

# ENHANCING THE IMF'S FOCUS ON GROWTH AND POVERTY REDUCTION IN LOW-INCOME COUNTRIES

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## LIST OF ABBREVIATIONS

AfGH	Action for Global Health
CSO	Civil Society Organisation
DFID	Department for International Development
DHE	Development Health Expenditure
DHMT	District Health Management Team
ECF	Extended Credit Facility
EHP	Essential Health Package
EHRP	Emergency Human Resource Programme
ESAF	Enhanced Structural Adjustment Facility
ESF	Exogenous Shocks Facility
FDI	Foreign Direct Investment
FHCI	Free Health Care Initiative
G-20	Group of Twenty
GCE	Global Campaign for Education
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IADB	Inter American Development Bank
IDA	International Development Assistance
IEO	Independent Evaluation Office
ILO	International Labour Organization
IMF	International Monetary Fund
INGO	International Non-Governmental Organisation
LIC	Low Income Country
MDGs	Millennium Development Goals
MGDS	Malawi Growth and Development Strategy
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organisation
PMTCT	Prevention of Mother to Child Transmission
POW	Programme of Work
PRGF	Poverty Reduction and Growth Facility
PRGT	Poverty Reduction and Growth Trust
PSI	Population Services International
RCF	Rapid Credit Facility
REO	Regional Economic Outlook (IMF)
RHE	Recurrent Health Expenditure
SBA	Stand-By Arrangement
SCF	Standby Credit Facility
SIDA	Swedish International Development Cooperation Agency
SSA	Sub-Saharan Africa
SWAp	Sector Wide Approach
TGE	Total Government Expenditure
THE	Total Health Expenditure
U5M	Under-five Mortality
U5MR	Under Five Mortality Rate
UK	United Kingdom
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
VAT	Value Added Tax
WEO	World Economic Outlook (IMF)
WHO	World Health Organization
WTO	World Trade Organization

## EXECUTIVE SUMMARY

### 1. Background, Objectives and Methodology

In July 2009, the IMF changed its concessional financing facilities for Low-Income Countries (LICs), introducing the Poverty Reduction and Growth Trust (PRGT) which can lend via the Extended Credit Facility (ECF), the Standby Credit Facility (SCF) and the Rapid Credit Facility (RCF). These facilities were intended by the IMF to have “an enhanced focus on growth and poverty reduction”, and the Norwegian government provided financing to support the SCF and RCF windows.

A coalition of Norwegian NGOs commissioned this report from Development Finance International, to analyse whether the new facilities are living up to this objective, and allowing countries to move faster towards the Millennium Development Goals. They asked DFI to look particularly closely at impact on the health sector. The paper analyses all 37 PRGT agreements, and presents case studies of Honduras, Malawi and Sierra Leone, written by local experts closely involved in IMF-government discussions. As the new facilities began only in 2010, this assessment should be seen as preliminary.

The report makes clear that the IMF is not, and should not be, a long-term development lender. However, it has committed to enhancing its focus on growth and poverty reduction through the PRGT, and donors have provided concessional funding to the IMF to support the PRGT on this basis: the facilities should therefore be judged on whether they are achieving this goal. The report also makes clear that it is analysing trends resulting from IMF-government agreements, not ascribing “responsibility” to the IMF for all trends and their impact on MDG prospects.

### 2. Conclusions and Recommendations

Overall, the report concludes that there is only very limited evidence of an enhanced focus on growth and poverty reduction compared to the previous PRGF facility programmes: mostly the PRGT has formalized or standardized evolutionary changes which have been occurring since 2000. There have been some steps forward showing increased flexibility by the Fund, but most were introduced before the PRGT, and those relating to macroeconomic policy look increasingly fragile. As a result, the report recommends 9 important steps to enhance PRGT focus on poverty reduction and growth.

There is no evidence of a broader “enhanced focus on poverty reduction and growth” in the content of PRGT documents. They are broadly the same as PRGFs, and there continues to be little or no analysis of the likely growth drivers, or poverty or distributional impact of programmes, even though increasingly reliable tools for analysing such issues are available outside the Fund.

**RECOMMENDATION 1: *The Fund should produce an annual PRGT review report specifying exactly how programmes are accelerating poverty reduction and growth, how it is analysing and acting on the fundamental drivers of such acceleration, and how it is analysing the poverty and social impact of its macro and structural conditions. This could possibly be combined with the current LIC Vulnerability Report, and could also discuss the fiscal, inflation control, structural conditionality and poverty reduction spending issues raised in recommendations 3-6 below. In addition, each programme document should analyse how it is accelerating growth, combating poverty/inequality, and assessing the poverty and social impact of the programme.***

LICs have made only very limited use of **SCF and RCF**: they prefer the ECF because they need longer-term IMF signalling via loans to attract donor budget support; because the SCF provides relatively small amounts of finance with high conditionality; and because the low-conditionality RCF provides only very limited resources which are woefully insufficient as a response to external shocks.

**RECOMMENDATION 2: *In principle, Norway should continue to limit its funds to RCF/SCF, in order to discourage countries from developing a longer-term lending relationship with the IMF. However, in order to ensure these funds are used, it should advocate a sharp increase in SCF and especially RCF loan sizes, and a frontloading of SCF disbursements. It should also advocate for a higher proportion of the PRGT to be funded by the IMF’s own resources (notably profits from gold sales) rather than by increasingly constrained bilateral aid budgets.***

IMF programmes have long been criticised for excessively restrictive **macroeconomic frameworks**, seen as constraining MDG spending and growth/poverty reduction in order to reduce budget deficits and inflation. Global inflation shocks and the financial crisis seemed to be changing the IMF mindset, with a limited trend to higher spending and inflation targets in 2009 pre-PRGT programmes. However, the PRGT did not explicitly aim to make macroeconomic frameworks more flexible, and therefore this flexibility seems to have been only temporary. In 2010-12, most IMF programme countries are cutting overall and health expenditure as % of GDP, while most non-IMF programme countries are not. By the end of 2012, PRGT countries will have expenditure/GDP only 0.6% higher than 2008 (compared to 2.3% for other LICs). However, this trend is not **due to** the PRGT. As explained in IMF publications, it reflects a view that any counter-crisis stimulus should be temporary, even though the Fund has not published any analysis showing that rapid deficit cuts are needed to ensure long-term fiscal sustainability. It also reflects a changing attitude of some major Board member countries, which since 2009 have become sceptical about anti-crisis stimulus.

**RECOMMENDATION 3: *There should be a transparent debate between the IMF, LIC policymakers and civil society, at global and national level, on planned spending levels, with the aim of:***

- ***Allowing deficit levels after grants to stay at 3-5% of GDP until the MDGs are reached, provided that grants or repayable levels of loans are available to fund such deficits;***
- ***Demonstrating that spending is sufficient to allow accelerated growth and MDG progress, and showing that there is an adequate balance between investment and recurrent spending, (including wage/employment levels necessary to recruit and retain key anti-poverty workers).***
- ***Explaining why any cuts are needed to avoid early unsustainable budget deficit or debt levels, especially justifying them in relation to projected moves to high risk of unsustainable debt;***
- ***Projecting alternative scenarios to show donors how MDG attainment or fiscal/debt sustainability will suffer without more aid, and thereby encouraging higher flows;***

In terms of **inflation targets**, IMF programmes set slightly higher inflation targets in the light of global food and fuel price spikes in 2007-08 and 2010. PRGT programmes seem to be slightly more flexible than their (pre-crisis) counterparts in 2003-07, by bringing inflation down more gradually and letting it stay at levels above 5%. However, this flexibility springs from the 2008 global food/fuel price increases: gradually (and not in all countries) the IMF has come to think that temporary global shocks should be treated more flexibly, and the focus should be on measuring “core” inflation excluding food and fuel shocks. However, as the impact of shocks has persisted and especially where inflation goes above 10%, the IMF is increasingly recommending fiscal cuts to reduce inflation.

**RECOMMENDATION 4: *The IMF should change its inflation targeting to keeping “core” (non-food/fuel) inflation at 8-10% levels during periods of exogenous shocks; target much more gradual inflation reduction (to 5-10% only over 3 years); rely much more on supply-side measures rather than fiscal tightening to achieve inflation targets; and provide more evidence to prove monetary and fiscal tightening can reduce inflation in a country before such measures are recommended. It should also encourage LIC central banks to target employment or other real sector variables as well as inflation, to ensure that they are not focusing excessively on inflation reduction.***

As regards **structural conditionalities**, major reforms in these (dropping issues such as privatisation and trade liberalisation which were outside the IMF’s core mandate; and scaling back the use of ceil-

ings or “caps” on wage spending) also predated the PRGT. However, wage caps have remained in 10% of PRGT programmes, where the IMF argues wage levels are so high that they are essential. In addition, the Fund still agrees wage forecasts with all countries, most of which plan reductions as a % of GDP, and 29% of programmes have “structural benchmarks” for measures which need to be taken to reduce the overall wage bill. It is unclear how MDG-related wage spending and employment levels are protected in these circumstances and PRGT documents do not analyse this issue.

**RECOMMENDATION 5: *The IMF work with the World Bank and other UN agencies to conduct work-force analysis to show explicitly in all programme documents how anti-poverty expenditures will provide adequate funding for employment and wage levels needed to attain the MDGs, as well as proof that overall wage bill cuts (whether in ceilings or forecasts) and benchmarks will not lead to anti-poverty sector wage or employment cuts.***

Minimum “poverty related” or “social” **spending “floors”** (in order to track and protect spending) were included in 35% of pre-PRGT programmes in 2008-10. They have been much more extensively used under the PRGT, in 70% of programmes. However,

- it is unclear why 30% of programmes still do not have a floor;
- 16% of countries with floors are not publishing data on floors or their performance;
- half of countries are not reaching their floors – and because they are only “indicative targets”, this has no impact on their programme reviews, and IMF documents do not analyse why.
- in 16% of countries, floors have been revised downwards in PRGT reviews, and it is not clear why this is happening or how it is compatible with the MDGs.
- the spending covered by the floors (and by structural benchmarks in a few countries) varies widely, in some countries including all health spending, and in others virtually none.
- floors only assess all social expenditure covered, making it impossible to analyse whether spending in individual sectors (such as health) is being protected.

**RECOMMENDATION 6: *The IMF should improve poverty reduction spending floors by:***

- ***Adopting such floors in all PRGT programme countries***
- ***Publishing standard and transparent data on floors and actual spending for all countries***
- ***Analysing the floors (including any changes to targets) and country performance on attaining them in all programme review documents***
- ***Enhancing efforts towards a more uniform definition of floors in programmes, and to monitoring a standard basket of anti-poverty spending across all low-income countries;***
- ***Publishing more detailed data disaggregated by sector to facilitate analysis of country spending on the MDGs, and avoid spending cuts in some sectors to protect others.***

***The last two recommendations will require close work with LIC governments, the World Bank, other UN agencies and other development partners, to improve expenditure and results tracking.***

Finally, how best to increase spending in key MDG sectors? Before the PRGT, the IMF introduced the practice of allowing some spending to be “adjusted” if donors provided more or less money than expected. The use of **adjusters** has not changed significantly since the PRGT, and it remains unclear why some countries still do not have them. However, the case studies show clearly that adjusters work most effectively where strong global pressure for free health care initiatives and improved health systems, has translated into strong national-level sector programmes with additional donor support. This has allowed large increases in health spending and improvements in MDG indicators, though there is evidence that cuts in other anti-poverty spending mean that health is crowding out other MDGs, and that even the strongest programmes suffer “gaps” between phases, or suspensions of disbursements when countries go “off track” with IMF programmes, which lead to volatile aid and spending.

#### **RECOMMENDATIONS 7-10:**

- ***Donors and developing countries should expand sector-wide initiatives for free health care to a much wider range of countries, enhance similar initiatives in other MDG sectors (such as education, water and sanitation, agriculture and food security, and social protection) to avoid health crowding out other MDGs, and ensure that new phases of such sector programmes are prepared and funded more quickly.***
- ***Enhancing efforts to increase tax revenues - through growth and economic diversification, as well as raising taxes on income and wealth; reducing tax avoidance through tax havens and transfer pricing; getting a fair share of taxes and royalties from large companies exploiting natural resources; and reducing tax preferences and exemptions given to investors.***
- ***The IMF should use adjusters to absorb increased spending in all LIC programmes, and increase the quality of its “signalling” to donors by projecting alternative spending and funding scenarios and their impact on growth and the MDGs.***
- ***Norway should encourage other governments to join it in making decisions on aid disbursement (especially on sector but also on general budget support) independent of IMF programme reviews, and more closely based on the potential disruptive impact on MDG planning and spending.***

**RECOMMENDATION 11: *The above recommendations may be challenging for the IMF and other organisations to implement. Norway should aim to overcome the challenges in the following ways:***

- ***If the IMF Board is not prepared to allocate additional staff resources for the various types of analysis and debate discussed above (even though it has large windfall resources accruing from gold sales), Norway and other like-minded governments should set aside a proportion of their PRGT funds for such analysis, to be conducted by both IMF and independent analysts.***
- ***Norway should work with like-minded donor governments, and especially LIC government representatives, to advocate such changes strongly during current discussions of PRGT replenishment, and to set clear conditions for funding the subsidy of PRGT loans, in order to justify why IMF lending is as good a use of Norwegian money as other concessional flows.***



Louana (12) from Haiti. Photo: Luca Kleve-Ruud/ Save the Children Norway.

## CHAPTER 1: INTRODUCTION AND METHODOLOGY

### 1.1. Introduction and Background

The global financial and economic crises of 2007-09 hit low-income countries (LICs) with higher food and petroleum prices in 2007-08, followed by collapses in remittances, FDI and exports in 2008-09. To prevent a worsening of this crisis in LICs, at the G-20 conference in London, April 2009, the heads of state agreed to triple the capacity of the International Monetary Fund (IMF) to lend to LICs.

**At the same time, the IMF moved fast to change its concessional financing facilities for LICs. In July 2009 its Executive Board approved wide ranging changes to make IMF support more flexible and better tailored to LICs' diverse needs. It replaced the previous trust fund which allowed lending over the medium term (through the Poverty Reduction and Growth Facility or PRGF) and to combat exogenous shocks (through the Exogenous Shocks Facility or ESF), with a Poverty Reduction and Growth Trust (PRGT), containing three windows as follows:**

- i) **The Extended Credit Facility (ECF).** Formally known as the PRGF, with agreements initially for three years, this provides sustained program engagement and financing for countries facing protracted balance of payments difficulties.
- ii) **The Standby Credit Facility (SCF).** This is similar to the Stand-By Arrangement (SBA), which is widely used by emerging markets. It provides financial assistance and policy support to LICs with shorter-term financing needs.
- iii) **The Rapid Credit Facility (RCF).** Similar to the Exogenous Shocks Facility, this will rapidly provide a limited amount of financing in response to urgent needs, with reduced conditionality.

Loans under the PRGT are also supposed to have three other differences from earlier facilities:

1. *an enhanced focus on poverty reduction.* All countries seeking any IMF financial assistance under PRGT will indicate how the program advances poverty reduction and growth.
2. *greater concessionality.* PRGT loan agreements have zero percent interest rates on outstanding loans until the end of 2012 (and probably thereafter if funds are available).
3. *more flexible and streamlined conditionality.* At the same time as restructuring the facilities, the IMF Board announced that it would abolish structural "performance criteria" in PRGT facilities, replacing them with structural "benchmarks", believed to be more flexible.

This report has been commissioned by Save the Children, Norway, the Norwegian Church Aid and the Norwegian Forum for Environment and Development to analyse whether these facilities are living up to expectations of an enhanced focus on poverty reduction and more flexible conditionality,<sup>1</sup> and thereby allowing IMF lending to make a greater contribution to attaining the Millennium Development Goals (MDGs). To assess their progress, the paper has compared loan agreements in 35 countries before and after the establishment of the PRGT. It studies in particular conditionalities such as spending ceilings and floors, inflation targets, and wage caps, which might affect the health sectors of the 35 countries, as well as on trends in overall and health spending as reflected in budget forecasts and out-turns. It also draws on the findings of case studies of Honduras, Malawi and Sierra Leone commissioned from local experts.

### 1.2. Methodology and Country Sample

The agencies commissioning this report asked the paper authors to place a particular emphasis on SCF and RCF programmes, as they are the windows the Norwegian government has funded. However, only 4 countries have accessed the SCF or the RCF, and one of these has subsequently switched to an

<sup>1</sup> Greater concessionality is not assessed as it is clear all PRGT loans have more concessional terms.

ECF.<sup>2</sup> None of these countries had comparable programmes with the IMF before the new facilities were introduced: as a result, the paper discusses only their experience under the new facilities in terms of whether the conditionalities were flexible and poverty-focussed. Fortunately, as shown in Box 1, there are no major differences between the SCF/RCF and ECF programmes, so conclusions of this study apply equally to both.

