitably involved distortions. The IMF made efforts to protect hiring in priority sectors, but in practice there was no way of ensuring that any room allowed under the ceiling was not used up by politically more powerful agencies. In practice, the health sector does appear to have been adversely affected. Moreover, the ceilings are only suited to short-term emergency situations and are not a good vehicle to promote broader civil service reform, which is still urgently needed. There are still major unanswered questions in Zambia about the longer term fiscal tradeoffs between scaling up employment in the health (and education) versus other claims on scarce resources. But these are not questions that can be addressed using a short-term conditionality instrument.
5. *The way in which IMF programs with Zambia respond to short-term shocks to aid should be modified to allow a greater smoothing of expenditures.* Designing how the programs respond to short-term shocks always involves a tradeoff between risks to macroeconomic stability and the costs of disrupting expenditures. Some components of health spending, especially at the district level, are particularly vulnerable to being squeezed in the event of such shocks, especially in present circumstances. Given the progress made in restoring macroeconomic stability, greater emphasis can be given to cushioning such expenditures.
6. *The IMF should do all it can to open up the debate on feasible policy options and priorities.* It could contribute to a broader discussion of macroeconomic (especially fiscal) policy options by facilitating a wider dissemination and discussion of the analytical work that forms the basis of its policy conclusions and by being explicit about the areas where a lack of concrete evidence hinders such assessments.
7. *More generally, the IMF "way of doing business" needs to adapt further to (i) the longer timeframe involved in the dialogue about policies; (ii) the changing nature of performance assessment frameworks with donors, which de-emphasize explicit conditionality; and (iii) greater emphasis on what is expected of cooperating partners (including the IMF), not just of Government.* But these issues go well beyond Zambia since they involved the overall architecture of the IMF role in aid-dependent countries.

b) *Government of Zambia*

1. *The Government should set and implement sharper priorities, especially for the health sector, based on concrete operational plans.* There are clearly many claims on Zambia's resources and hard choices have to be made. But government spending on health has not yet received the priority suggested by various undertakings (the National Development Plan, Abuja targets etc). Real government spending on health was about the same level in 2006 as in 2001, although the 2007 Budget implies a substantial increase. Three types of steps are needed to encourage a clearer delineation of priorities:
 - A deeper political debate over choices requires better information on what is being "bought" with extra resources. The strategic plan for the health sector and the long-term human resource plan provide the basis for such information but need to be translated into prioritized and costed proposals for next several years that make an effective case for

greater budgetary resources; in other words, the strategic plans need to be converted into a fiscal plan.

- The capacity of the Ministry of Health to undertake such budgetary planning should be strengthened.
- The ongoing efforts to strengthen overall budgetary processes are an important part of the longer-term solution. But in the interim the Government should consider reinforcing some mechanisms to ensure that key expenditure categories receive the additional resources planned. For example, it is especially important to protect district-level expenditures at this time, given the reallocation of some donor support away from the “basket” funds. So the Government could adopt internal budgetary rules ensuring that allocations for these categories are fully released.

2. *The Government should prepare an overall wage strategy for the government health sector, to complement the human resources plan.* The strategy will have to be consistent with the level of fiscal resources expected to be available for health over the medium term, which will require hard choices. Implementing such a strategy would obviously be a major challenge--requiring considerable political support-- especially in light of previous failed efforts within the health sector and the lack of progress on broader civil service reform. But the present approach of ad hoc retention schemes does not seem a sufficient response.

c) *Donors*

1. *Predictability of aid and long-term commitments of aid are critical for effective planning of a scaling-up of health spending.* There have been some 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 the Zambian Government is 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 Zambia, which will inevitably affect the incentives to undertake such an expansion.
2. The system of basket funding for the health sector has grown overly complex and, by fragmenting the policy dialogue over expenditure priorities, could inhibit the strengthening of national budgetary processes to set and implement such priorities. But as a ‘second-best’ device it has helped to protect some key spending during difficult periods, so *the transition away from the basket funds needs to be handled carefully. One possible approach to manage the transition would be for the Government to adopt its own explicit budgetary rules to ensure such categories of spending are adequately funded.*
3. *The rapidly growing size of the ‘vertical’ funds and their operation largely outside the existing government health system (e.g., in the case of PEPFAR) is creating many tensions.* It is beyond the scope of this paper to discuss the merits of different modalities for helping countries to address the burden of major diseases. But two obvious points are worth repeating:
 - a. Once started, donors have to be in for the long haul on such initiatives, because it will be beyond the fiscal capacity of the Zambian government to take them over for a very long time.

- b. Choices on how to implement the initiatives should take careful account of how they will affect Zambia's existing health system.¹

d) *Civil society*

1. *Civil society should give greater attention to monitoring and influencing the actual choices made on budgetary priorities in the annual Budget and during its implementation.* 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. For instance, more systematic analysis and responses to the priorities set out in the annual Green Paper (on the medium-term expenditure framework) is needed.