**BOX 1:**

**Comparison Between RCF/SCF and ECF Programmes**

***Fiscal Space and Flexibility***

In terms of changes in planned expenditure from budget documents, there is no consistent pattern of difference between RCF/SCF and ECF programmes. Of the 3 countries under a RCF or SCF programme which have data available, the Solomon Islands' programme has a planned increase in overall and health expenditure, whilst expenditure patterns in Nepal are fairly stagnant, and a reduction is planned in Honduras.

***Flexibility on Inflation***

All 3 countries currently under RCF and SCF have similar inflation targets to ECF countries. The Solomon Islands and Honduras foresee an increase in inflation in the short term, before a reduction toward 5%, while Nepal is planned to reduce inflation year on year until also converging at 5%. These inflation targets tally with ECF countries, in that inflation targets in the short term are tending to increase, with a fall to 5% planned in the longer term.

***Tracking and Protecting Anti-Poverty Spending***

Of the two countries with a current or recent RCF loan agreement, one (the Kyrgyz Republic) had a social expenditure floor. The same pattern was observed with SCF agreements, with Honduras having an expenditure floor, but not Nepal. Therefore, like ECF agreements, it is not clear why some countries have a floor in place, while other countries do not. In terms of implementation, Honduras has met its floor and no data are available for Kyrgyz.

***Structural Conditionalities***

The key difference between SCF/ECF and RCF is the use of structural benchmarks. Due to the short period of RCF loan agreements, there are no structural benchmarks (though there are prior actions in the Kyrgyz Republic). Therefore, whilst both SCF countries had wage management benchmarks, neither RCF country did.

**Conclusions**

It can be seen that ECF and SCF agreements appear very similar in all the analysed areas. This is also the case between ECF and RCF, although the short term of RCF agreements means there are no structural benchmarks, only prior actions.

However, the very limited use of the new SCF (Honduras and Solomon Islands) and RCF (Nepal and Kyrgyz Republic) facilities by low-income countries does also raise the issue of whether the facilities are designed with sufficient tailoring or flexibility to meet LIC needs. Preliminary feedback from country authorities indicates that most of them require longer-term support from the IMF of the type provided by the ECF, in large part to provide policy assurances to donors who make budget support conditional on IMF programmes. In addition, the amounts available from the SCF with high conditionality, and

<sup>2</sup> Honduras and the Solomon Islands for the SCF; and the Kyrgyz Republic and Nepal for the RCF. Kyrgyz has changed in 2011 from RCF to ECF.

from the RCF with lower conditionality, are generally insufficient to cover their financing needs. As a result, the SCF and RCF are likely to be of limited usefulness except in the event of a very temporary exogenous shock,<sup>3</sup> and the ECF will be the main interaction between LICs and the IMF, unless the amounts available under the SCF and RCF are raised sharply, and their disbursements are more heavily frontloaded, and donors accept shorter-term IMF programmes as the basis for their engagement. This implies that the Norwegian government's funding would only be helping a relatively small sub-group of LICs, unless it insists on increased access under the SCF/RCF.<sup>4</sup>

On the other hand, 32 countries with prior IMF loan agreements, have subsequently signed an ECF: 16 have had their agreements changed from PRGF to ECF in mid-loan, 9 countries that finished PRGFs later agreed ECFs, and 6 countries with no-PRGF loans later signed an ECF loan agreement. All of these 32 countries are currently under a three year ECF agreement, and the paper focuses on comparing the objectives of the ECF agreement with those of its predecessor. There is therefore much more discussion of ECF achievements in the paper, because there are a wider sample of experiences to analyse. In addition, the Maldives has an Exogenous Shocks Facility programme which is funded from the PRGT, so it is added to the group analysed here.

The sources for information and data have been IMF programme and review documents, IMF World Economic Outlook (WEO) and Regional Economic Outlook (REO) statistics (September 2011 update) as well as national budget documents. Overall spending data were available for all 35 of the PRGT countries, but detailed budget breakdowns for health spending only for 26. In addition, in order to compare countries with/without IMF programmes, the authors examined a further 29 other LICs, for which all had overall spending data, but only 16 had separate health spending data. The expenditure data takes planned overall expenditure, as well as planned and actual health expenditure, from budget documents. Actual past overall expenditure, as well as planned overall expenditure for 2011 and 2012 is taken from IMF WEO and REO databases, which provide consistent datasets for all countries and match IMF programme document numbers.

In the analysis of expenditure data, we highlight the differences between countries with PRGF/PRGT loans, and LICs without such loans. However, of course expenditure changes within countries may spring from internal or external shocks, or government policy changes, rather than being solely a result of IMF advice. The figures therefore indicate trends and differences, not "responsibility".

Another key methodological issue is that most ECF, SCF and RCF facilities began in 2010. Though all IMF and budget documents have been consulted, it is difficult to assess their impact only one year in. This assessment should be regarded as preliminary, and preferably updated annually hereafter.

The study was conducted in two phases. The first analysed expenditure trends and conditionalities for all PRGT countries, to identify overall trends and key issues meriting further analysis, as well as the basis for choosing case studies. The key factors used to choose countries were that they should:

- have followed both a PRGF and a PRGT-financed programme with the IMF (including at least one SCF or RCF country), to allow comparison between previous and current IMF facilities;
- have mixed experiences in terms of expenditure trends, but with at least one year of cuts, to analyse why IMF programmes have different effects in different countries;
- have wage expenditure ceilings or benchmarks in their IMF programmes; and

<sup>3</sup> In 2009, 6 LICs used the Exogenous Shocks Facility (ESF), the RCF predecessor, as a temporary buffer against the global economic crisis. Of these, 3 (Mozambique, Senegal and Tanzania) previously had non-lending Policy Support Instrument programmes with the IMF and have since returned to these; 3 (Kyrgyz Republic, Maldives and Malawi) moved onto longer-term programmes with the IMF; and only one (Ethiopia) used the ESF alone.

<sup>4</sup> The IMF also has a non-lending instrument to assist countries with policy frameworks, the Policy Support Instrument. Six countries recently had PSI agreements (Cape Verde, Mozambique, Rwanda, Senegal, Tanzania and Uganda). For a comprehensive analysis of the advantages and disadvantages of a PSI, see Oxfam 2008.

- have social expenditure floors designed to protect such expenditures in their IMF programmes.

On this basis, Honduras (SCF), Malawi and Sierra Leone (both ECF) were chosen: all 3 have social expenditure floors and at least one year of spending cuts as % of GDP, and Honduras and Sierra Leone have wage benchmarks.

The second phase then included a much more detailed analysis of expenditure trends and conditionalities across all countries, including detailed analysis of health expenditures in budget documents, as well as the writing of the case studies and learning of lessons for the overall report. Key lessons from the case studies are quoted where relevant in the report, as well as in section 4 which provides brief summaries of the case study findings.

### **1.3. Structure of Report and Key Questions**

The remainder of the study is structured as follows:

- Chapter 1 examines literature on IMF conditionality, particularly its impact on the health sector.
- Chapter 2 analyses PRGT programmes to answer the following questions:
  - ⇒ has the PRGT provided less restrictive macroeconomic (especially fiscal) frameworks, allowing countries to spend more overall (including potentially on anti-poverty spending)?
  - ⇒ has the PRGT given more focus to tracking and protecting anti-poverty spending?
  - ⇒ has the PRGT provided more flexibility in structural conditions, notably on wage ceilings, which would allow countries to spend more towards reaching the MDGs?
- Chapter 3 examines budgets and outturns of spending by low-income countries during 2008-12, with particular emphasis on the health sector, to answer the following questions:
  - ⇒ Have countries with PRGT programmes increased their overall budget spending, expressed in nominal or real terms, and as a percentage of GDP?
  - ⇒ How do their spending trends compare with those of other LICs without PRGT programmes?
  - ⇒ Have countries with PRGT programmes increased their health spending, and how does this compare with other LICs without PRGT programmes?
- The fourth chapter provides summaries of the case studies.
- The fifth chapter concludes the study and presents preliminary recommendations.





Deba Poudel (in blue sari) is a trained healthworker in Nepal. She started to walk between the houses and villages in the mountains 18 years ago to look after the children. Photo: Luca Kleve-Ruud/ Save the Children Norway.

## CHAPTER 2: LITERATURE ON IMF PROGRAMMES' HEALTH SECTOR IMPACT

The consultants have conducted a review of existing literature on IMF programmes and their impact on the health sector in LICs. Analysis of this is separated between the pre-crisis period, to assess “business as usual” under the Poverty Reduction and Growth Facility (PRGF); the reaction to crisis in 2008-10 under PRGF; and the continuing reaction to crisis in the new PRGT.

### 2.1. The Pre-Crisis Period: PRGFs

Most existing literature focuses on the period between 2000 and 2010, when the IMF was using the Poverty Reduction and Growth Facility (PRGF) for its concessional loans. This aimed to take more account of poverty and social impacts of macroeconomic policy measures than the preceding Enhanced Structural Adjustment Facility (ESAF). This was partly because its loan conditionalities were to be based on LICs' own Poverty Reduction and Strategy Papers (PRSPs) (IMF 2009). On this basis, the PRGF was initially welcomed as a major step forward. However, it became subject to growing criticism that its macroeconomic and structural conditionalities were not very different from those of the ESAF, and therefore harmed growth and curtailed spending on poverty-related sectors, such as health and education, in turn hampering MDG progress. The main criticisms were of:

#### 2.1.1. Macroeconomic Frameworks

Independent analysts have found the macroeconomic frameworks (and the related quantitative performance criteria) in PRGF programmes were too restrictive, constraining fiscal space for MDG-related spending unnecessarily. Several examples of these conclusions were:

- the Center for Global Development (2007) found that IMF programmes were too risk adverse and conservative, and that often the IMF did not explore more expansionary scenarios containing sustainable ways to increase public expenditure.
- the Wemos foundation (2006) concluded that strict macroeconomic policies that favoured stabilisation rather than growth, had impeded and constrained government budgets, which effected poverty-related sectors, including health.
- Martin and Bargawi for SIDA (2005) outlined that although PRGF programmes were based on poverty reduction, there had been little change in flexibility, with economic stabilisation still favoured and programmes aiming for inflation < 5%, and 0-3% of GDP budget deficits. They argued that resulting interest rate increases and deficit cuts were not the only way to reduce inflation, as pro-poor growth in itself can reduce inflation by increasing supply response.
- Salop et al (2007) found that the IMF was still recommending that most sub-Saharan African countries should cut inflation to below 5% a year (even when they were receiving increased aid flows), rather than allowing them to increase spending more sharply.
- Goldsbrough, Adovor, and Elberger (2007) stated that insistence by the IMF on pushing inflation below 5% in LICs risked an unintended contractionary stance in the event of shocks.
- Global Campaign for Education (2009) argued that insisting on very low inflation in PRGFs caused reduction in social expenditure, as often low inflation was achieved by increasing interest rates, which potentially lowers growth, reduces tax revenues and curtails social expenditure.

While critics have argued that strict macroeconomic frameworks have constrained poverty-related (including health) expenditure, the empirical evidence on this is mixed. Goldsbrough, Adovor, and Elberger (2007) found that in 2005 health expenditure was lower as % of GDP for LICs with PRGF programmes (2.6% compared to 3.5% for LICs without programmes), but grew marginally faster (by 0.5% of GDP from 1998 to 2005, compared with 0.4% for non-programme countries). It also pointed out that spending in most countries remained way short of the levels needed to achieve the health MDGs. An IMF study by Clements, Gupta and Nozaki (2011) similarly found that over the longer-term, between 1985 and 2009, health and education spending increased faster in IMF programme countries, particularly for

LICs, because IMF programmes increased revenue mobilization, and catalysed debt relief and more aid.

The IMF has also found that in the last decade it has shown greater flexibility in a few programmes, targeting inflation of 5-10%, and 3% or greater budget deficits where additional grants are mobilised (for example in Mozambique and Tanzania). It has also increasingly introduced “adjusters” into programmes via which higher spending is allowed if more donor money is forthcoming (IMF 2006).

Overall, the conclusions of these studies are not dramatically different. The reason why PRGF programme macroeconomic frameworks caused significant contention has been that authors have different perspectives on the role of the IMF. Many independent authors believe that the IMF should play a role in helping countries work out how to accelerate MDG-related spending more rapidly, notably by mobilising more aid, tax revenue and debt relief, and being even more flexible on inflation and budget deficit levels. On the other hand, the IMF has been relatively content to conclude that there has been some increased spending as % of GDP over a longer period, as well as greater flexibility in some countries’ programmes if additional aid is mobilised.

### 2.1.2. Structural Conditionalities

The other main criticism of PRGFs was their structural conditionalities. These can be:

- **Prior actions** – conditions to be met before the IMF releases any finance.
- **Structural performance criteria** – reform actions which must be implemented by a target date, or postponed by IMF staff requesting a formal waiver by the Board, for the next tranche of a programme loan to be disbursed.

There have been two main criticisms of these conditions. One is that they are too numerous (and therefore overburdening and micro-managing government policy). Part of the remit for PRGF-ESF Trust was to reduce the number of conditionalities compared to ESAFs, by making structural conditions more “macro relevant” i.e. essential to successful macro performance. However, although it achieved this goal in 2000-02, conditionalities increased again in 2003 to 2005 (Martin and Bargawi 2005). Overall, by 2007 the number of conditions was back to 2000 levels (Harris 2010). The IMF’s own Independent Evaluation Office (2007) found little change in numbers of conditions between 2002 and 2004. IEO also indicated that there has been no clear increase in the macro relevance of conditionalities.

In addition, the scope of conditionality has often been criticised, as it used to go way beyond IMF “core mandate” issues into detailed privatisation and trade liberalisation conditions. This is an area in which most analysts (IEO 2008; Martin and Bargawi 2005) have found that conditions have been cut back sharply since 2000, moving instead to focus on tax policy, public expenditure management and financial sector reform. Nevertheless, LICs still face conditionalities in these areas, coming from e.g. the World Bank on privatisation and the WTO on trade liberalisation, or from joint donor agreements with multiple conditionalities for budget support (see also EURODAD 2006).

As Bird (2009) puts it, “the streamlining initiative therefore appears to have refocused rather than reduced structural conditionality.” As a result of these findings, Bird indicates that there continues to be too little country ownership of IMF programmes, and countries would prefer to avoid using IMF resources wherever possible.

One structural condition which was particularly strongly criticised was that of setting ceilings on government wages and salaries expenditure – known as “**wage caps**”. To the IMF overall wage capping is often seen as vital to reduce inefficiency and overstaffing in the public sector. It has been intended to be used as a short term condition at the programme’s outset, while more sophisticated government employment reforms (such as identifying and removing ghost workers, or changing salary structures) are designed and implemented.

Given that, as countries adopt ambitious health MDGs, an increasingly large share of wage expenditure has been for social sector employees (in particular doctors, nurses, midwives and other health staff), such caps have caused alarm among health professionals, academics and NGOs. The IMF’s own study of this issue found that wage caps should not have constrained social expenditure because they were never applied to a specific sector - although it stressed that caps often remained in programs longer than needed and delayed wider reforms in wage spending (Fedelino et al 2006). However, looking in detail at country-level impact, Marphatia et al (2007) found that wage capping in IMF programmes in Malawi, Mozambique and Sierra Leone was a key reason for a freeze in hiring in the education sector. In addition, the Center for Global Development (2007) detailed how PRGF-ESF Trust programmes constrained the health sector by insisting on overall government wage caps.

There was an extremely active debate between the IMF and CSOs on this issue during 2005-07 (see also Médecins Sans Frontières 2007; Oxfam 2007; Wood 2005), resulting in new guidelines for the use of ceilings - they were to be used in exceptional circumstances, consistent with the MDGs, of limited duration, flexible to accommodate scaled up health and education spending where aid finance was available, and reassessed at each programme review (IMF 2007). GCE (2009) subsequently found that there were far fewer wage ceilings in IMF programmes (down from around 40% of LICs to only around 10 %, and all of these were more flexible “indicative targets” rather than performance criteria), but that nevertheless only 30% of countries were intending to increase wages spending, with 39% intending cuts: in other words, the overall fiscal framework was still pushing wage spending down. The policy advice had not changed though the conditionality mechanism had.

### 2.2. The Impact of the Global Financial Crisis: a Fundamental Shift in IMF Programmes?

The global financial crisis appeared in 2009-10 to be provoking a fundamental change in the mindset of the IMF (following a similar trend among major G20 countries). It came to be seen as crucial for countries (including LICs) to employ counter-cyclical economic policy, whereby increased budget spending and investment would stimulate growth and poverty reduction to offset the recessionary impact of the crisis (Van Waeyenberge et al 2010). However, many LICs had suffered significant shocks to their economies, and therefore lacked the resources to employ counter cyclical economic policies. To help assist developing countries through the economic crisis, the G20 group of countries in April 2009 tripled IMF capacity to lend to LICs (Conway 2010). At the same time, the IMF promised to reform its conditionalities and facilities (St. Louis and Philipson 2010).

The first reform to be operationalised was to conditionality. In March 2009, the IMF stated that;

- Conditionalities would be further streamlined to reflect the core areas of IMF expertise and also tailored to different countries’ needs.
- Structural performance criteria would be replaced with benchmarks, described as more flexible.
- A new conditionality would strengthen government spending to ‘protect the vulnerable during the crisis’, in the form of an indicative target floor on poverty-related expenditure.

Reforms of IMF lending facilities were introduced in July 2009, with a shift in programme design to a new Poverty Reduction and Growth Trust (PRGT) (see IMF 2009b). This was designed to be more flexible, providing three types of arrangements to respond to different LIC needs;

- i) **Extended Credit Facility (ECF)** – equivalent to PRGF, this provides sustained financing (initially for 3 years) for countries with protracted balance of payments difficulties.
- ii) **Standby Credit Facility (SCF)** – equivalent to Stand-By Arrangements (SBAs) used by emerging markets, and providing shorter-term (12-24 month) assistance for LICs with shorter-term financing needs.
- iii) **Rapid Credit Facility (RCF)** – providing a limited amount of rapid financing in response to urgent needs, with reduced conditionality.

As detailed in Chapter 1 of this study, the IMF also promised that these programs would provide:

- greater concessionality, with zero interest until 2011 (recently extended through 2012);
- an enhanced focus on poverty reduction, as all countries seeking any PRGT assistance would need to indicate how the program would accelerate poverty reduction and growth; and
- more flexible conditionality, by converting structural “performance criteria” into benchmarks, intended to be more flexible.

Have these reforms delivered – and thereby responded to earlier criticisms of Fund programmes? Whilst the new PRGT facilities were announced in July 2009, it was not until mid-2010 that most countries signed PRGT programmes. As a result, the impact of the reforms is best analysed (especially for this study which seeks to trace the impact of the new facilities on IMF practice) by looking separately at responses under the PRGF-ESF Trust from 2009 to mid-2010; and those under the PRGT from mid 2010. Given the recent time period, the literature assessing this is relatively limited – which is one of the key reasons for commissioning the current study - but some preliminary conclusions have been drawn by various authors.

### **2.2.1. PRGF-ESF Trust programmes since the crisis (2009 to mid 2010)**

**Macroeconomic flexibility:** evidence of increased flexibility after the financial crisis is mixed. Kyrili and Martin (2010b), who studied LIC budget documents, found that three quarters of LICs with IMF programmes planned to increase expenditures in 2009 and 2009/10 budgets, and that LICs with IMF programmes planned to increase their deficits in 2009 more sharply than countries without programmes. This was also in line with an IMF study (2009a), which found that there had been a trend to stimulus, but warned that this should in general be temporary. Not surprisingly, therefore, Kyrili and Martin (2010a&b) found that stimulus was being reversed in 2010 through a sharper tightening of fiscal targets in IMF programmes than elsewhere: half of African countries and 75% of other LICs with IMF programmes were targeting spending cuts. Oxfam (2011a) and IMF (2009a) also found that there was evidence that the IMF had allowed LICs to target inflation rates of 5-10% (higher than the previous rather 2-5%), because the sharp rises in global food and oil prices made lower inflation targets impossible; and that the transition back to lower inflation targets in 2009 was made more gradual so as not to compromise growth.

Weisbrot et al (2009) reviewed 41 PRGF and Standby-by agreements (SBA) after the financial crisis and found that in 31 pro-cyclical policies were proposed. They concluded that the main reason for this was overoptimistic IMF growth assumptions, which were not met, necessitating fiscal tightening in the IMF programmes. They went on to state that although the IMF was promoting counter-cyclical policies at the onset of the crisis in the European Union, there appeared to be double standards in relation to low and middle income countries in that the Fund was not encouraging expansionary policies (in some cases because of a perceived financing constraint). Molina-Gallart (2009), studying IMF review documents after the financial crisis found that most continued to have stringent monetary and fiscal tightening, including strict deficit targets, but did not try to explain this trend.

More specifically on social spending, Kyrili and Martin (2010 a/b) found that as a % of GDP, health spending increased on average across LICs with IMF programmes in 2008-10, but was intended to fall in 2010 for non-SSA countries, and to rise less sharply for IMF programme countries than others. In addition, spending on related MDG areas such as education and social protection fell in 2008-10.

In relation to structural conditionality, independent research and LIC policymakers have suggested little progress. For example Molina-Gallart and Muchhala (2010) suggest that while the removal of structural performance criteria was positive in principle, in reality it led to more prior actions and the continued use of structural benchmarks (which they find to be very similar to performance criteria in terms of how binding they are on government policy). LIC Ministers have also indicated that the switch from performance criteria to benchmarks has made virtually no difference to the impact on their “space” to choose among policies (Martin et al 2009).

This research seems to tally with Ortez, Chai and Cummins (2010 and 2011) who highlighted that many current programmes continue to contain wage bill caps, elimination or reduction of subsidies, and rationalizing social protection schemes; as well as increasing revenue collection from regressive taxes such as VAT. In relation to taxation policy in IMF programmes, Triago (2011) found that the IMF still continues to promote indirect regressive VAT, whilst offering tax incentives for companies and maintaining low wages to ensure country competitive advantage. Weisbrot et al (2009) also point out that many programmes continue to contain caps on the public wage bill, and that 18 countries were expected to reduce wage bills compared to only 7 expanding.

On the other hand, the IMF suggests (2009a) that the number of structural conditions has fallen by one third between 2001-04 and 2009, and that there has been a continuing narrowing of focus to the Fund’s core areas (public financial management, financial sector) but also an increasing focus on trying to increase social spending. It has also argued (Clements, Gupta and Nozaki 2011) that new poverty-related expenditure floor conditionalities highlight that the IMF is committed to insuring that this expenditure does not fall. In addition, as highlighted in the report by Triago (2011), a recent IMF policy paper (Cottarelli 2011) and public statements by senior IMF officials hint at possible shifts in IMF thinking, towards a more equitable, pro-poor and flexible tax policy position in the future.

### **2.2.2. Early opinions and analysis on the new PRGT programmes (since mid 2010)**

When the IMF announced its new facilities, many in the global CSO community expressed significant scepticism about any real change in IMF policies. For example, Lidy Nacpil, coordinator of the Asia Pacific Movement on Debt and Development, stated in September 2009 that “all the press releases and announcements [for PRGT] were a mere smoke screen for continuing in the same failed policies that force countries to eliminate public services and load up on debt.” (Chowla 2009). In addition, Batniji (2009) outlines that the PRGT funding levels would make it woefully inadequate to respond to growing health needs in LICs due to rising global food prices and higher unemployment, and that this finance might not reach budgets (being kept instead in reserves).

There has not yet been any detailed examination of whether conditionalities have changed under the new facilities. Some initial conclusions have been suggested on spending levels by two studies. Ortez, Chai and Cummins (2011) for UNICEF outline that comparing actual expenditure from 2008-09 with projected expenditure for 2010-12, 66% of LICs with a PRGT programme will have reduced overall expenditure, compared to only 37% of LICs without a programme. Kyrili and Martin (2010a) looked at overall expenditure, finding that the reversal of anti-crisis stimulus measures was intended to accelerate in 2011 with tighter deficit reduction targets. There has not yet been any detailed analysis of planned or actual health expenditure under PRGT: this is therefore a focus of this study.

Oxfam (2011) and Stiglitz (2011) have indicated that the IMF has taken a different response to renewed global food and fuel price rises when combined with global recession, urging countries to reduce inflation faster and take stronger monetary measures. The IMF (2011) has suggested that it is to a considerable extent adopting the same type of flexibility as in 2008, except where inflation is well in excess of 10%, but signalled that tightening may be needed soon in many countries.

There has been no research on whether the move to PRGT facilities has changed the IMF’s positions on inflation, or on wage caps/ceilings. Oxfam 2011 suggests that formal conditions have been replaced by behind the scenes pressure on governments to reduce wage spending. Similarly, there is no research on the effects of the new poverty-related expenditure floors: Oxfam 2011 welcomes these but notes that they are only “indicative targets” and therefore might not be met if they are overruled by post-crisis fiscal tightening. The remainder of this study covers these areas, as well as providing a more comprehensive picture of differences in expenditure levels (overall and in the health sector) since the PRGT was introduced.



## CHAPTER 3: PRGT CONDITIONALITY AND ITS IMPACT ON THE HEALTH SECTOR

This chapter examines the impact of PRGT programmes on health sector spending. It looks in turn at:

- the macroeconomic (fiscal and inflation) frameworks in the programmes, and whether the PRGT has allowed countries to have higher spending (including potentially anti-poverty spending), or higher inflation rates, than previous PRGFs or other countries;
- the new focus in PRGT on tracking and protecting anti-poverty spending, especially through indicative poverty reduction spending floors, and whether these have worked well; and
- developments in structural conditions, especially any increased flexibility in conditions on wage ceilings, which would allow countries to spend more on wages towards reaching the MDGs.

However, this chapter does not discuss the broader “enhanced focus on poverty reduction and growth” which PRGT was supposed to bring. This is because the authors have not been able to find any evidence of enhanced focus on poverty reduction in the PRGT, of the kind which would for example be shown by Poverty and Social Impact Analysis of the macroeconomic framework or individual structural conditionalities. While there is more discussion of how to increase growth between IMF and country authorities, this appears to take place mostly in the more relaxed context of Article IV discussions, and may be incorporated into clearer reasons for growth targets in PRGT documents, but there is not any notable increase in discussion of growth or poverty reduction issues or evidence of accelerated growth or poverty reduction targets in PRGT documents, compared to those prepared under the PRGF. One key priority going forward is for the Fund to specify exactly how it is (or is intending) to implement this commitment by presenting the fundamental drivers of (preferably accelerated) growth and poverty reduction more obviously in PRGT documents.

### 3.1. Macroeconomic Frameworks

As discussed in Chapter 1, one major criticism levelled against IMF programmes has been that excessively restrictive macroeconomic frameworks seriously constrain LICs ability to increase spending on essential services such as health and education. The PRGT did not aim to change macroeconomic frameworks to make them less restrictive or promote counter-cyclical spending. It continued to have the same aim as PRGF/ESF loans: for countries to adopt economic programs aimed at moving toward a stable and sustainable macroeconomic position consistent with strong and durable poverty reduction and growth. Pre- and post-crisis facilities therefore aim for:

- i) **Fiscal balance** – reducing fiscal deficits by increasing budget revenue, reducing expenditure or increasing financing from grants/loans.
- ii) **Low inflation** – reducing inflation through the use of monetary policy, reducing domestic credit or foreign assets (reserves), or changing interest rates.

The key issue explored here is whether these frameworks became more or less restrictive under the post-crisis facilities. Although the IMF Executive Board announced the shift from PRGF to PRGT loan facilities in July 2009, most countries did not have PRGT programme reviews until early to mid 2010. Therefore this analysis will look at the percentage change in planned Government total expenditure and health expenditure from two different periods, between 2009-2010, under PRGF programmes, and 2010-2011, under the new PRGT programme, using government budgetary data.

#### 3.1.1 Fiscal Space and Flexibility

Figures 1 to 3 show the percentage of countries with PRGT programmes, and of other LICs, that planned

either stagnation or falls in overall and health expenditure, from 2009 to 2010 (the period of PRGF facilities) and from 2010 to 2011 (PRGT facilities). Three different measures have been used for this analysis: nominal and real percentage spending increases, and the change in spending/GDP.<sup>1</sup>

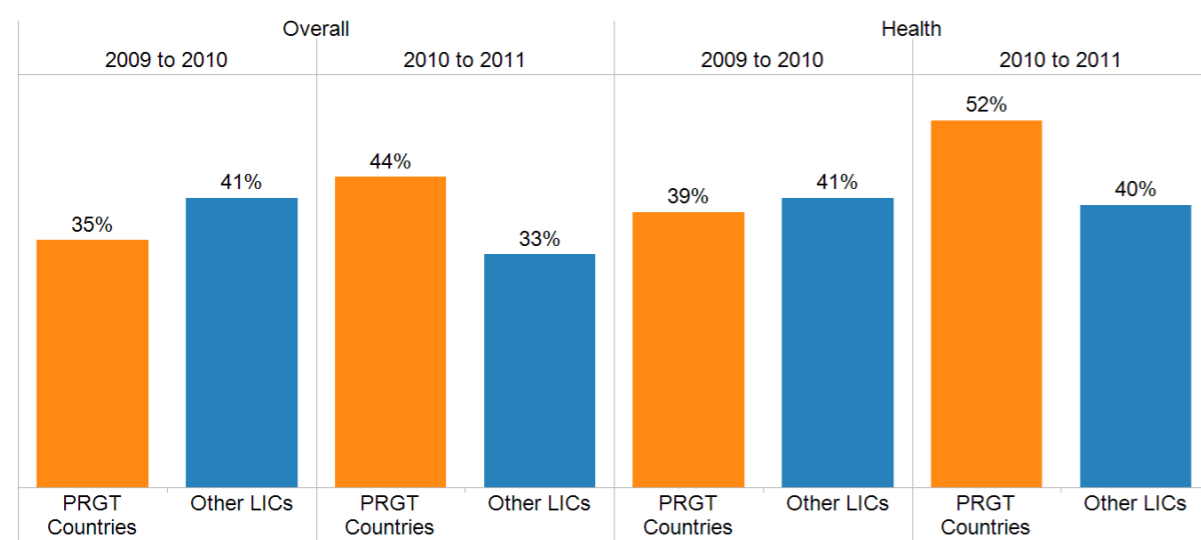
**In 2009-2010 (see also Annex 1 and 3 for detailed graphs),** figures 1 to 3 highlight that more than three quarters of countries in both groups planned nominal spending increases, and 60-65% planned real increases. In other words, most countries in both groups employed counter cyclical policies against the global economic crisis. However, this did not mean an increase in expenditure/GDP - 57% of countries with IMF programmes and 65% of other LICs planned cuts - largely because many planned faster GDP growth in 2010 without matching expenditure rises.

The changes in health expenditure in 2009-10 are remarkably similar to overall expenditure, with the majority of countries in both groups planning nominal and real increases, but falls as % of GDP.

**However, in 2010-11, when countries are implementing PRGT agreements (see also annex 2 and 3), there is a marked difference between countries with and without programmes.** Four-fifths of non-PRGT LICs are planning a continued nominal increase in spending, and two-thirds a continued real increase; in addition, 60% plan to increase expenditure/GDP. Conversely, though around two-thirds of PRGT countries will increase nominal expenditure, only a small majority will increase real expenditure, and a majority will cut expenditure/GDP.

An even starker picture appears in health, with a minority of PRGT countries increasing real spending, and only one third increasing spending/GDP, while 60% of other LICs are planning increased real expenditure and almost 50% are planning increased expenditure/GDP.