¹ Later this year, 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.

Measuring Government Spending on Health in Zambia ⁶⁹

Discussions about trends in public health expenditures in Zambia are complicated because different commentators often refer to different measures of such spending and because full information on the broadest concept is only available with long lags. For example, the published version of the National Health Accounts (NHA) for Zambia is only available through 2002, although updated estimates through 2004 are now available in a draft version.⁷⁰ Obtaining complete information on externally funded health spending is especially difficult and a number of different concepts of what parts of such spending represent “government” spending are in use. These differences account for widely varying interpretations of how much progress Zambia has made toward the Abuja target of allocating 15 percent of government spending to the health sector.⁷¹

The broadest measure of general government health spending would include the following:⁷²

1. Spending by the Ministry of Health (MoH) and the Central Board of Health (CBoH), before its recent merger with the MoH, financed from the central government’s own revenues or general budgetary support by donors.
2. MoH/CBoH spending financed by external donor support dedicated to the health sector under SWAp arrangements. These resources are channeled through various “basket funds,” to various categories of health sector activities (of which the most important is the District basket fund), but otherwise do not restrict how the money is spent.⁷³ This support was about \$36 million in 2005, but is projected to decline over the medium term as a few donors (Denmark, Ireland) have switched their areas of support away from the health sector and some other donors (especially the U.K) have switched to general budgetary support.⁷⁴
3. MoH spending on very specific agreed activities financed by the Global Fund to Fight Aids, Malaria, and TB and by GAVI. These resources are channeled through the government system but are not available for funding any other health service activities (i.e., they are similar to project spending).
4. Externally funded project loans for the health sector (including from ADB, World Bank, JICA, OPEC Fund). The projects generally follow separate implementation procedures, with disbursements depending on the rate of implementation of each project. Actual spending on some projects is only captured with a lag in government accounts.
5. Spending on health by other central government agencies (primarily the Defense Forces Medical Services) and local authorities. This is relatively small (0.1 percent of GDP in 2004).

In addition, the concept of public sector health spending also used in Zambia’s National Health Accounts, would include spending by parastatal organizations. Such spending was significant before the privatization of the state-owned copper mines (e.g., it was about K32 billion or 0.4 percent of GDP in 1999) but is now small as the latter is captured in private sector spending on health.

In addition, there is large “off-budget” spending focused on particular disease-based interventions financed by external donors, of which the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR)

is by far the largest. The total amount budgeted for Zambia in FY2005 was \$130 million, which is larger than the total Ministry of Health budget, although a substantial proportion of these funds (for overhead costs of the US implementing partners etc) are not spent in Zambia.⁷⁵ Some official references to the share of public health spending include the part of this spending for which a Zambian government agency is the prime or sub-partner (e.g. the University Teaching Hospital or the Zambian National Blood Transfusion Service).

The data on government health spending reported in the main text (e.g., in Table 9) includes health categories 1 through 5 for the broader “NHA concept,” for which data is only available through 2004. More recent estimates for 2005-2006 cover only categories 1 and 2. We have also made an estimate of what the 2007 budget would imply for this narrower definition, if the budget were implemented as planned: K 830 billion of spending by the MoH from central resources (category 1) plus \$35.1 million of donor support through the basket funds (category 2).

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II. Stakeholders interviewed

Mr. David Andrews, African Department, IMF
Mr. Birgir Arnason, Resident Representative in Zambia, IMF
Ms. Pamela Bwalya, Macroeconomic Policy Unit, Planning Department, Ministry of Finance and National Planning
Mr. Francesco Caramazza, African Department, IMF
Mr. Collins Chansa, SWAP Coordinator, Ministry of Health, Zambia
Ms. Pamela Chibonga, Budget Department, Ministry of Finance and National Planning
Mr. Nicholas Chikwenya, Principal Planner, Multilateral and Bilateral Cooperation, Ministry of Health, Zambia
Mr. Davis Chimfwembe, Director, Planning and Development, Ministry of Health, Zambia
Mr. Alan Harding, Department of International Development (DfID), Zambia office
Ms. Barbara Hughes, Director—Population, Health and Nutrition Office, USAID, Zambia
Professor Dirk Jonsson, Department of Economics, University of Zambia
Mr. Henry Kansembe, Ministry of Health, Zambia
Dr. Maboshe, Zambia Office, World Health Organization
Mr. Jon Mikkelsen, African Department, IMF
Ms. Jane Miller, Department of International Development (DfID), Zambia office
Ms. Besinati Mpepo, Network Coordinator, Civil Society for Poverty Reduction (CSPR)
Mr. Dale Mudenda, Health Economics Project, Department of Economics, University of Zambia
Mr. Bona Chitah Mukosha, Health Economics Project, Department of Economics, University of Zambia
Mr. Crane Muleya, Ministry of Finance and National Planning
Ms. Priscilla Musole, Budget Department (Health Desk), Ministry of Finance and National Planning
Mr. Cosmos Musumali, Health Services and Systems Program (HSSP)
Mr. Mark Plant, Policy Development and Review Department, IMF
Mr. Emilio Rosetti, Second Secretary (Social Sectors, Governance), Delegation of the European Commission in Zambia
Dr. Rosemary Sunkutu, Zambia Country Office, World Bank
Mr. Siddarth Tiwari, Deputy Director, African Department, IMF