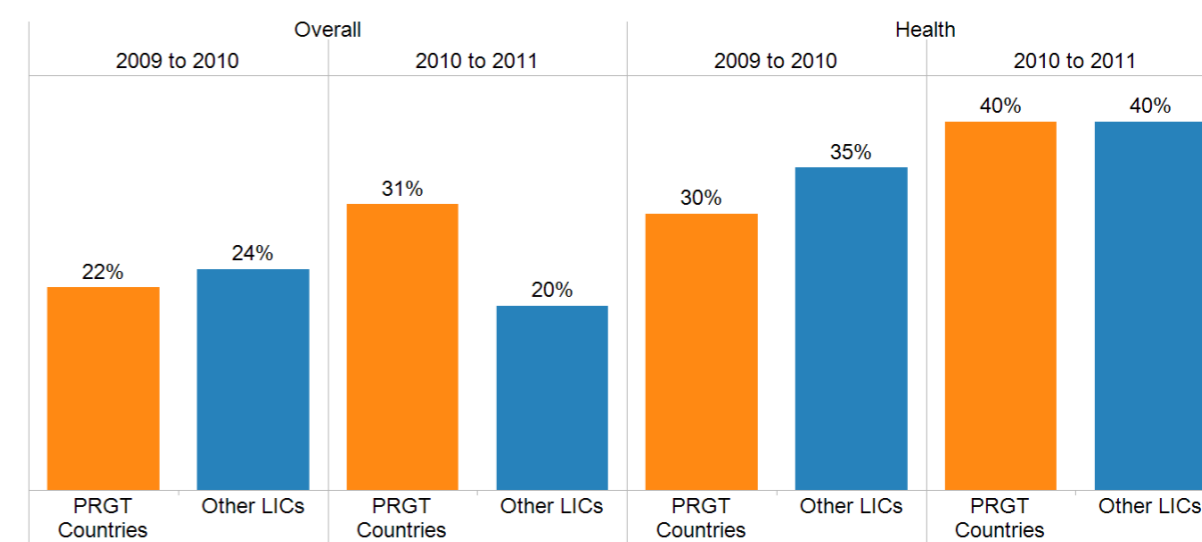
**Figure 1 – Percentage of Countries Planning Nominal Expenditure Stagnation or Cuts**



Source: Expenditure data from Country budget documents (see annex 3 and 4 for details)

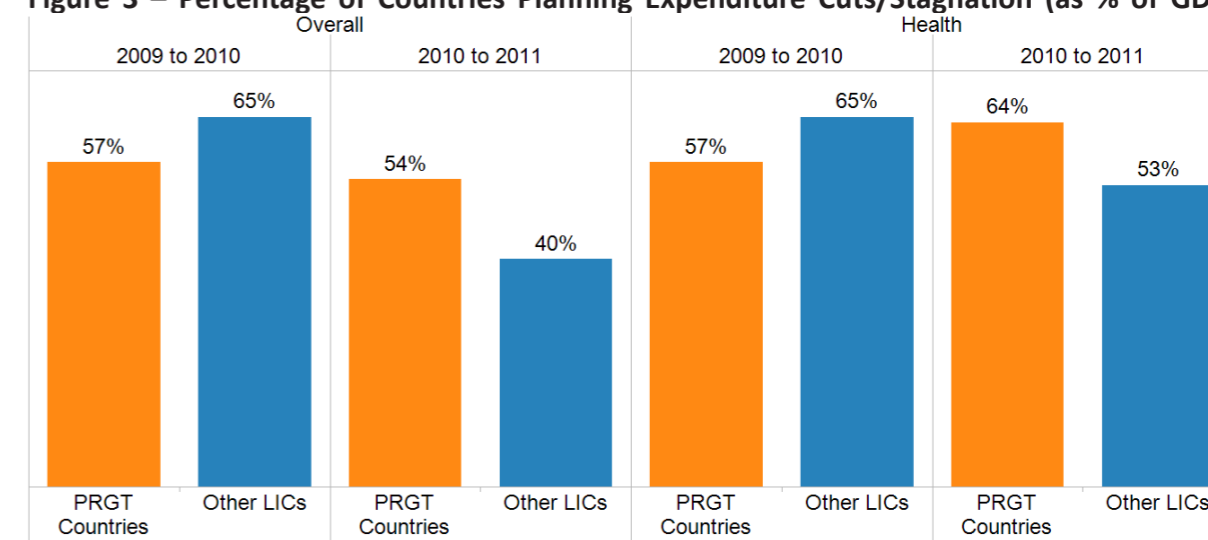
<sup>1</sup> Of the 29 other LICs, 2 (Angola and Pakistan) have IMF stand-by arrangements. If they are reclassified as countries following IMF programmes, this reinforces the conclusion that IMF programme spending has been more restricted. For example, in 2009-10 only 40% of IMF programme countries would have planned to increase total expenditure/GDP compared to 50% of other LICs; while 40% of both groups would have planned to increase health expenditure; and in 2010-11 a 15% higher proportion of non-IMF countries planned total expenditure/GDP rises, and more than half of non-IMF countries planned health spending increases compared to 1/3 of IMF.

**Figure 2 – Percentage of Countries Planning Real Expenditure Stagnation or Cuts**



Source: Expenditure data from Country budget documents (see annex 3 and 4 for details)

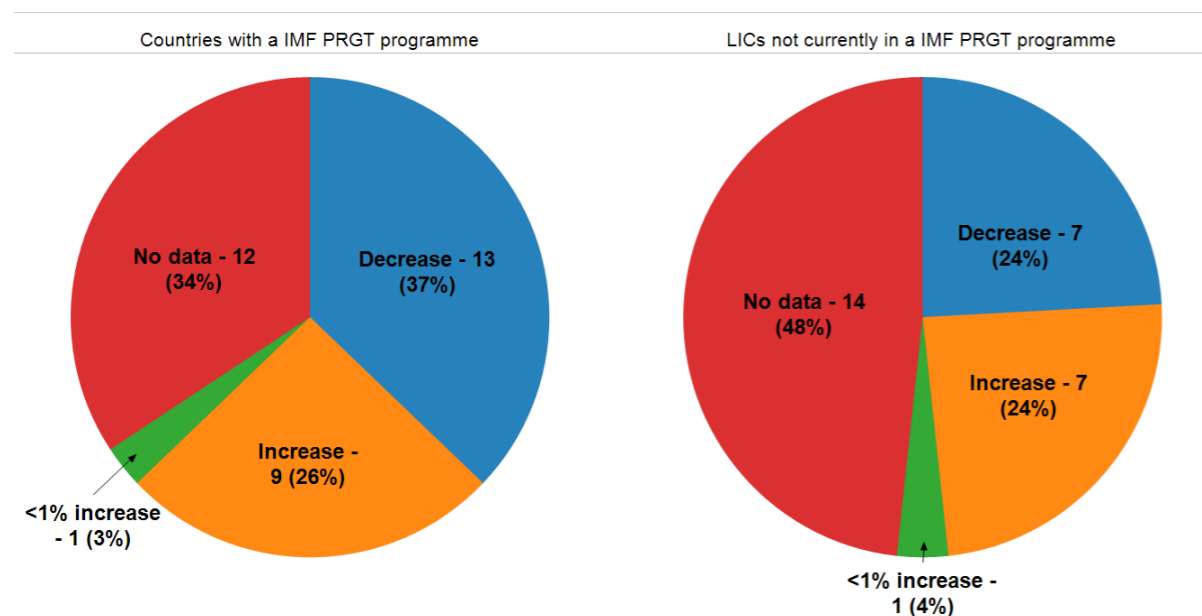
**Figure 3 – Percentage of Countries Planning Expenditure Cuts/Stagnation (as % of GDP)**



Source: Expenditure data from Country budget documents and GDP figures from IMF WEO (see annex 3 and 4 for details)

When looking at planned overall and health expenditure as a percentage of GDP in 2011 compared to 2009, the picture is again of PRGT countries exhibiting a relative decrease in spending compared to other LICs. Figure 4 highlights that PRGT countries are predominantly reducing total expenditure as a percentage of GDP, whereas there is a balance between increases and decreases for other LICs.

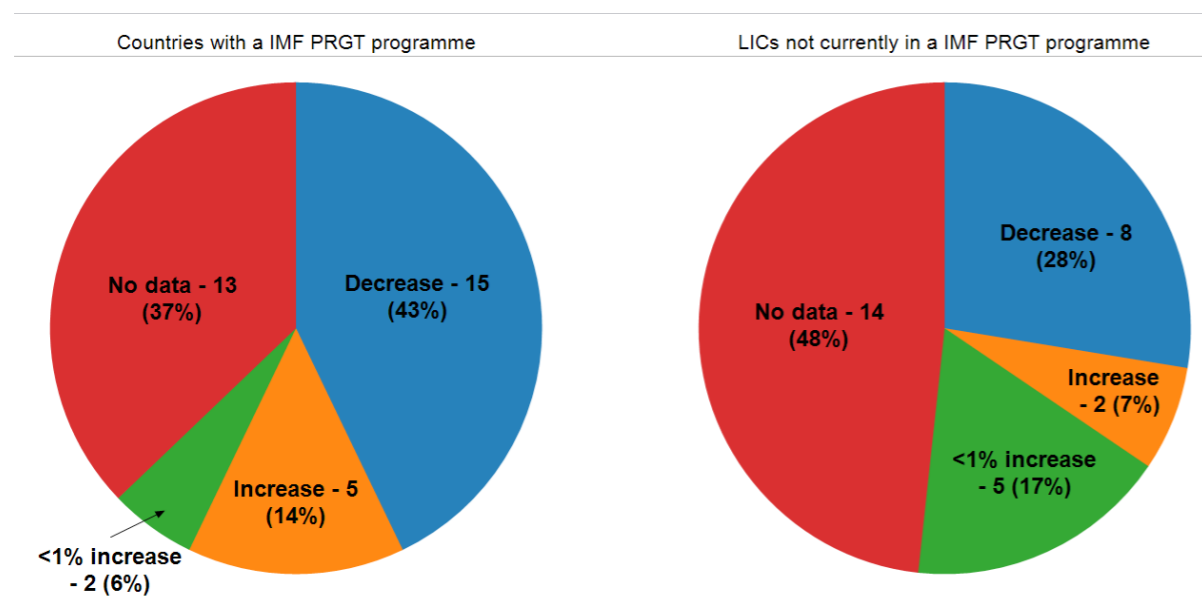
**Figure 4 – Planned Total Government Expenditure/ GDP, 2011 vs 2009**



Source: Government planned expenditure from budget documents (see annex 3 and 4), GDP figures from IMF WEO September 2011

In relation to planned health expenditure, the difference between PRGT countries and other LICs is seemingly wider. Figure 5 illustrates planned health expenditure as a percentage of GDP will have decreased in 68% of PRGT countries for which data are available, but only around 53% of other LICs.

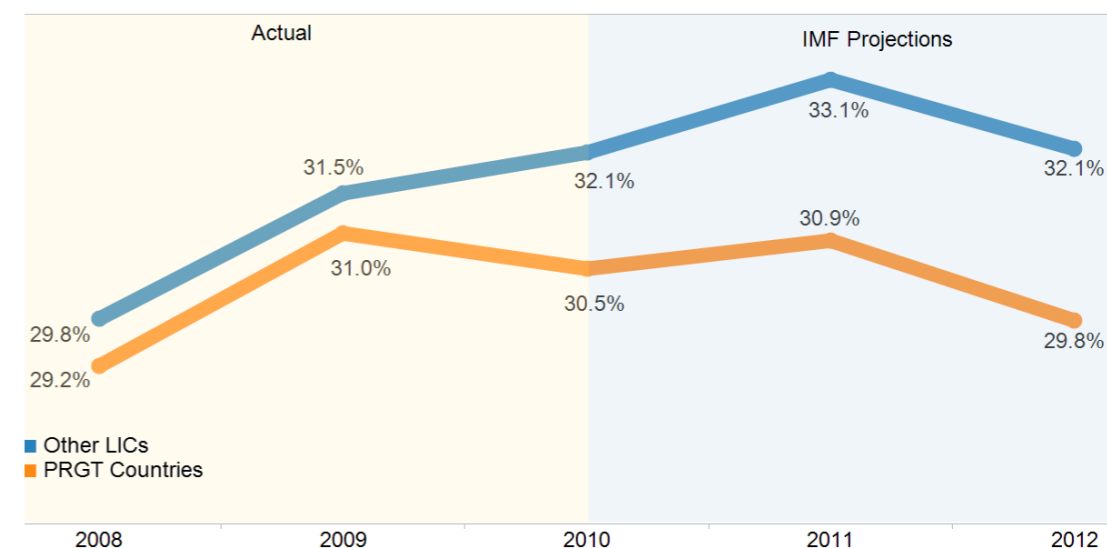
**Figure 5 – Planned Government Health Expenditure/ GDP, 2011 vs 2009**



Source: Government planned expenditure from budget documents, current GDP figures from IMF WEO September 2011

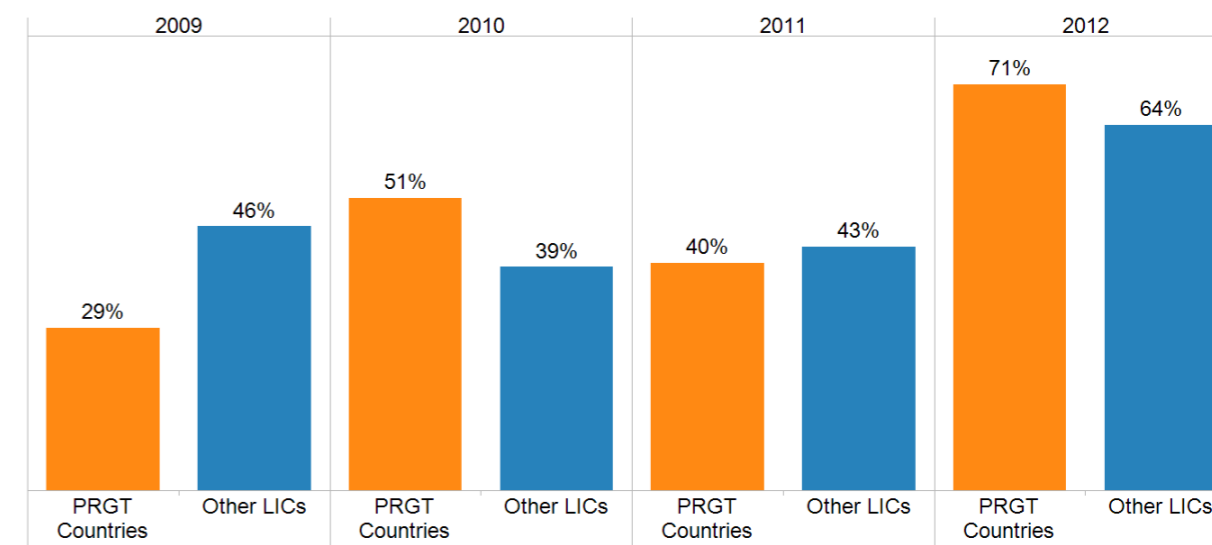
Figures 6 and 7 extend this analysis for all countries into 2012 using overall spending data (actual for 2008-09, IMF projections for 2010-12) from IMF World Economic Outlook September 2011. They show that sharp cuts (1-1.1% of GDP) are expected in 2012 for both groups. This will leave PRGT countries with expenditure/GDP only 0.6% higher than 2008 (compared to 2.3% higher for other LICs), and 71% of PRGT countries plan to cut expenditure/GDP in 2012 compared to 64% of others.

**Figure 6 – Actual and projected Government expenditure (% of GDP 2008-2012)**



Source: IMF economic outlook (September 2011). Note: Several countries projected data starts from 2009.

**Figure 7 – % of PRGT countries and other LICs cutting expenditure (as a % of GDP) 2009 to 2012**



Source: IMF economic outlook (September 2011)

These findings match those of earlier Oxfam/UNICEF/UNESCO studies. At first sight these trends appear to indicate that the new facilities, introduced in 2009 but not applied to LICs fully till 2010, have

had a contractionary effect. However, this appears to be entirely coincidental rather than a reflection of any change in the design of the new facilities. The IMF to a limited degree adopted a policy of counter-cyclical measures to combat the global crisis in 2009, but then returned to a path of fiscal conservatism and reducing spending levels from 2010 onwards. According to IMF sources, the spending reductions in 2011 reflect a view which would have predominated in the Fund under PRGF or PRGT, that any stimulus could be only temporary and needed to be followed by a reduction of deficits, achieved where necessary by reducing expenditure. They also reflect a change of attitude among some major IMF Board members, many of whom have also been tightening their own fiscal positions since 2010. In other words, it is certainly possible to criticise the IMF for encouraging tightening in countries which need to spend dramatically more if they are to reach the MDGs: but it is not possible to ascribe the tightening to the new facilities.

There is a considerable literature (see also Martin and Bargawi 2005 for a more detailed discussion) indicating that there is no a priori reason why budget deficits before grants should be reduced below 3-5% of GDP, provided that the financing used to fill the deficit is sustainable in terms of the national debt burden. The IMF (2009c) has itself acknowledged this in defining as “mature stabilisers” (i.e. countries with sustainable economic stability) countries with a budget deficit of less than 5.5% of GDP. It should therefore aim to allow low-income countries to maintain deficit levels at around 5% of GDP if either grants or repayable levels of loans are available to fund such deficits, while they accelerate their efforts to reach the MDGs in 2012-15.

Earlier analysis for Oxfam and UNESCO (Martin and Kyrili 2010a/b) indicated that the key potential for increasing “fiscal space” for low-income countries to spend more on the MDGs lies in increased aid and increased budget revenue. The case studies indicate that the IMF has tended to follow behind country authorities and donors in relation to aid: once much larger amounts of aid are agreed for the health sector, higher spending may be possible, but sometimes offset by spending cuts in other sectors. There has been considerable progress in the IMF allowing a higher share of aid mobilised to be spent. But the IMF should play a more active role at country level in helping to advocate higher levels of aid financing, in particular by assisting countries to calculate alternative scenarios showing donors which MDGs will suffer if financing is not forthcoming.

In addition, the Fund should place even more emphasis on increasing budget revenues (and therefore on accelerating growth and economic diversification to increase revenue yield). Many LICs have made remarkable progress in recent years in increasing their revenue levels (for example, Sub-Saharan Africa increased revenue/GDP from 21% to 28% in 2002-08, tripling the amounts collected - see OECD/UNECA 2011). They have achieved this by increasing indirect taxes, widening the tax base, and/or improving the efficiency of tax collection. However, it is also generally accepted that excessive rises in tax levels, especially for the limited number of individuals and enterprises with sufficient income to be able to pay tax in low-income countries, can be inimical to long-term growth prospects by undermining incentives for earnings and profitability; and that indirect taxes are usually highly regressive, hitting the poor hardest (see also Itriago 2011). IMF programmes therefore need to increase their focus on these issues, putting particular stress on raising taxes on income and wealth; reducing tax avoidance through the use of offshore tax havens and transfer pricing, getting a fair and transparent share of taxes and royalties from large companies exploiting natural resources (oil and gas, minerals and land); reducing tax preferences and exemptions given to investors.

### 3.1.2 Flexibility on Inflation

To judge trends in flexibility on inflation, we have used the same methodology as Goldsbrough, Adovar and Elberger (2007). Table 1 below is taken from their analysis of ‘late PRGF’ programs from 2003-2007, showing the initial inflation rates and the next year’s inflation target. It shows that inflation targets in PRGF programmes insisted on strict adherence to inflation rates under 10%, within a very short time scale. For example, for 7 of the 8 countries with an initial inflation rate of 10-20%, the IMF targeted inflation in the subsequent year of below 10%. For 7 of the 11 countries with initial inflation of 5-10%, 7 had a year 2 target below 5%.

**Table 1 – Initial and Targeted Inflation in PRGF Programmes (2003-07)**

Initial inflation rate (at t)	Targeted inflation (at t+1)					Totals
	3% or below	3.1%-5%	5.1%-10%	10.1%-20%	Above 20%	
<b>3% or below</b>	<b>Chad; Mali; Senegal; Dominica; Armenia, Cameroon; Benin; Albania</b>					<b>8</b>
<b>3.1%-5%</b>	<b>Burkina Faso; Niger</b>	Kyrgyz Republic; Tanzania; Georgia				<b>5</b>
<b>5.1%-10%</b>	<b>Central African Republic;</b>	Rwanda; Nepal, Mauritania; Burundi; Afghanistan	Mauritania; Honduras; Sri Lanka; Moldova			<b>11</b>
<b>10.1%-20%</b>		Kenya; Malawi	Madagascar; Haiti; Mozambique; Sierra Leone; Ghana	Zambia		<b>8</b>
<b>Above 20%</b>						<b>0</b>
<b>Totals</b>	<b>12</b>	<b>10</b>	<b>9</b>	<b>1</b>	<b>0</b>	<b>32</b>

Source: Goldsbrough, Adovar and Elberger (2007). Countries in bold are members of a currency union, which set regional targets of 3%

PRGT programmes seem less focused on strict and sudden inflation reduction. Using the same methodology, Table 2 shows initial and targeted inflation under PRGT, and is quite different from table 2. Of the 15 countries with initial inflation of 5-10%, 14 will remain over 5% after year one, including 3 over 10%. In addition, in countries with initial inflation below 5%, there is less insistence to reduce inflation further, with 5 out of 8 non-currency zone countries planning inflation over 5%.

**Table 2 – Initial and Year 1 Targeted Inflation in PRGT Programmes (2010-11)**

Initial inflation rate (at t)	Targeted inflation (at t+1)					Totals
	3% or below	3.1%-5%	5.1%-10%	10.1%-20%	Above 20%	
<b>3% or below</b>	<b>Burkina Faso; Comoros; Cote d'Ivoire; Mali</b>	<b>Benin; Central African Republic; Grenada; Guinea-Bissau; Togo</b>	Solomon Islands			<b>9</b>
<b>3.1%-5%</b>	<b>Niger</b>	Maldives	<b>Congo, Republic of; Gambia; Haiti</b>	Burundi		<b>6</b>
<b>5.1%-10%</b>		Lesotho	Armenia; Ghana; Honduras; Kenya; Liberia; Malawi; Mauritania; Moldova; Nicaragua; Yemen; Zambia	Kyrgyz Republic; Sierra Leone; Tajikistan;		<b>16</b>
<b>10.1%-20%</b>			Nepal			<b>1</b>
<b>Above 20%</b>				Condo, DR; Sao Tome		<b>2</b>
<b>Totals</b>	<b>7</b>	<b>7</b>	<b>15</b>	<b>5</b>	<b>0</b>	<b>34</b>

Source - IMF country programme review documents. Countries in bold have currency union inflation targets of 3%. See Table 4 for details.

Table 3 extends this analysis to year 2 inflation targets and shows a similar picture. Again, 13 of 15 countries are targeted to remain over 5% after 2 years, though members of a currency union (in bold) are making a greater push to reduce inflation below 3% to meet their convergence criteria.

**Table 3 – Initial and Year 2 Targeted Inflation in PRGT programmes**

Initial inflation rate (at t)	Targeted inflation (at t+2)					Totals
	3% or below	3.1%-5%	5.1%-10%	10.1-20%	Above 20%	
<b>3% or below</b>	<b>Benin; Burkina Faso; Comoros; Cote d'Ivoire; Mali; Central African Republic; Grenada;</b>	Solomon Islands				<b>10</b>
<b>3.1%-5%</b>	<b>Niger</b>	Gambia	<b>Congo, Republic of; Haiti; Maldives</b>	Burundi		<b>6</b>
<b>5.1%-10%</b>		Armenia; Kenya	Ghana; Honduras; Lesotho; Liberia; Malawi; Mauritania; Moldova; Nicaragua; Sierra Leone; Zambia	Kyrgyz Republic; Tajikistan; Yemen		<b>15</b>
<b>10.1%-20%</b>			Nepal			<b>1</b>
<b>Above 20%</b>				Condo, DR; Sao Tome		<b>2</b>
<b>Totals</b>	<b>10</b>	<b>4</b>	<b>14</b>	<b>6</b>	<b>0</b>	<b>34</b>

Source - IMF country reviews. Countries in bold have set currency union convergence targets of 3%. See Table 4 for complete data.

Overall, this bears out the conclusions of the IMF Sub-Saharan Regional Economic Outlook (September 2011) about more recent flexibility on inflation, although the report outlines that the reason for this is rising global prices, rather than the new PRGT lending facilities. As discussed in Chapter 2, there is evidence of less flexibility than in 2007-2008, because now higher global food and fuel prices are combined with recession. This is exemplified by three groups of Sub-Saharan oil importing countries outlined in the REO report, which should have different anti-inflation policies:

- **Countries where output and employment have yet to recover to pre-crisis levels.** Here, if financing is not constrained (i.e. for countries like South Africa with access to strong domestic and international market financing and relatively low debt burdens), stimulus could continue; but if financing is constrained (i.e. in almost all such LICs), scope for stimulus is limited.
- **Countries where there are clear signs of inflationary pressures.** In 4 countries, the IMF is now recommending decisive tightening of monetary policy as well as tighter fiscal policy.
- **Countries growing close to “speed limits”.** This applies to many economies in Africa, where inflation is rising and supply constraints emerging, and there are severe downside risks from continuing global recession. Again the IMF is recommending decisive monetary tightening if non-food inflation is above 10% (and fiscal tightening if non-debt finance is unavailable).

It is fascinating that although tightening is being recommended, it is not expected to bring inflation down rapidly or sharply. As a result, if fiscal tightening accelerates, it would reduce prospects of attaining the MDGs and spending money on health, without reaching low inflation levels. To get inflation down below 5% might therefore take several years of restrictive policies unless more non-debt financing is forthcoming, which given global stagnation in aid looks unlikely.

There is a wide literature which shows growth-maximising levels of inflation are 5-10% or higher, including Adam and Bevan (2001), Pollin and Zhu (2005), and other sources cited in Center for Global Development (2007) (for a much more detailed discussion see Martin and Bargawi 2005). Even the IMF's own studies (2009c) indicate that a country with inflation of 12.5% or below can be considered a “mature stabilizer”. As a result, there is no case for IMF programmes to be putting sharp downward pressure on inflation which is in single figures, especially when it is due largely to global fuel and food price rises. The IMF should therefore change its inflation targeting to allow “core” (non-food/fuel) inflation to reach 8-12% levels during periods of exogenous shocks; and thereafter target much more

gradual inflation reduction (to reach 5-8% only after 3 years).

In this context, there is little justification for sharp fiscal or monetary tightening to reach lower inflation. Monetary tightening by raising interest rates risks reducing lending to the private sector; and fiscal tightening can undermine growth, poverty reduction and MDG progress without (as the IMF Independent Evaluation Office has concluded) freeing funding for private investment. It is therefore vital that the IMF rely much more on supply-side measures to achieve inflation targets; and that it provides more evidence to prove that monetary and fiscal tightening can reduce inflation without other major negative effects before such measures are recommended.

In addition, the Fund should encourage LIC central banks to think more broadly about targeting employment or other real sector variables as well as inflation, as is done in monetary policy decisions by the US Federal Reserve, to make sure that they are not focussing excessively on reducing inflation to the detriment of development. This type of rethinking by the Fund and central banks was most recently recommended by Joseph Stiglitz (2011) at the March 2011 IMF conference on “Macro and Growth Policies in the Wake of the Crisis”, but has also been suggested by Epstein (2009) and UNDESA (2009).



**Table 4 – Inflation Targets for PRGT Countries**

Country	Consumer Price Index - average annual inflation (%)								
	2008	2009	2010	2011	2012	2013	2014	2015	
<b>Armenia</b>									
Second review under the ECF June 2011	5.3	6.7	8.5	6.7	4	4	4	4	
<b>Benin</b>									
First Review Under the ECF Feb 2011	7.8	2	1.8	3.2	2.6	2.7	2.6	2.6	
<b>Burkina Faso</b>									
Second review under the ECF June 2011	..	2.6	-0.6	2.8	2	2	2	2	
<b>Burundi</b>									
Sixth Review Under the ECF June 2011	..	9.5	4.1	14 projected	10.9	9.5	..	..	
<b>Central African Republic</b>									
Six review under ECF May 2010	9.3	3.5	2	3.1 projected	2.5	2.5	2.5	2.5	
<b>Comoros</b>									
Second review under the ECF Dec 2010	4.8	2.7	2.7	3	2.9	2.9	3	3	
<b>Democratic Republic of Congo</b>									
Third review under ECF April 2011	..	46.2	23.5	12	11	9	8.8	8.3	
<b>Republic of Congo</b>									
Fifth and sixth review under ECF July 2011	6	4.3	5	5.9	5.2	3.5	..	..	
<b>Côte d'Ivoire</b>									
Second review under ECF June 2010	6.3	1	1.4	2.5	2.5	..	..	..	
<b>Djibouti</b>									
No ECF documents published	..	..	..	..	..	..	..	..	
<b>The Gambia</b>									
Seventh review under ECF Dec 2010	..	4.6	4.1	5.2	5	5	..	..	
<b>Ghana</b>									
Third and Fourth reviews Under the ECF May 2011	..	..	8.6	9	8.5	8	7.5	7	
<b>Grenada</b>									
Fifth review under ECF March 2010	8	-0.3	3.6	1.9	2	2	2	2	
<b>Guinea-Bissau</b>									
Second review under ECF May 2011	10.4	-1.6	1.1	4 projected	2	2	2	..	
<b>Haiti</b>									
First review under ECF April 2011	3.4	4.1	7	7.4	5.9	..	..	..	
<b>Honduras</b>									
First Review Under the SCF April 2011	..	3	6.5	8 projected	6.5	..	..	..	
<b>Kenya</b>									
First review under ECF June 2011	..	5.3	6.8	7.4 projected	5	5	5	..	
<b>Kyrgyz Republic</b>									
Request under ECF June 2011	24.5	6.8	7.8	20 projected	8.7	7.5	7.5	6.6	
<b>Lesotho</b>									
First review under ESF March 2010	10.7	7.2	3.8 projected	5.4	5.6	5.7	5.6	5.6	
<b>Liberia</b>									
Sixth review under ECF June 2011	..	7.4	7.3	8.1 projected	5.8	5.2	..	..	
<b>Malawi</b>									
Request under the ECF Feb 2010	..	7.6	9.2	8.5	7.2	6.8	6	..	
<b>Maldives</b>									
First review under ESF March 2010	12.3	4	4.3 projected	5.3 projected	4.8 projected	..	..	..	
<b>Mali</b>									
Sixth Review under ECF May 2011	..	..	1.4	2	2.2	2.3	2.3	..	
<b>Mauritania</b>									
Second review under ECF June 2011	7.3	2.2	6.3	7.3 projected	6.7	converging to 5% by 2016	..	..	
<b>Moldova</b>									
Third review under ECF June 2011	7.3	0.4	8.1	8	5.7	5	5	5	
<b>Nepal</b>									
Request under the RCF May 2010	13.2	11.8	8	5.6	5	5	5	5	
<b>Nicaragua</b>									
Sixth review under ECF April 2011	19.8	3.7	5.5	8.7 projected	8.4	7.3	7.1	..	
<b>Niger</b>									
Third review under ECF Jan 2010	11.3	4.8	2.3	2	2	2	2	..	
<b>Sierra Leone</b>									
First Review Under the ECF Nov 2010	..	5.3	15	8.5	7.3	6.3	6	5.1	
<b>São Tomé and Príncipe</b>									
First review under ECF Feb 2010	26	16.7 projected	11.3	7.4	5.5	5	..	..	
<b>Solomon Islands</b>									
Second review under SCF June 2011	..	7.1	1	6	5	..	..	..	
<b>Tajikistan</b>									
Fourth review under ECF April 2011	20.4	6.5	6.5	13.9 projected	9.7	7.6	5	5	
<b>Togo</b>									
Sixth review under ECF July 2011	..	1.9	1.4	4.3 projected	2.6	1.4	..	..	
<b>Yemen</b>									
Request under ECF July 2010	19	3.7	9.8	8.9	10.2	10.8	..	..	
<b>Zambia</b>									
Sixth review under ECF June 2011	..	13.4	8.5	9 projected	6.5	5.5	..	..	

Source: IMF country report documents

### 3.2. Tracking and Protecting Anti-Poverty Spending

One major criticism of past IMF programmes was that they neither monitored systematically nor aimed to protect the level of anti-poverty/pro-MDG spending in each country. This study therefore examines the degree to which the new facilities have tracked and tried to protect social spending.

One of the main changes to PRGF and PRGT programs after the financial crisis was that the IMF under its conditionality reform stated that they programmes would include a poverty related or social expenditure floor, which would help protect the vulnerable in society. It is important to realise that (according to IMF staff) these types of targets are not a result of the new facilities. Rather they spring from a decision taken in 2008 to track and protect social spending more clearly, which was piloted in PRGF but has gradually been extended into most programmes under the new facilities.

As shown in Table 6, this does look as though the IMF is making greater efforts to safeguard social spending. The main measure used to achieve this has been to add into quantitative criteria an indicative target of a floor on social or poverty related expenditure. This was already beginning under PRGF-ESF Trust agreements (9 of 26 countries had an indicative target), but has accelerated under the ECF, under which 25 of 35 countries have such targets.

However, 10 PRGT countries do not have any social expenditure floor in their programmes. It is not clear why this is the case – whether the country authorities rejected a floor, the IMF decided for an objective reason that it was not needed, or data were not available to set it. Clarification of the circumstances in which countries do not have a floor is vital, as its absence may imply that anti-poverty spending is not being seriously monitored by the IMF or the authorities.<sup>2</sup>

Another major issue is that the floors are only having limited overall success. Figure 5 shows clearly how many PRGT countries have met their floors. It shows that of the 25 countries with targets, only 10 have spent more than their targets - and of these, Guinea-Bissau achieved its target only after the initial floor was reduced by almost 50%. Worryingly, almost as many - 8 countries - were below their floors, and three countries only just reached them. In addition, four countries (Comoros, Kyrgyz Republic, Malawi, and Yemen) had statements in their documents saying that floors were in place, but the documents did not contain any actual data on the levels of the floors, so it was impossible to judge whether they had been met. It is not clear what the reason was for this lack of data – whether the authorities did not want the floor published, or there were other technical reasons. The Malawi case study indicates that clear threshold levels were not agreed because it became rapidly clear that they might not be met as expenditure cuts were being made and any floor levels might not be met. The Fund should clarify at an early stage why these levels were not agreed or not published.

It should also be of strong concern that there is little or no discussion in IMF review documents of why countries have or have not met their floors, and what is being done to ensure that this changes and anti-poverty spending increases in future. This seems to indicate that the issue was not a major subject of policy discussion during review missions or on the IMF Board, especially as the countries missing the floor targets have all been allowed to complete reviews without delay. **Based on evidence from the case studies, of the possible reasons** which might be overall fiscal compression, inadequate social sector absorptive capacity or shortfalls in donor resources for the social sectors, the main explanation seems to be shortfalls in donor resources in Malawi. However, the IMF should systematically report on these reasons and what is being done to avoid them in future.