Zambia: Actual Outcome (Latest IMF Data)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Growth and inflation											
Real GDP growth (percent)	-1.9	2.2	3.6	4.9	3.3	5.1	5.4	5.2	6.0		
Inflation (percent; annual average)	24.5	26.8	26.1	21.4	22.2	21.4	18.0	18.3	9.1		
External Targets											
Grants (\$m)	203.0	153.0	185.0	253.0	305.0	285.0	283.0	418.0	429.0		
Total net aid flows (\$m)*	365.0	466.0	336.0	518.0	639.0	299.0	337.0	597.0	599.0		
Current account balance before grants (%of GDP)	-18.2	-16.8	-19.2	-20.8	-17.3	-15.9	-12.2	-11.8	-2.3		
Current account balance after grants (%of GDP)	-11.6	-8.8	-13.5	-13.9	-9.2	-9.3	-7.0	-6.1	2.3		
Fiscal targets (% of GDP)											
Grants (excluding MDRI related)	6.6	8.0	5.7	5.8	8.3	7.0	5.5	5.6	4.6		
Revenue excluding grants	18.8	17.7	19.4	19.2	17.9	18.0	18.3	17.4	16.9		
Total expenditures (excluding interest)	27.2	26.5	27.9	29.7	27.2	27.1	23.2	23.0	21.5		
of which: wage bill	5.4	5.4	5.3	6.8	8.0	8.4	7.8	7.6	7.1		
Overall balance, before grants	-14.6	-12.0	-12.7	-13.8	-14.6	-13.5	-7.2	-8.2	-6.7		
Overall balance, after grants	-8.0	-4.0	-7.0	-8.0	-6.3	-6.6	-1.7	-2.6	-2.8		
External financing, including grants and debt relief	4.4	3.0	5.3	3.6	4.3	1.5	0.9	0.7	-15.6		
Domestic Financing	3.7	1.0	1.8	4.5	2.1	5.1	0.8	1.9	-3.7		
Domestic Debt	n/a	n/a	7.7	22.1	21.0	21.9	18.1	16.3	14.9		
Zambia: Original program (July 2004)											
Growth and Inflation											
Real GDP growth (percent)					3.3	5.1	3.5	4.5	5.0	5.0	
Inflation (percent; annual average)					22.2	21.5	18.5	17.4	12.6	7.6	
External Targets											
Grants (\$m)			185.0	253.0	305.0	285.0	279.0	321.0	360.0	390.0	
Total net aid flows (\$m)			442.0	518.0	639.0	301.0	480.0	501.0	515.0	506.0	
Current a/c balance before grants (% of GDP)					-17.3	-14.3	-11.4	-11.6	-11.5	-11.9	
Current a/c balance after grants (% of GDP)					-6.5	-5.6	-4.6	-3.9	-3.7	-3.8	
Fiscal Targets (% of GDP)											
Grants					8.3	7.0	5.4	6.6	6.9	7.0	
Revenue excluding grants					17.9	18.1	18.7	18.6	18.6	18.6	
Total expenditures (excluding interest)					27.8	27.3	23.1	24.5	24.8	25.4	
of which: wage bill					8.0	8.4	7.9	7.9	7.9	7.7	
Overall balance, before grants					-13.4	-12.9	-8.6	-9.8	-9.3	-9.3	
Overall balance, after grants					-6.3	-6.6	-3.4	-3.2	-2.4	-2.4	
External financing, including grants and debt relief					4.3	1.5	1.2	1.5	0.8	0.9	
Domestic Financing					2.1	5.1	2.2	1.2	0.9	0.5	
Domestic Debt					21.0	20.8	20.3	17.3	15.3	14.2	