<sup>2</sup> As all the country case studies chosen had floors, there is no evidence from countries on why some countries did not.

**TABLE 5: IMF PRGT Programme Social Expenditure Floors<sup>3</sup>**

Country	Social/Poverty	Data year	Expenditure floor	Percentage above	Future floor targets
Armenia	Social spending of the government floor - 100% of the budgeted amount of the family benefit program and lump-sum financial aid.	2010	31 billion Drams	0%	2011 year end - 36 billion Drams
Benin	Priority social expenditure floor - consists of selected (nonwage) expenditures in the following sectors: health; energy and water; agriculture; youth, sports and leisure; family and national solidarity; education, microfinance and employment; and culture, literacy, and the promotion of national languages.	2011 - 3 months to March	45.3 billion CFA francs	20.1% under floor	132.6 billion CFA francs
Burkina Faso	Poverty-reducing social expenditures - Health, education, rural roads and women's welfare & other poverty-reducing social expenditure	2010	274.5 billion CFAF	7.6% above floor	2011 year end - 314.4 billion CFAF
Burundi	Pro-poor spending floor - based on (i) social character of spending, based on the administrative classification of spending (this includes "social services" spending and part of "general services" and "economic services" spending if it has a social character component); (ii) consistency with one of the four PRSP pillars; and (iii) pro-poor investment spending, financed by donors.	2010	342.2 BIF billion	5.4% under floor	..
Central African Republic	Poverty-related spending floor - Total spending on health and education including wages and salaries, goods and services, and capital expenditure.	2009	21 billion CFA francs	30.2% above floor	Year end 2010 - 26.2 billion CFA francs
Comoros	Domestically financed social spending floor - classified according current and capital investment in health and education (includes external budget support, but not external investment expenditure).	2010	11,870 million Comorian francs	no data	..
Democratic Republic of Congo	n/a	..	..	..	..
Republic of Congo	n/a	..	..	..	..
Côte d'Ivoire	Pro-poor expenditure floor - derived from a detailed list of pro-poor spending produced in the SIFBUD /SIGFIP system	2010	885.2 billion CFA francs	0%	2011 year end 840.1 billion CFA francs
Djibouti	n/a	..	..	..	..
The Gambia	n/a	..	..	..	..

<sup>3</sup> For reference, Angola's standby arrangement also has a social expenditure floor indicative target. None of its 2010 or March 2011 targets were met, but the June 2011 target was. The expenditure floor is 17.7% higher in 2011 (997 billion Kwanzas) than 2010. Pakistan the other country with an IMF programme among the "other LICs" does not have a social expenditure floor.

Ghana	Poverty-reducing budget expenditures floor - the government is working with development partners to review the current classification of poverty-reducing expenditure to ensure that this measure focuses on the key programs.	2010	2106 million Cedis	13.7% above floor	2011 year end - 2700 million Cedis
Grenada	n/a	..	..	..	..
Guinea-Bissau	Social and priority spending - Current and domestically financed capital spending on health, education, agriculture and infrastructure.	2010	8,647 million CFAF (revised downwards from 16,247 million CFAF)	5.5% above floor (using lower target)	2011 year end - 12,227 CFAF millions
Haiti	Poverty reducing expenditures - Domestically-financed spending on health, education and	2010	12,716 million gourdes	11.8% under floor	2012 year end - 23,689 millions gourdes
Honduras	Social investment related spending floor - programs and projects of social content that are financed with domestic resources, debt	2010	1197 million Lempiras	62.6% above floor	2011 year end - 3477 million Lempiras
Kenya	Priority Social Expenditures of the central government floor (no further information given)	June 2010 to March 2011	17.6 billion Kenyan shillings	10.2% above floor	Year end June 2011 24.6 billion Kenyan shillings; Year end June 2012 26.1 billion
Kyrgyz Republic	Cumulative state government spending on targeted social assistance floor - consists of the total of the Unified Monthly Benefit (UMB) and Monthly Social Benefit (MSB) programs	2010	2302 million soms (actual)	..	Year end 2011 - 2,800 million soms
Lesotho	Central government social expenditure floor - Covers quarterly spending on school feeding program, old age pension and HIV/AIDS	2010 - Quarter between September and December	170 million maloti	0%	Each quarter target until September 2011 is set at 170 million maloti
Liberia	Social and other priority spending floor - fiscal expenditure on the four basic pillars of PRS spending defined in the Liberian Poverty Reduction Strategy paper.	2010 - year end December 2010	\$US65 million	22% above floor	Year end June 2011 - US\$65 million
Malawi	Social spending floor - Sum of central government spending on health, education and the fertilizer subsidy - no downward adjustment.	No data	..	..	..
Maldives	n/a	..	..	..	..
Mali	Priority Spending Floor - key priority areas identified in the Growth and Poverty Reduction Strategy Paper (G-PRSP II), including education, health, food security and rural development	2010	233.2 billion CFAF	0.8% under floor	2011 year end - 352 billion CFAF
Mauritania	Poverty-related expenditure floor (no further information given)	2010	106.7 billion ouguiyas	15.7% under floor	Year end 2011 - 106.5 billion ouguiyas
Moldova	Priority social spending of the general government floor - sum of essential recurrent expenditures for social assistance, unemployment insurance, and pension payments by the Social Insurance Fund as well as 95 percent of health expenditures.	2010	9,634 million lei	0.85% above floor	Year end 2011 - 10,457 million lei
Nepal	n/a	..	..	..	..
Nicaragua	Floor on poverty-related expenditures of the central government (no further information given)	2010	18,368 million Cordobas	1.4% under floor	Year end 2011 - 20,474 million Cordobas

São Tomé and Príncipe	n/a	..	..	..	Unknown
Sierra Leone	Poverty-related expenditures floor - expenditures in the areas identified in Table 2 of the Sierra Leone HIPC Decision Point Document.	2010 - 6 months to June	252.5 Le billions	14.4% above floor	2010 year end 417 Le billions, 2011 year end 514.2 Le billions
Solomon Islands	n/a	..	..	..	..
Tajikistan	Social and poverty-related expenditure floor - sum of current and capital expenditures in the education, health, and social protection sectors as shown in the functional classification of the budget.	2010	4,428 million somoni	5.5% under floor	Year end 2011 - 5,478 million somoni
Togo	Total domestically financed social spending floor (no further information given)	2010	87.7 billion CFA francs	1.8% under floor	Year end 2011 - 106.5 billion CFA francs
Yemen	Social spending floor - total of budget current and capital social spending including spending on the Social Welfare Fund, health, education and social protection, as recorded in the government's Financial Statistics Bulletin.	2010	517 million Yemeni rials	..	2011 year end target of 631 million Yemeni rials
Zambia	Social spending by the government of Zambia floor (no further information given)	2010	3,938 billion kwacha	5.4% above floor	Year end 2011 - 5,385 billion kwacha

Source: IMF country report documents

It is equally worrying that in Côte d'Ivoire, Liberia, Mauritania and Guinea-Bissau the future target floor (see the final column of Table 5) is actually programmed to be lower in nominal terms than the previous target. There does not seem to be any pattern of a relationship between whether the country met its previous floor, and the future direction of change – Cote d'Ivoire met its previous floors, Liberia exceeded its floor, and Mauritania did not meet its floor. So there does not seem to be a clear logic such as revising floors down due to previous over ambition. Nor is there any clear indication in documents of a technical reason for downwards revisions. As the practice of revising floors down appears to encourage countries to spend less on poverty reduction, which appears counter to the IMF's aim of protecting such expenditure, it would be useful to have the earliest possible clarification of why floors are revised downwards.

The other less common way to safeguard social expenditure is through a structural benchmark, which involves getting a country to report on social/poverty reducing expenditure. But as shown in Table 5, the definition of social or poverty reducing expenditure varies widely across countries. They include only benefit programs in Armenia and Kyrgyz Republic, specific program expenditures in Lesotho, education and health only in quite a few countries, infrastructure in some; and some include donor funding or external budget support while others limit to domestically-funded spending. Although some flexibility to allow countries to tailor definitions to their own plans is desirable, it is very difficult to do any cross-country comparisons or analysis of whether the Fund is succeeding in increasing overall anti-poverty expenditure without any uniformity of definitions.

In addition, though health spending is predominately included in country floor targets, the precise definitions vary widely. While 95% of Moldova health expenditure is included, in Kenya only anti-retroviral treatment expenditures are included and in Sao Tome and Principe while the majority of expenditure of the Ministry of Health is covered, the categories of 'individual', 'project costs', 'private institutions' and 'food' are not. The Honduras case study indicates that virtually all health spending is excluded from its floor. It would also be worth exploring in discussions with the IMF why these variations are occurring.

A bare minimum for a uniform definition would be to cover all basic health and education expenditure, both donor- and domestic revenue-financed. But ideally there would be a broader definition, so as to ensure that countries are not reaching floors by cutting another poverty-related sector (e.g. water, agriculture) which is not included in the definition. To avoid this possibility, it would be desirable to have a disaggregation of the target by sector in each country (not so as to set sectoral targets, but so as to improve tracking and analysis of why targets are being met or revised).

### 3.3. Structural Conditionalities

As discussed in Chapter 1, the third major criticism levelled against past IMF programmes is that they have often contained structural reform conditions which have been inimical to increasing social sector spending and MDG progress. Based on analysis in the first phase of this project, the only clear and widespread conditionalities with a direct impact on the health sector were found to be wage constraint measures (such as wage ceilings on the overall public sector, and reviews of wage bills or structures, or employee numbers), and therefore this section concentrates on these measures.

In 2007, partly as a result of past CSO pressure, the IMF took a decision to reduce sharply the use of wage ceilings in its programmes, and this has been implemented – but has nothing to do with the introduction of the new facilities, since decisions were taken well before their introduction. This decision has been largely implemented – there has been a dramatic reduction in the use of wage ceilings. However, as shown in Table 7, 4 PRGT programmes (Côte d'Ivoire, Honduras, Moldova and Nicaragua) still contain ceilings on government wage bills, and 10 countries (including Côte d'Ivoire and Honduras who also have wage bill ceilings) have structural benchmarks specifically relating to wage bill management. In addition, as discussed in Chapter 1, early PRGT evidence is that the fiscal framework contains forecasts of reduced wage bills in most programmes whether or not there is a structural benchmark for a ceiling.

In these cases it is not always clear how social sector spending is to be protected, as it constitutes the major proportion of wage bills in most LICs. An overall ceiling on the government wage bill, other structural benchmarks relating to wage management, or forecasts of reduced overall wage bills, can be compatible with increased or reduced health wage spending and it is not possible to judge a priori which will be the effect. In each country, in the process of agreeing an overall wage ceiling or wage bill forecast, or other structural benchmarks, the IMF and government will discuss the potential wage needs of the social sector and make joint decisions on funding levels. In some countries like Burundi and Liberia, programme documents clearly describe that priority sectors such as health are protected and actively hiring. In others it is not explicit what is happening to social sector wages/staffing: it should be a priority for the IMF to specify this in every review document.

The Malawi and Sierra Leone case studies make clearer how these processes occur:

- Both countries earlier suffered from excessive restraint on wage bills (restricting either wage levels or numbers of employees) and were unable to hire or retain the levels of staff needed to accelerate progress towards the health MDGs).
- However, both put together (Malawi with a Health Sector SWAp, Essential Health Package and Emergency Human Resource Programme; and Sierra Leone with a Free Health Care Initiative in 2009 supplemented by wage rises) very credible sector programmes which emphasised the need for higher health spending, and dramatic increases in health sector wages.
- Both programmes successfully convinced donors to provide large amounts of additional funding, much of which was targeted to the health sector through sector budget support, and even to the enhancement of wage levels and hiring additional employees.
- As part of these discussions, and given that the additional spending would be funded by additional donor flows, the IMF agreed to allow higher health spending
-

- The spending has resulted in sharp increases in recruitment (>50% in Malawi; and doubling of staff in Sierra Leone) and in health workers' pay, resulting in increased utilisation of health services and considerable improvement in health MDG indicators.
- Nevertheless, in both countries anti-poverty spending has grown much less rapidly as a % of GDP, implying that non-health anti-poverty spending is being cut or "crowded out".
- In addition, Honduras and Malawi have had considerable problems with meeting the planned spending levels because broader problems fulfilling the wider IMF programme conditions (as well as broader political problems), and resulting suspension of donor funds, have blocked disbursements of donor funds.
- Finally, problems with health spending have also been caused in Malawi (and other countries) by gaps between disbursements at the end of one sector programme, and starting disbursements to fund the next.

**Table 6 – PRGT Wage Bill Quantitative Criteria and Structural Benchmarks<sup>4</sup>**

ECF			
Countries	Wage bill performance criteria	Structural benchmarks relating to wage bill management	Description of Benchmark(s)
Armenia	..	..	..
Benin	..	●	Civil service reform - "authorities aim to limit the expansion of the wage bill and to maintain fiscal space."
Burkina Faso	..	●	Finalize the social audit of the public service
Burundi	..	..	..
Central African Rep.	..	..	..
Comoros	..	●	Completion of the census of Civil Service employees to improve control of the wage bill
Congo, DR	..	..	..
Congo, Republic of	..	..	..
Côte d'Ivoire	●	●	i) Estimate the expected impact of the civil service census on the wage bill; ii) Implement medium-term wage bill strategy
Djibouti	No information	No information	..
The Gambia	..	..	..
Ghana	..	●	Steps to strengthen oversight and control of the public service recruitment
Grenada	..	..	..
Guinea-Bissau	..	●	Publish the verified data of the biometric census of public administration systems
Haiti	..	..	..
Kenya	..	..	..
Lesotho	..	..	..
Liberia	..	..	..
Malawi	..	..	..
Mali	..	..	..
Mauritania	..	..	..
Moldova	●	..	..
Nicaragua	●	..	..
Niger	..	..	..
São Tomé and Príncipe	..	..	..
Sierra Leone	..	●	Develop and start implementing a pay reform for public services
Tajikistan	..	..	..
Togo	..	..	..
Yemen	No information	No information	..
Zambia	..	●	Approval by Cabinet of the policy reform to strengthen payroll management, and increase productivity of the public sector
SCF			
Countries	Wage bill performance criteria	Structural benchmarks relating to wage bill management	Description of Benchmark(s)
Honduras	●	●	Transfer the control over education payroll to the Ministry of Finance
Solomon Islands	..	●	Incorporate all line ministries and employees into the new payroll accounting system
RCF			
Countries	Wage bill performance criteria	Structural benchmarks relating to wage bill management	Description of Benchmark(s)
Kyrgyz Republic (RCF & ECF)	..	..	..
Nepal	..	..	..

Source – IMF loan review documents

<sup>4</sup> Note that neither Angola's nor Pakistan's standby arrangement contains any quantitative criteria or structural benchmarks on wages



Ramatulai, 8 months, is at the clinic with her mother Fatmata. Due to the free health care her mother is now able to go to the clinic. Photo: Louise Dyring/ Save the Children Denmark.

## CHAPTER 4: SUMMARIES OF CASE STUDY FINDINGS

This chapter provides brief summaries of key findings from the case studies. The complete studies, written by local experts with close knowledge of IMF-government discussions, are in Annex 1.

### 4.1. Honduras

Honduras has had IMF-supported programmes since the mid-1990s. Its last PRGF ended in 2007, and was replaced by a temporary Standby-Arrangement in 2008. This was intended to lead to a PRGF in 2009, but a protracted political crisis and economic sanctions meant no IMF programme. In 2010 the IMF agreed a blended Standby Arrangement/Standby Credit Facility arrangement for 18 months.

#### 4.1.1. Macroeconomic Framework and Impact on Health Spending

All IMF programmes aimed to contain spending. However, spending increased by 2% of GDP in 2006-08, with roughly half of the increase being due to wage rises. The 2008 Standby Arrangement was slightly more flexible in light of the global crisis, targeting only maintenance of % of GDP in 2009. The outturn however (while Honduras was off-programme with the IMF) was a rapid rise of 1.4% of GDP. The new SBA/SCF therefore targets a cut of 3.2% of GDP in non-interest expenditure between 2009 and 2012, part of which is necessary because interest payments have risen by 0.7% of GDP, due to domestic borrowing when aid flows were suspended during 2009.

Reducing the budget deficit has been a consistent core goal of the programmes. It fell by more than three-quarters as a % of GDP between 2003 and 2006, exceeding programme targets, but then rose sharply in off-programme years (2007 and 2009), and was not successfully reduced in 2008. The latest programme is targeting (and achieving) sharp reductions (1.3% of GDP in 2011), reflecting higher revenue mobilisation and tight expenditure control.

Unlike many other countries, Honduras' IMF programmes did not include "adjusters" to allow increased spending if donor flows exceeded planned levels. Indeed the SBA/SCF specifically says that any excess donor flows will be used to increase reserves rather than spending, which might not seem necessary given that reserve levels are over 4 months of imports. The absence of an adjuster may be due to the fact that Honduras' dependence on donor flows for budget funding is very low.

Honduras has had two periods since 2004 without an IMF programme. The first was in 2006-08 when it went off track due to missing virtually all targets, especially as a result of rapid wage rises in a pre-electoral period. The second was in 2009-10, when IMF support was suspended due to the political crisis in Honduras which led to it being placed under international sanctions (prohibiting BWI loans). On both occasions (but more rapidly and sharply in 2009-10) it suffered from severe shortfalls of donor flows, and had to resort to additional domestic borrowing, which pushed up debt service expenditures and crowded out other spending. Mobilising donor flows has been further complicated by the fact that Honduras is no longer an IDA-only country, which means that several key health-oriented donors (e.g. Sweden, UK) have closed their programmes. Honduras has therefore increasingly based its planning on falling levels of aid and increased reliance on tax revenue.

In terms of inflation targets, Honduras appears to have benefited from considerable flexibility under the SBA and SCF agreements. This may be because it has never during this period had an inflation rate over 10%, so fiscal and debt sustainability (rather than inflation control per se) has been the top priority of programmes. Whereas the PRGF initially envisaged a reduction of inflation to 2.5%, the SBA allowed inflation to stay at around 9% in 2009 because in spite of global food and fuel price increases, "core" (non-food/fuel) inflation remained low. When the 2009 outturn was only 5.7%, the initial targets for the SCF foresaw only a 0.5% reduction over five years from 2010; and in spite of a further projected rise to 8% in 2011, the planned decrease is only 1.5% in 2012.

Health spending has mirrored trends in overall spending. It rose slightly during 2006-08 and sharply in 2009 (due largely to wage rises), though actual spending fell somewhat short of planned levels in 2006-08 due to delays in donor disbursements. In 2010-11 there have been cuts (in 2011 focussed particularly on wage spending), but these have been less severe than those in all other anti-poverty sectors, even though Honduras' progress on the MDGs has been better in health than elsewhere.

#### **4.1.2. Poverty Reduction Spending Floors and Structural Benchmarks**

Honduras has had poverty reduction spending floors in all its PRGF, SBA and SBA/SCF programmes. Government has even insisted on maintaining these throughout the period because it has regarded them as useful in pushing parliament and government to meet its anti-poverty spending commitments. However, the definition of anti-poverty spending has been narrowed considerably. In 2004-07 it included most social sector (health and education) spending under the PRGF (a total of around 7-8% of GDP).

In 2010-11 it is limited in the SBA/SCF to a relatively narrow set of programmes which are felt to be more closely targeted on the poor, principally the Bono 10,000 programme (see above) but also the Honduran Social Investment Fund (FHIS), community education, family allowances, free school meals and various scholarships and transport allowances. As a result, the amount of anti-poverty spending which has been "protected" in 2010-11 has remained relatively small. Though it has risen sharply from 1% to 1.5% of GDP, and all the targets set have been considerably exceeded, virtually none of it is direct health expenditure (though the cash transfer programme should increase use of health services, and some other programmes help the poorest to increase health indicators).

Wage spending control has been a constant focus of all IMF programmes. The 2004-06 PRGF contained a comprehensive wage reform programme, which also covered health and education sectors. All PRGF years contained quantitative performance criteria limiting wages, but these had little effect on spending levels, which increased especially sharply as a % of GDP in 2006-07, driving the overall IMF programme off track; and again in 2009. Overall, they rose by 4% of GDP between 2005 and 2009, leading government to establish an objective of reducing them by 1% of GDP in 2010-11 (which it has implemented through a nominal wage freeze). Most of the "excess" increases were however for the education sector, and wage restraint seems to have been more accepted in the health sector (for example in 2010-11 there was expected to be an education sector pay increase but no nominal increase for health workers). In 2008, wages did fall as % of GDP, but then they rose sharply again in 2009. In the 2008 standby the wage ceiling was changed from a performance criterion to a quantitative benchmark, and it has remained in every programme review since then: it was met initially in 2008 but not in late 2008/early 2009, and has been met again in 2010/11.

In addition, various programmes have contained structural benchmark actions to control wages, including comprehensive reforms in 2004-06, and a verification exercise for health and education employees in 2010-11. In years when structural reform actions have not been specified, this has typically been because the budget (approval of which was a structural action) contained very detailed expenditure control measures including on wage controls (for example a census and audit of health employees in 2008; and no nominal increases in wages in 2010-11). There has been no specific donor-funded programme targeted to increasing health sector wages or employment levels.

Honduras has made considerable progress towards the MDGs since the mid-1990s, reducing infant mortality by 37%, and maternal mortality by 41%. However, wide disparities remain (especially between urban and rural areas) in access to health services, and therefore in health indicators. As a result, Honduras will probably meet only a few of the health MDGs – relating to prevalence of tuberculosis and malaria, and child mortality. However, the other health MDGs (maternal mortality and HIV prevalence) will be missed, and the vast majority of the non-health MDGs (apart from access to water and sanitation) are also unlikely to be met.

Government is currently focusing its anti-poverty efforts on a conditional cash transfer program, focused on rural villages which contain most of the poorest citizens. The program (Bono 10,000) provides cash in return for attendance at primary school, and nutrition and health checks, and is now covering 200,000 households. It will extend to another 100,000 households in 2012, and in the medium-term to urban households. The government has also developed sectoral strategies for water and sanitation, maternal and child health, and food security, which now account for a large proportion of the public investment programme, to accelerate progress on the Health MDGs. The cash transfer programme in particular has attracted considerable amounts of donor funding, notably from the IADB and World Bank, and is already increasing utilisation of health, nutrition and education services. However, due to the national political and economic crisis, poverty rose by 100,000 in 2010. With sharp cuts in health, education and other anti-poverty spending, partly due to reduced donor flows, many of the MDG indicators could go further off track.

#### **4.2. Malawi**

Malawi has had IMF-supported programmes in most of the period since 2005, including a PRGF between August 2005 and August 2008, as well as an Exogenous Shocks Facility loan in 2008/09. In February 2010, the government adopted a 3-year Extended Credit Facility Programme.

##### **4.2.1. Macroeconomic Framework and Impact on Health Spending**

The fiscal framework in Malawi has consistently targeted budget deficit reductions, ranging from 4% of GDP over 3 years under the PRGF, to 5.3% under the ECF). To achieve these reductions, large-scale spending cuts have been targeted (10% of GDP in the PRGF, 3% of GDP under the SCF). However, these targets have not been met – spending rose by 5% of GDP and the deficit by 2% of GDP under the PRGF, the ESF deficit reduction target was missed by 1.5% due to grant shortfalls, and the 2010/11 deficit targets were again missed.

Overall spending rose by about 80% in nominal terms between 2006 and 2011. However, during the same period, health spending has virtually trebled in nominal terms. As a proportion of total government spending, health spending was forecast in the budget to fall in 2006/08, but actually rose to exceed the Abuja Declaration target of 15% of government expenditure. It fell below 15% in 2008/10 but rose above it again in 2010/11.

The key determinant of health spending has been the health sector "Sector Wide Approach" (SWAp) programme. It was developed in 2002 and led to a consistent rise in health spending, until 2008/09 when the SWAp was being reviewed and reorganised, and some spending switched to other areas in an electoral period. Health spending has also risen as a % of GDP in all years except 2009/10 (average from 4% in 2006/08 to 5% in 2009/11). The reasons for this rise were that government improved its planning, budgeting and outcomes; and donors therefore provided increasing funding.

Under all agreements, several quantitative performance criteria and indicative targets constrained government spending. However, these were subject to "adjusters", notably allowing more health spending if donor funding exceeded program assumptions. This provided more flexibility in increasing spending as donors increased money to support the Government's SWAp. For example, in the sixth PRGF review (June 2008), the ceiling on central government discretionary expenditures was increased by 7.7% due to an increase in donor funded health expenditure. Under the ECF, it was assumed that health spending would continue to rise, and it did in 2010/11, due to increased government prioritisation and donor flows, despite a tightening of the overall fiscal position.

On the other hand, it is vital that Malawi meet the overall programme targets. To the extent that Malawi met these until 2007/08 under the PRGF, this also encouraged donors to provide more support. However, missing 2008/09 ESF targets and the need to negotiate a new programme for 2010/11 led to reductions in donor support, and in health sector spending. In 2010/11, missed ECF targets resulted in IMF programme suspension and cuts in donor support in 2011/12. This shows that health spending remains highly vulnerable, partly because donor support is linked to the overall IMF programme. Problems with IMF programmes can lead to unpredictable flows for the health sector, undermining long-term planning of drug purchases and capital investment, and potentially delaying or reversing some MDG gains.

In terms of inflation targets, more flexibility appears to have been introduced since the global food and fuel price spikes. In 2003-07 the PRGF programme targeted rapid reduction from over 10% to below 5%; however, the most recent published programme review envisages only a fall from 9% to 6% over four years. This does not mean that ECF fiscal targets are looser: they are still tight in order to offset overspending in 2009/10, and reduce the deficit and repay domestic debt.

#### **4.2.2. Poverty Reduction Spending Floors and Structural Benchmarks**

Malawi did not have a poverty reduction spending floor in its earlier programmes, but introduced one in its ECF in 2010/11. This is based on the budget definition of priority social expenditure (health, education, social services and the agricultural fertiliser/input subsidy programme). The level for this has not been published. However, as a result of a change in government priorities, spending on roads and agriculture rose as a proportion of the total in 2010/12, and social sector allocations fell. Within social spending, actual health spending did not meet planned levels in 2010/11, and planned levels were cut in 2011/12, to below 2006/07 levels as a % of GDP.

Malawi's PRGF agreement had structural benchmarks which included wage adjustments by grade (met in September 2005), though its subsequent programmes had no benchmarks which impacted directly on the health sector. All 3 of its different agreements had forecasts for wage spending, which obviously restrained overall wage expenditures. However, the SWAp stressed that there had been high turnover and shortages of medical personnel, due partly to poor wages. It included an "Emergency Human Resource Programme" and the resulting increase in finance specifically allocated for this purpose, there was a 53% increase in health service personnel numbers, partly reflecting salary supplements. Nevertheless, staff numbers are still not able to keep pace with the increased workload, implying a need for even more flexibility in future IMF programmes.

As a result of the SWAp making the IMF programme more flexible, there has been considerable progress towards the Health MDGs since 2005, making it possible that under five mortality and HIV indicators will be attained. However, the fall in spending in 2010/12 could throw this off track, and considerable additional spending will be needed to reach the remaining MDGs. The key question is whether donors will be prepared to provide additional funding, or government can mobilise additional revenue, to ensure that this spending can be achieved under a future IMF programme.

### **4.3. Sierra Leone**

Sierra Leone had IMF-supported programmes throughout 2005-2011, including a Poverty Reduction and Growth Facility (May 2006-May 2010), and an Extended Credit Facility from June 2010.

#### **4.2.1. Macroeconomic Framework and Impact on Health Spending**

In Sierra Leone, planned government expenditure increased sharply in 2008-09 (by 1.9% of GDP), partly as a response to the global financial crisis; but since 2009 it has barely risen at all (by only 0.3% of GDP). The planned budget deficit has widened slightly, but this reflected domestic borrowing in 2009-10, as well as the availability of higher external loans in 2011; higher actual expenditure in 2010 and 2011 was funded by higher than expected domestic borrowing and budget revenue respectively.

In 2011-12 expenditure is expected to fall by about 3% in real terms which, combined with higher revenue mobilisation, will reduce the deficit from 3.9% to 2.2% of GDP. Overall, the case study concludes that the IMF framework has been too tight, especially in a context of global shocks hitting Sierra Leone and the need for accelerated spending to reach the MDGs.

Health spending has followed a very different path. It was constrained in 2008-09, falling well short of budgeted levels due to higher spending on other areas, but since 2010 has risen sharply as a % of GDP, exceeding budget plans, as a result of the launch of the National Free Health Care Initiative. Health spending has also more than doubled as a percentage of total spending. However, it remains woefully short of the Abuja Declaration target percentage of 15% of budget. Actual spending has until recently fallen short of planned levels due to shortfalls in donor funding and weak absorptive capacity (especially for decentralised health spending by local councils).

Sierra Leone made remarkable progress in improving its health indicators between the end of its war in 2002, and 2008 – for example halving under five, infant and maternal mortality. However, it was still a long way from the MDGs because indicators worsened so much during the war: mortality and disease indicators remain very high. As a result, the Free Health Care Initiative was launched in 2009, attracting large additional donor support, and reinforcing government efforts to accelerate delivery and absorb spending in the sector. This has been the key determinant of the sharp increase in spending in 2010-11, with the IMF once again showing flexibility in fiscal targets because large additional amounts of donor funding were available for the sector and government was demonstrating enhanced absorptive capacity.

Under all agreements, several quantitative performance criteria and indicative targets constrained government spending. These were subject to some "adjusters" for donor budget support, allowing more overall spending if donor funding exceeded program assumptions. For example, spending could increase by 1% of GDP in the 2008 second review. However, this did not impact directly on health spending as it did not specify where additional spending was to be focused.

Sierra Leone has missed several IMF programme targets since 2003, but only in early 2007 (an electoral period) did it miss so many that its IMF programme was suspended. This resulted in suspension of some donor flows and spending cuts. However, in other years, donors have been encouraged to increase flows: nevertheless, the case study indicates that both overall/sector budget support and project-related funding has been volatile, disrupting government planning, and it is one of the key priorities going forward for donors to live up to their Paris/Accra/Busan aid effectiveness commitments by providing more predictable flows, to facilitate long-term planning for the MDGs.

In terms of inflation targets, Sierra Leone appears to have seen some flexibility in the initial global food and fuel price spikes, but less recently. In 2003-07 the PRGF programmes targeted rapid reduction from over 10% to below 5%; in 2008 it was targeting a reduction of 6% in the first year and a further 2% over three years; but the 2010 programme targeted an 8% reduction in 1 year, and the 2011 programme 8.5% over 2 years. The case study concludes that at times the IMF has seemed to be focussing on low inflation at the expense of other development objectives.

#### **4.2.2. Poverty Reduction Spending Floors and Structural Benchmarks**

Sierra Leone had poverty reduction spending floors in its PRGF and ECF programmes since 2008. These are based on a relatively broad definition of poverty-related spending from the national development strategy, which includes health, education, agriculture, energy, water, roads and housing. The ceilings have risen sharply in nominal terms and slightly as % of GDP (in line with overall expenditures) since 2008, and outturns have considerably exceeded the ceiling in 2008, and marginally exceeded it in 2009 and 2010. Initially health expenditures represented less than 10% of the total, with large investments in energy and water predominating. However, they doubled their share to 21.6% of the total by 2011, though are budgeted to fall back to only 13% in 2012 due to large new investments in roads. The case

study concludes that overall poverty reduction spending floors have helped to increase overall allocations, but has not necessarily been able to influence health spending levels, or protect wage and salary allocations within anti-poverty spending: these have been determined by other factors.

There were wage-related indicative quantitative targets in Sierra Leone's PRGF programmes until 2007, together with structural benchmarks to complete a database of civil servants and issue wage and salary guidelines. However, the quantitative targets were consistently breached, and attempts to bring the wage bill down as a share of GDP were not successful. Once the structural benchmark had been partly met and the quantitative targets met in 2007, the Fund assessed that wages were more under control, and ended the quantitative targets. The ECF has nevertheless reintroduced a structural benchmark on developing and starting to implement a pay reform programme for public services. Both PRGF and ECF programmes contained forecasts for wage spending, which restrained overall and health wage expenditures until 2009, but did not reduce them as % GDP. However, the Free Health Care Initiative also acknowledged that there was a critical shortage of health workers, and rapid rotation of personnel, partly due to low wages. It was therefore complemented by large salary increases for health workers, as well as initiatives to accelerate recruitment and training, which were again funded by larger donor contributions. The number of frontline staff has doubled since the launch of the FHCI, increasing the health share of the overall wage bill from 5% in 2009 to 15% in 2011. The case study concludes that the "guarantee" of additional donor funding was crucial to convincing the IMF to accept the increased salary levels in the 2010 programme.

The FHCI has resulted in large increases in donor funding, as well as sharp improvements in sector absorptive and institutional capacities. This has in turn brought a dramatic improvement in MDG and other health indicators, including a 12% increase in the immunisation rate, and a reduction of 61% in maternal fatalities in clinics. This has resulted in the conclusion by a recent MDG progress evaluation that the health MDGs are much more likely to be met than other MDGs, provided that the current efforts can be sustained. However, this also raises the risk that other sectors may be being "crowded out", and the question as to how (in a context of limited global aid flows) to achieve similar accelerated progress in poverty, hunger, education and gender equality indicators. Government is increasingly intending to count on higher budget revenue (royalties from iron ore and petroleum) to fund these programmes sustainably, and make them less dependent on volatile donor funding.