Zambia: Second Review (March 2005)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Growth and Inflation											
Real GDP growth (percent)					3.3	5.1	5.0	5.0	5.0	5.0	
Inflation (percent; annual average)					22.2	21.5	18.0	16.2	12.3	7.3	
External Targets											
Grants (\$m)			185.0	253.0	305.0	285.0	290.0	373.0	449.0	464.0	
Total net aid flows (\$m)			336.0	518.0	639.0	299.0	344.0	526.0	621.0	590.0	
Current a/c balance before grants (% of GDP)					-17.3	-16.2	-11.9	-11.8	-12.0	-11.7	
Current a/c balance after grants (% of GDP)					-6.5	-7.5	-4.8	-4.3	-3.9	-3.9	
Fiscal Targets (% of GDP)											
Grants*						6.9	5.6	6.5	6.9	6.7	
Revenue excluding grants						17.9	18.4	18.3	18.4	18.4	
Total expenditures (excluding interest)					27.2	27.0	23.3	23.5	26.7	26.1	
of which: wage bill						8.4	7.8	7.9	8.1	7.9	
Overall balance, before grants						-13.5	-7.3	-8.7	-9.4	-8.7	
Overall balance, after grants						-6.6	-1.7	-2.2	-2.5	-2.0	
External financing, including grants and debt relief						1.5	0.9	0.6	1.4	1.4	
Domestic Financing						5.1	0.8	1.6	1.2	0.6	
Domestic Debt						21.8	18.2	17.7	15.7	14.7	
Zambia: Third Review (December 2005)											
Growth and Inflation											
Real GDP growth (percent)			3.6	4.9	3.3	5.1	5.4	4.3	6.0	6.0	6.0
Inflation (percent; annual average)			26.1	21.4	22.2	21.4	18.0	18.4	14.4	6.3	4.9
External Targets											
Grants (\$m) *			185.0	253.0	305.0	285.0	290.0	411.0	425.0	475.0	495.0
Total net aid flows (\$m)			336.0	518.0	639.0	299.0	360.0	567.0	627.0	598.0	561.0
Current a/c balance before grants (% of GDP)			-19.2	-20.8	-17.3	-16.2	-10.7	-11.9	-10.9	-9.4	-10.2
Current a/c balance after grants (% of GDP)			-13.5	-13.9	-9.2	-9.6	-5.4	-6.0	-5.7	-4.0	-5.0
Fiscal Targets (% of GDP)											
Grants			5.7	5.8	8.3	7.0	5.5	6.0	6.2	6.2	6.0
Revenue excluding grants			19.4	19.2	17.9	18.0	18.3	17.8	18.0	18.2	18.4
Total expenditures (excluding interest)			27.9	29.7	27.2	27.1	23.2	23.8	24.4	24.6	24.5
of which: wage bill			5.3	6.8	8.0	8.4	7.8	7.9	7.9	7.9	8.0
Overall balance, before grants			-12.7	-13.8	-14.6	-13.5	-7.2	-8.7	-8.8	-8.0	-7.4
Overall balance, after grants			-7.0	-8.0	-6.3	-6.5	-1.7	-2.7	-2.6	-1.8	-1.4
External financing, including grants and debt relief			5.3	3.6	4.3	1.5	0.9	0.7	1.0	1.1	0.9
Domestic Financing			1.8	4.5	2.1	5.1	0.8	1.9	1.5	0.7	0.5
Domestic Debt			7.7	22.1	21.0	21.9	18.1	16.5	15.5	14.7	13.8

Zambia: Fourth Review (June 2006)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Growth and Inflation											
Real GDP growth (percent)						5.1	5.4	5.0	6.0	6.0	6.0
Inflation (percent; annual average)						21.4	18.0	18.3	9.2	8.6	4.9
External Targets											
Grants (\$m)						285.0	283.0	418.0	493.0	510.0	540.0
Total net aid flows (\$m)						299.0	337.0	597.0	646.0	646.0	646.0
Current a/c balance before grants (% of GDP)						-15.9	-10.7	-9.6	-7.9	-9.0	-9.7
Current a/c balance after grants (% of GDP)						-9.3	-5.5	-3.8	-3.8	-5.1	-5.9
Fiscal Targets (% of GDP)											
Grants*						7.0	5.5	5.6	4.1	3.9	3.8
Revenue excluding grants						18.0	18.3	17.4	16.8	17.5	17.9
Total expenditures (excluding interest)						27.1	23.2	23.1	21.5	22.1	22.5
of which: wage bill						8.4	7.8	7.6	7.5	7.9	7.8
Overall balance, before grants						-13.5	-7.2	-8.3	-6.9	-5.9	-5.9
Overall balance, after grants						-6.6	-1.7	-2.6	-2.8	-2.0	-2.0
External financing, including grants and debt relief						1.5	0.9	0.7	-15.3	1.0	0.9
Domestic Financing						5.1	0.8	1.9	-3.3	1.0	1.0
Domestic Debt						21.9	18.1	16.3	15.3	14.6	14.3

* MDRI debt relief is subtracted from grants.

Endnotes

¹ For a different interpretation, see Weeks et al. (2006). They place more emphasis on the consequences of the economic structure inherited from the colonial period and the high costs of Zambia's geopolitical position during the prolonged independence struggles in Zimbabwe and Mozambique.

² Zambia fell into arrears to the IMF in the mid-1980s. These arrears, which rose to peak of about \$1 billion, were cleared in 1995—essentially by refinancing following a 3-year period of monitoring (under a process called the “rights accumulation program”).

³ Frederick Chiluba defeated Kenneth Kaunda, who had ruled Zambia since independence, in the 1991 elections. He was succeeded in 2001 by President Mwanawasa, who won reelection in 2006.

⁴ The state-owned Zambia Consolidated Copper Mines (ZCCM) was eventually split up and privatized during 1997-2000. The Anglo-American Corporation, which had purchased a majority ownership in one component (the Konkola Copper Mines) eventually withdrew from Zambia in 2002.

⁵ Zambia's official poverty line is based on the amount of income required to purchase basic food to meet a minimum caloric requirement for a family of six.

⁶ Stunting is defined as a height-for-age ratio of more than two standard deviations below the norm for the age group.

⁷ The IMF staff's Ex-Post Assessment of Performance under Fund –Supported Programs (March 2004) concluded that a different repayment modality for the arrears would have been desirable and that the hump in debt service to the IMF “*complicates the discussions.*” This is an oblique way of saying that there were strong pressures to agree on new programs even if there were question marks about their ownership and hence implementability.

⁸ See IMF Ex-Post Assessment, para 26.

⁹ Staff-monitored programs are not approved by the IMF Board and do not involve any financing. Therefore, they do not imply any formal IMF endorsement of a country's macroeconomic policies and so are typically not regarded as a sufficiently strong ‘signal’ from the IMF for debt relief under the HIPC Initiative..

¹⁰ Financing under the new PRGF was significant, equivalent to about \$323 million over the 3-year period).

¹¹ The PRSP targeted a sharp decline in inflation, from 19 percent in 2001 to 5 percent by end-2004, a reduction in the fiscal deficit (after grants) from 8.1 percent to 6.4 percent of GDP over the same period, and a sharp decline in the external current account deficit.

¹² Appendix 3 gives a full list of the documents reviewed and stakeholders interviewed. The only IMF document not reviewed was the staff report for the First program review of the PRGF, which has not been made public.

¹³ The definition of net external aid used in this paper includes IMF financing and is net of debt amortization actually paid. The projections include additional financing to fill any financing gaps on the grounds that the program design assumed such gaps would eventually be filled (e.g., through debt relief).

¹⁴ Original program targets refer to the 2004-2006 PRGF. They were often revised at the time of program reviews; see Appendix Table 1 for details.

¹⁵ Estimated for 2006, based on partial-year data (from IMF staff report for fourth program review).

¹⁶ Change (in percentage points of GDP) between t_1 and t_{+2} , where t_0 is the year in which the original program was approved.

¹⁷ Including analysis in the 2003 Ex-Post Assessment of the IMF long-term program involvement in Zambia and various Article IV consultation papers.

¹⁸ For example, the World Bank Country Assistance Strategy (CAS), prepared around the same time, assumed a “low” financing scenario for World Bank assistance because of Zambia's weak implementation record. The CAS discussed a number of benchmarks that would justify a shift to higher World Bank financing scenarios, including better performance under the IMF-supported program.

¹⁹ See Chapter I: “The Macroeconomic Impact of Scaling Up Donor Assistance: A Simulation Analysis” in *Zambia: Selected Issues and Statistical Appendix, December 23, 2005*. This was prepared at the same time as the third program review.

²⁰ Although commitments data has generally proved to be a relatively poor guide to actual dollar disbursements, the comparison here is in terms of trend rates of growth.

²¹ Estimated outcomes are based on partial-year data for 2006.

²² In a sense, the long delay in completing comprehensive debt relief for Zambia—whatever the merits of the reasons underlying the delay—postponed the discussion of what a rational “post debt-relief” fiscal policy for

Zambia should look like. In this earlier period, civil society commentators tended to point to the large size of scheduled debt service payments compared to social spending needs. But such comparisons were misleading because most of the debt service was not paid, being refinanced in one way or another. Others, including the IMF, pointed to the total public debt indicators which signaled unsustainability and hence the need for substantial fiscal adjustment. But this judgment was also somewhat misleading since the debt could not be realistically repaid. In this situation of “debt irrelevance,” there was no obvious guide to the appropriate fiscal path.

²³ The Government also had to issue a substantial amount of domestic debt in 2001 to recapitalize the Bank of Zambia and the state-owned Zambia National Commercial Bank.

²⁴ See chapter II of *Zambia: Selected Issues and Statistical Appendix, made public in July 2004*.

²⁵ Devarajan and Go (2002): *A Macroeconomic Framework for Poverty Reduction Strategy Papers, with an application to Zambia*. The approach taken was to model the link of macroeconomic policies to poverty outcomes through two channels: (i) the effect of government spending on output, assuming no change in relative prices or wages; and (ii) the effect of government spending on distribution (through its effect on relative prices and wages, taking account of the composition of income and expenditures of households at different income levels). The short-term impact of government spending on output was estimated using vector autoregression (VAR) estimates of the links between government expenditure, the real exchange rate, and growth. The estimates suggest that the cumulative impact of government spending on output was negligible over a two-year period as a small positive Keynesian effect of higher spending in the first year was largely dissipated in the second year. This result was largely driven by the assumption of no additional foreign financing: with no room (by assumption) to expand the current account deficit, the higher fiscal deficit largely crowded out private investment.

²⁶ Devarajan and Go (2002) attempt to capture the effect of changes in the composition of spending on poverty by using the data of household expenditure survey data to estimate the extent to which households were benefiting from public health expenditure spending. They treated the impact of such spending as a direct transfer to households. Such an approach cannot capture any longer term effects of such spending on productivity.

²⁷ The assessment followed the recently introduced IMF-World Bank Debt Sustainability Assessment (DSA) framework. That framework, discussed in more detail in the background note prepared for the Working Group on *The Nature of the Debate Between the IMF and its Critics* sets indicative, country-specific debt burden thresholds that depend on the quality of a country’s policies and institutions. As measured by the World Bank’s Country Policy and Institutional Assessment (CPIA), Zambia ranks as a “medium performer” in terms of policies and institutions. The indicative thresholds of potential debt distress for countries in this category are a net present value (NPV) of debt-to-exports ratio of 150 percent, an NPV of debt-to-reserve ratio of 250 percent, an NPV of debt-to-GDP ratio of 40 percent, and debt-service-to-exports and revenue ratios of 20 and 30 percent, respectively. Zambia’s debt indicators remained well below these threshold levels both under the baseline scenario and under most stress tests, except for a scenario involving a sharp fall in copper prices. After MDRI debt relief, debt and debt service burden indicators never came close to their respective thresholds even in such an adverse scenario.

²⁸ The baseline scenario assumed that external grants were stable at around 6 percent of GDP (i.e., growing by about 6 percent per annum in real terms) and that external concessional borrowing declined gradually from about 2 percent to 1 percent of GDP. Government expenditures were assumed to rise to 25 percent of GDP and remain stable thereafter while domestic financing fell to ½ percent of GDP in 2008 and remained stable thereafter.

²⁹ 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:

“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).

³⁰ Weeks et al. (2006) propose a different approach to the domestic financing issue. They suggest a partial default and restructuring of existing domestic debt and suggest that domestic financing of about 3 percent of GDP would be sustainable thereafter. They also argue that expanded public investment would “crowd in” private investment.

While it is true that concrete evidence on the importance of “crowding out” mechanisms in Zambia is limited, such a strategy would be very risky, especially given the thinness of Zambia’s domestic financial markets. Partial default followed by expanded borrowing is a hard trick to pull off, to say the least.

³¹ A real rate of return of 15 percent was assumed for all additional pro-poor spending.

³² The IMF recently completed a review of Zambia’s tax system, but some of its suggestions (including a broadening of the scope of the value-added tax) have proven to be politically controversial. One issue that could be explored further – and is more of an option now than when the initial program was formulated – is expanding taxation of the copper sector. A number of those interviewed thought there were ways of doing this that do not violate the investment agreements with the privatized copper companies, but the issue goes beyond the scope of this paper.

³³ 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.

³⁴ The background paper on *The Nature of the Debate between the IMF and its Critics* discusses some of the empirical evidence.

³⁵ Future program targets can also be modified at the time of the (six-monthly) program reviews.

³⁶ See, for example, the responses by the IMF Director of External Relations to the ActionAid and Global Campaign for Education criticisms at www.imf.org/external/np/vc/2004/093004.htm and www.imf.org/external/np/vc/2004/111804.htm.

³⁷ The 2005 assessment of Zambia’s Public Financial Management system rated the effectiveness of its payroll controls at only a “D+.”

³⁸ See the World Bank Country Economic Memorandum of 2004 for a fuller discussion of these structural problems.

³⁹ See [IMF LOI].

⁴⁰ Steps were also taken in 2004 to improve the public sector wage bargaining process and integrate it more effectively with budget formulation to ensure that political choices on the wage structure were made along with other resource allocation decisions. For example, the timing of wage negotiations was brought forward to coincide with preparation of the annual budget (rather than being conducted later) and steps were taken to ensure greater transparency and predictability, with all parties being aware of the budgeted wage bill.

⁴¹ The discussion of such additional recruitment did not make clear whether such numbers reflected gross new hiring or an overall increase in the staff establishment, after taking account of attrition. In practice they appear to have referred to gross new hiring. Moreover, part of the recruitment appears to have reflected a regularization of staff already working but not yet on the central payroll.

⁴² Decline for 2006 compared to the third review largely reflects projected faster growth in GDP. Ceiling in kwacha terms was reduced only slightly (from K 3.019 billion to K 2.967 billion).

⁴³ For example, (1) 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. (It had been expected that a Dutch grant would fund separation payments for 7,000 inactive teachers, thereby making room for an equivalent number of new hires, but a subsequent audit identified fewer inactive teachers so additional resources were needed to bring the total hiring to 7,000). (2) The third review said the ceiling would allow for net recruitment of 2000 teachers and “retention of core health workers”. (3) 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.

⁴⁴ One of the pillar’s of Zambia’s Public Sector Reform Programme is to “right-size” the civil service and implement pay reform to align government operations more closely with the poverty-reducing and growth objectives of the National Development Plan. But progress has been slow, partly because of the high cost that pay reform could have on pension liabilities. A new Payroll Management and Establishment Control System (PEMC) has been introduced. According to the 2005 assessment of Zambia’s Public Financial Management system (p33), the Ministry of Health payroll was one of the last to be added to the new system. But the main problems are not just integration of payroll systems but the reliability and timeliness of the data contained. The 2005 assessment concluded that quality of data feeding into the systems, both the old and new, was not yet adequate.

⁴⁵ In contrast, some officials were of the view that the IMF had pushed too hard on some “structural” policies, including the timetable for privatizations. They agreed with the broad goals but thought more scope should have been allowed for a flexible timetable within which to build the necessary political support.

⁴⁶ For a more comprehensive discussion, see the final chapter of Weeks et al (2006).

⁴⁷ See World Bank Country Economic Memorandum, 2004. In 2003, Zambia met only 3 of 16 criteria for sound public expenditure management established to assess the capacity of HIPC countries to track poverty-reducing expenditures; by the end of 2004, it met 6 out of 16 benchmarks—the average for SSA HIPC countries. See Update on the Assessments and Implementation of Action Plans to Strengthen Capacity of HIPC Countries to Track Poverty-Reducing Public Spending (April, 2005). Available at www.imf.org/external/np/pp/eng/2005/041205a.pdf

⁴⁸ See Dinh et al. (2002) for a detailed discussion of how the cash budget system operated in practice and its consequences.

⁴⁹ Dinh et al. report data for the late 1990s that show large, erratic fluctuations in recurrent departmental charges (i.e., non-wage spending) by the Ministry of Health caused by the cash budget system. They report that at one point these fluctuations forced the interruption of inoculation programs, which had to be restarted later at higher cost.

⁵⁰ The assessment of the PFM system rated predictability in the availability of funds for the commitment of expenditures a “D+.”

⁵¹ The agreed conditions that Zambia was to meet in order to reach the HIPC completion point included one designed to promote better expenditure targeting for the health sector: funds released to District Health Management Boards were to be at least 80 percent of the amount budgeted.

⁵² The 2004 program did include a commitment to agree with stakeholders on a wider definition of poverty-reducing spending.

⁵³ A separate background paper is being prepared for the Working Group to analyze different budgetary approaches to “protecting” or “prioritizing” certain expenditure categories.

⁵⁴ We deflated nominal health spending by the overall GDP deflator (when available) or the consumer price index. This may not reflect accurately the trend in costs in the health sector.

⁵⁵ See Appendix 1 for details.

⁵⁶ For example, three “triggers” associated with the health sector were established for Zambia to move to the HIPC completion point, including that actual cash releases to the District Health Boards should be at least 80 percent of the amount budgeted. (See IMF and World Bank, 2005, pages 13-14.)

⁵⁷ The Sector-Wide Approaches (SWAs) in Zambia were introduced in early 1993, when the Danish International Development Agency (DANIDA) perceived a need to improve the district health system and started providing direct recurrent support to districts. In the same year, this idea was bought into by other Cooperating Partners including DFID, the EU, Sida, UNICEF and the World Bank, and the concept was expanded into the so-called “basket funding.”

Since 2005, some of the main donors in the health sector such as DFID and the EU have changed their financing modalities to GBS (though in the case of the EU, the operation of “variable trenches” protects spending to health somewhat). Other main donors such as DANIDA and Development Corporation of Ireland (DCI) have shifted their support to the education sector. This has left only Sweden (Sida) and the Netherlands maintaining sector support to the district and expanded baskets.

⁵⁸ This issue is not confined to the health sector. A recent public expenditure review of the education sector concluded that “*unfortunately, the Ministry of Education’s existing budget system [structure and processes] is complex and considerably bifurcated between expenditures financed from GRZ’s own resources and expenditures financed from development partners...Each of these “components” has its own budget structure and processes.*” [World Bank 2006, para. 2.07.]

⁵⁹ Some inputs to the budgetary process are provided. For example, The Civil Society for Poverty Reduction (CSPR) now issues pre- and post-budget statements.

⁶⁰ Several commentators said they had been struck by the lack of any response from civil society to the proposals for increased defense spending in the 2007-2009 Medium-Term Expenditure Framework (Green Paper).

⁶¹ According to the Fifth Development Plan (P126), “The Basic Health Care Package (BHCP) is a set of carefully selected high impact interventions to be offered to the public freely or on a cost-sharing basis at appropriate levels. Interventions outside this package are offered on a full cost recovery basis. Interventions included in the

BHCP were selected on the basis of an epidemiological analysis of those disease and conditions that cause the highest burden of disease and death.”

⁶² For example, Mphuka (2005) used a baseline nominal GDP value of K31,172 billion (as obtained from the MTEF 2005-2007) and a growth rate of 5.0 percent per annum over the 11 year MDGs period, whereas in the FNDP the baseline nominal GDP value is K32,610 billion and GDP growth is assumed to be 7.0 percent per annum over the Plan period.

⁶³ The Fifth National Development Plan (FNDP) estimates an overall financing gap equivalent to 3.3 percent of GDP if all its developmental aspirations, including those in the health sector, were to be met. The gap would have to be met through some mix of additional resource mobilization and tradeoffs between expenditure priorities.

⁶⁴ The CboH et al (2004) and Mphuka (2005) estimates do not even partially address the crisis. The FNDP, and to a greater degree the NAC (2006) costing, manage to partially take account of the crisis.

⁶⁵ A substantive case was described in terms of a performance based cases with full analytical accounting for previous funding disbursements, stating the forward-looking short- to medium-term priorities and clearly indicating the projected amount of extra resources required to fund additional priorities at different levels of budgetary provision

⁶⁶ Hiring in the health sector, as in any other part of Government, is regulated by the Cabinet Office. The process involves the Ministry of Health negotiating with the Public Service Management unit (PSM) under the Cabinet Office to establish whether and how new posts and even posts falling vacant can be accommodated within the overall government structure. The PSM unit then flags the agreed position to the Ministry of Finance to establish if additional resources would be available to sustain the proposed new structure.

⁶⁷ Private doctors’ salaries are more than double the salaries of government doctors, midwives’ salaries are almost one third higher, and laboratory technicians’ salaries are more than three times the amount paid by government. NGOs reportedly pay between 23 percent and 46 percent more than Government. These salary differentials pose an additional challenge to retaining cadres in the public health system.

⁶⁸ According to the HRH Plan, a sample of the 2005 salaries and allowances for doctors, nurses and paramedics revealed that allowances make up a considerable portion of the composite total – in the case of doctors this was just under 40 percent.

⁶⁹ We are grateful to Dale Mudenda of the Department of Economics, University of Zambia, and Mr. Henry Kansambe of the Ministry of Health for discussions on the various concepts and measures being used in Zambia. Mr Emilio Rosetti also kindly took time from his busy schedule for a very useful discussion of measurement concepts and data sources. Any remaining errors of fact or interpretation are the authors’ responsibility.

⁷⁰ See Zambia National Health Accounts, 1999-2002 and National Health Accounts for Zambia, 2002-2004. The WHO NHA website <http://www.who.int/nha/en/> also contains estimates for government health spending through 2004, but the data for 2003-2004 are imputed from the growth rate of general government spending and are not as accurate as the latest Zambian estimates included in Table 9 of the main text.

⁷¹ Different measures of overall government spending to which the 15 percent ratio should be applied are also in use. Official publications (e.g., The Economic Report of the Ministry of Finance and National Planning) tend to refer to the share of health spending as a proportion of total discretionary spending (i.e., excluding debt service).

⁷² See *The Guide to Producing National Health Accounts* for a detailed discussion of the underlying methodology. In terms of the classification scheme and terminology used in that guide, the general government is the “financing agent” (i.e., the pooler and distributor of money, which may come from its own revenues or other sources – mainly donor funds in the case of Zambia.) This distinction is important because some discussions of the “share” of government expenditures (e.g., in relation to GDP) refer only to that part of government spending for which the government is also the *financing source*. Indeed, the discussion of trends in government health spending in the main text of the Zambia NHA documents tends to use this concept, which explains why the tables in the main text of the documents show a smaller share of government spending than the “NHA concept” estimates given in Table 9. The differences are solely due to this definition of what is government spending, where we follow the approach taken by the WHO; all of the underlying numbers are taken from the Zambia NHA sources.

⁷³ Table 11.2 of the 2005 Annual Report of the Ministry of Health gives a detailed breakdown and cash flow analysis of the basket funds for 2005.

⁷⁴ The UK (DfID) has also committed \$5 million annually to help offset the impact of the elimination of user fees in rural areas.

⁷⁵ See <http://www.pepfar.gov> for details.