Life in the Hmong village, Lao People's Democratic Republic.  
Photo: Luca Kleve-Ruud/ Save the Children Norway.

## CHAPTER 5: OVERALL CONCLUSIONS AND RECOMMENDATIONS

This study provides the first examination of the impact of the change from PRGF to PRGT facilities, in 2009-10, on IMF conditionality, and therefore potentially on progress to the health MDGs. What overall conclusions and recommendations can be drawn from its analysis?

1. It is not clear what was meant at its inception by the PRGT having an “*enhanced focus on poverty reduction and growth*”, and there is no evidence in programme documents that this is occurring (though some interesting and useful analysis is being done in Article IV and REO reports, this is not being linked to programme documents). Two key priorities going forward should be for *the Fund* to
  - a. *produce an annual PRGT review report specifying exactly how programmes are accelerating poverty reduction and growth, how it is analysing and acting on the fundamental drivers of such acceleration, and how it is analysing the poverty and social impact of its macro and structural conditions. This could possibly be combined with the current LIC Vulnerability Report, and could also discuss the fiscal, inflation control, structural conditionality and anti-poverty spending issues in recommendations 3-6 below.*
  - b. *specify in each programme document how it is accelerating growth, combating poverty/inequality, and assessing the poverty and social impact of the programme's macroeconomic framework and major structural conditions.*
2. **Very little use is being made of the PRGT facilities funded by the Norwegian government** (the Standby Credit Facility and the Rapid Credit Facility). This partly reflects their short-term nature - and the Norwegian government deliberately funded these facilities so that it could discourage the idea that countries should get into long-term lending and policy relationships with the IMF. However, because most other donors insist on long-term IMF programmes (with or without lending) as a macroeconomic policy signal for their budget support disbursements, and the short-term facilities have very low levels of funding attached to them, LIC governments generally ignore them and move straight to the ECF. This means that the Norwegian government is helping only a relatively small subset of LICs which need financing from the IMF.

*In principle, Norway should continue to limit its funds to RCF/SCF, to discourage countries from developing a longer-term lending relationship with the IMF. However, in order to ensure these funds are used, it should advocate a sharp increase in SCF and especially RCF loan sizes, and a frontloading of SCF disbursements. It should also advocate for a higher proportion of the PRGT to be funded by the IMF's own resources (notably its windfall profits from gold sales) rather than by increasingly constrained bilateral aid budgets.*

3. In terms of **fiscal flexibility**, the paper finds considerable increases in expenditure in nominal and real terms, and in many countries (and average) expenditure/GDP, in 2008-09 and 2009-10. The result is similar for countries with or without IMF PRGF programmes, and for health expenditure as well as total expenditure. The initial impression was that the financial crisis seemed to be changing the IMF mindset. However, the PRGT did not explicitly aim to make macroeconomic frameworks more flexible, and therefore this flexibility seems to have been only temporary. As a result, however, in 2010-12, under PRGT programmes, there will be falls in overall and health expenditure as a % of GDP, on average and for two-thirds of countries. As a result, in 2010-12, most IMF programme countries are cutting overall and health expenditure as % of GDP, while most non-IMF programme countries are not. By the end of 2012, PRGT countries will have expenditure/GDP only 0.6% higher than 2008 (compared to 2.3% for other LICs). However, these cuts have nothing to do with the existence of the new facilities. As explained in IMF publications, they reflect a view that any counter-crisis stimulus should be temporary, even though the Fund has not published any analysis showing that rapid deficit cuts are needed to ensure long-term fiscal sustainability. They also reflect a hardening attitude of some major Board member countries, which since 2009 have become sceptical about anti-crisis stimulus.

Insofar as many other stakeholders and LIC policymakers disagree with this view, *there should be a much more transparent debate between them and the IMF, about how much expenditure is necessary to accelerate growth and meet the MDGs, and how this can be funded. The global report discussed above should be used as a tool to stimulate this debate, and the national PRGT documents for national debate. Several key issues should be included in the debate:*

- a. *There is no evidence that deficits of 3-5% of GDP are bad for growth unless they are resulting in poor spending decisions or unsustainable debt levels.*
  - b. *The IMF should therefore be required to show that higher deficits will lead to high risk of debt distress, or actual debt distress, as assessed under the LIC-DSF, or that spending is of low quality/return - or else to allow countries to keep deficits at 3-5% of GDP while the MDGs are reached (at least until 2015).*
  - c. *The IMF should be required to analyse (if necessary in conjunction with the World Bank, other UN agencies and independent sources) whether spending is sufficient to allow accelerated growth and MDG progress, and to show that there is an adequate balance between investment and recurrent spending, (including wage/employment levels necessary to recruit and retain key anti-poverty workers).*
  - d. *The IMF should in all programmes project alternative spending and financing scenarios to show donors how MDG attainment or debt sustainability will suffer if required spending levels are not financed by more aid, and thereby encourage donors to provide higher flows.*
4. As for **inflation**, the study finds evidence that there has been more flexibility in terms of planning more gradual reductions of inflation and letting it stay at levels over 5% for longer. However, this flexibility springs from the 2008 global food/fuel price increases: gradually (and not in all countries) the IMF has come to think that temporary global shocks should be treated more flexibly, and the focus should be on measuring “core” inflation excluding food and fuel shocks. However, as the impact of shocks has persisted and especially where inflation goes above 10%, the IMF is increasingly recommending sharp monetary and fiscal tightening to reduce inflation, which could compromise growth and MDG progress.

*The IMF should continue to countenance inflation at 8-10% levels once global prices stabilise, if these are necessary to maintain growth; change its inflation targeting to measure “core” (non-food/fuel) inflation and use this as the inflation target in periods of exogenous shocks; reduce inflation much more gradually to reach 5-10% only over 3 years; rely much more on supply-side measures (especially increasing food production) rather than fiscal and monetary tightening to reduce inflation; and provide more evidence to prove that monetary and fiscal tightening can reduce inflation in each LIC before it recommends such measures (given that its Independent Evaluation Office has found that market-based transmission mechanisms and public sector crowding out of private investment do not usually operate in LICs). **It should also encourage LIC central banks to target employment or other real sector variables as well as inflation (as the US Federal Reserve does, helping higher and more stable US growth and employment), to ensure that they are not focusing excessively on inflation.***

5. In terms of **structural conditionalities**, wage ceilings persist in only 4 of 35 programmes, where the overall wage level is felt to be a crucial macroeconomic issue. However, 10 countries have other structural benchmarks designed to reduce wage bills; and forecast wage expenditures are being cut compared to non-wage spending in most PRGT programmes. In this context, and in the absence of detailed analysis in IMF documents, it is not clear how MDG-related wage spending and employment levels are being protected. A few programme documents describe how this is happening, and the case studies of Malawi and Sierra Leone have shown how vital strong government health sector leadership and strong support from donor sector funding can be in increasing health employment and wages.

***The IMF should therefore work with the World Bank and other UN agencies to conduct workforce analysis to show explicitly in all PRGT programme documents how anti-poverty expenditures will provide adequate funding for employment and wage levels needed to attain the MDGs, as well as proof that overall wage bill cuts (whether in ceilings or forecasts) and benchmarks will not lead to anti-poverty sector wage or employment cuts.***

6. The PRGT has helped to generalise significant changes in the way IMF programmes treat social spending. Partly due to earlier advocacy campaigns by CSOs, the IMF is paying more positive attention to tracking this spending, by **introducing social sector spending floors, and requesting closer monitoring/reporting of social expenditure**. However, this results from decisions taken before the PRGT was introduced. In addition:
  - it is unclear why 30% of countries have no floors, or why 16% do not publish data on floors in programme documents: **they should be standard and transparent in all programmes**
  - 33-50% of countries are not meeting these floors, yet there is little or no discussion in IMF documents of why or what will be done to ensure this changes. **There should be comprehensive discussion of reasons underlying shortfalls, in all review documents.**
  - some countries are having their targets revised down, or having targets set which are stagnant in nominal terms, without any clear reason. **The logic behind each target and any downward revision should be clearly specified in each programme document.**
  - definitions of anti-poverty spending (and health spending included) in programmes vary enormously. **It is essential to have more uniform IMF definition of anti-poverty spending, and more disaggregation of spending by sector, so as to be sure that some sectors are not being cut to protect others,** as seems to have been true in Sierra Leone.

It may be suggested that analysis of social sector spending is not the IMF’s job: it is true that the recommendations above might imply joint work with the World Bank and other UN agencies, and consultation of LIC governments, country stakeholders and other development partners. However, the IMF has started along this road, and needs to ensure it is working better,

7. Well-designed sector programmes and initiatives (for example in Malawi and Sierra Leone) have dramatically increased health spending, aid flows and MDG indicators. Countries where health spending has been cut have generally been those without such strong sector programmes.

**Global pressure for free health care and improved health systems needs to be maintained and translated into sector programmes, higher spending and improved indicators in a much wider range of countries. However, it is also vital to ensure that health programmes do not crowd out other spending, by designing similar programmes for sectors such as education, water and sanitation, agriculture and food security, and social protection, especially as many of these are also crucial to improvements in health indicators. It is also fundamental to ensure that new phases of such sector programmes are designed and funded more quickly and flexibly, to avoid planning and budgeting suffering from “gaps” between phases which reduce spending and achievement levels.**

8. ***A more sustainable way to finance MDG spending is for countries to increase their own mobilisation of tax revenue. All IMF programmes should discuss how they are encouraging efforts to enhance tax revenues - through growth and economic diversification, as well as raising taxes on income and wealth; reducing tax avoidance through tax havens and transfer pricing; getting a fair share of taxes and royalties from large companies exploiting natural resources; and reducing tax preferences and exemptions given to investors.***

9. Sector programmes and increased aid disbursements have encouraged the IMF to be more flexible in using “adjusters” to allow higher spending, including on wages and recruitment. However, the IMF can also improve its signalling to donors of the potential positive impact their financing (or negative impact if it is not delivered). ***The IMF should use adjusters to absorb increased spending in all LIC programmes, and increase the quality of its “signalling” to donors by projecting alternative spending and funding scenarios and their impact on growth/MDGs.***
10. Suspensions of IMF programmes continue to result in cuts in general and sector budget support, producing volatility in health spending which undermines MDG progress even in countries with strong and well-executed health sector programmes.

***Norway needs to encourage other governments to join it in making decisions on aid disbursement (especially on sector but also on general budget support) independent of IMF programme reviews, and more closely based on the potential disruptive impact on MDG planning and spending.***

11. Finally, the above recommendations may be challenging for the IMF and other organisations to implement. ***Norway should aim to overcome the challenges in the following ways:***
- ***If the IMF Board is not prepared to allocate additional staff resources for the various types of analysis and debate discussed above (even though it has large windfall resources accruing from gold sales), Norway and other like-minded governments should set aside a proportion of their PRGT funds for such analysis, to be conducted by both IMF and independent analysts.***
  - ***Norway should work with like-minded donor governments, and especially LIC government representatives, to advocate such changes strongly during current discussions of PRGT replenishment, and to set clear conditions for funding the subsidy of PRGT loans, in order to justify why IMF lending is as good a use of Norwegian money as other concessional flows, in attaining accelerated equitable and sustainable growth and the MDGs in LICs.***

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## ANNEX 1: COUNTRY CASE STUDIES

### Annex 1a: Honduras Case Study

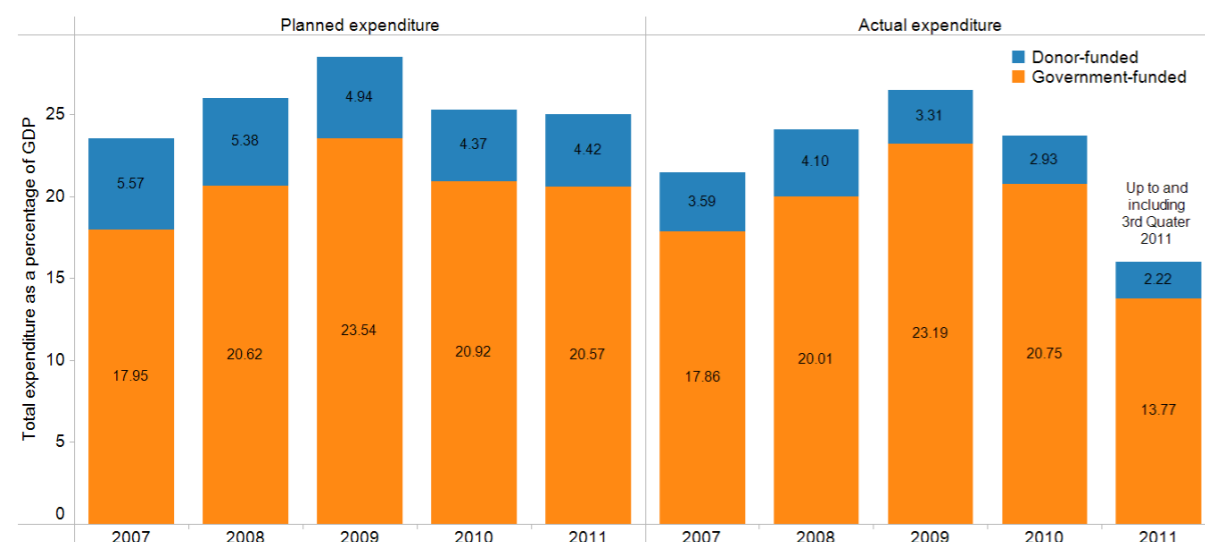
#### THE IMF AND THE HEALTH SECTOR: HONDURAS CASE STUDY

Honduras has had IMF-supported programmes since the mid-1990s. Its last PRGF ended in 2007, and was replaced by a temporary Standby-Arrangement (SBA) in 2008. This was intended to lead to a PRGF in 2009, but a protracted political crisis and economic sanctions prevented this. In 2010 the IMF agreed a blended Standby Arrangement/Standby Credit Facility arrangement for 18 months.

#### 1. Macroeconomic Framework and Impact on Overall Expenditure

All of Honduras' IMF programmes have aimed to contain overall government spending. However, during the last PRGF, spending increased by 2% of GDP with roughly half of the increase being due to wage rises. The 2008 Standby Arrangement was slightly more flexible in light of the global crisis, targeting only maintenance of the percentage of GDP achieved in 2008 for 2009. The outturn however (once Honduras was off-programme with the IMF) was a rapid rise of 1.4% of GDP. This spending increase from 2007 to 2009 is exemplified in figure 1 below.

Figure 1- Total Expenditure as a % of GDP



Source: Secretaria de Finanzas and IMF World Economic Outlook (Sept 2011)

After the removal of President Manuel Zelaya in June 2009, Roberto Micheletti announced central government cuts of 10%, due to falling exports and remittances because of the financial crisis, as well as the removal of international support. This move to austerity continued with the election of President Pepe Lobo in 2010, and has been maintained under the IMF SBA/SCF, which has targeted a cut of 3.2% of GDP in non-interest expenditure between 2009 and 2012. Part of this is necessary because interest payments have risen by 0.7% of GDP, due to domestic borrowing when aid flows were suspended during 2009.

Reducing the budget deficit has been a consistent core goal of the IMF-supported programmes. It fell by more than three-quarters as a % of GDP between 2003 and 2006, exceeding programme targets, but then rose sharply in off-programme years (2007 and 2009), and was not successfully reduced in 2008. The latest programme is targeting (and achieving) sharp reductions (1.3% of GDP in 2011), reflecting higher revenue mobilisation and tight expenditure control.

In terms of inflation targets, Honduras appears to have benefited from considerable flexibility under the SBA and SCF agreements. This may be because during this period it has never had an inflation rate over 10%, so fiscal and debt sustainability (rather than inflation control per se) have been the top priorities of the programmes. Whereas the PRGF initially envisaged a reduction of inflation to 2.5%, the SBA allowed inflation to stay at around 9% in 2009 because, in spite of global food and fuel price increases, "core" (non-food/fuel) inflation remained low. When the 2009 outturn was only 5.7%, the initial targets for the SCF foresaw only a 0.5% reduction over five years from 2010; and in spite of a further projected rise to 8% in 2011, the planned decrease is only 1.5% in 2012.

As in all IMF programmes, the Honduran PRGF, SBA and SBA/SCF agreements have contained quantitative performance criteria to constrain government spending. However, unlike many other countries, these did not include "adjusters" to allow increased spending if donor flows exceeded planned levels. Indeed, the SBA/SCF specifically says that any excess donor flows will be used to increase reserves rather than increasing spending, which might not seem necessary given that reserve levels already over 4 months of imports. The absence of an adjuster may be due to the fact that Honduras' dependence on donor flows for budget funding is very low.

Honduras has had two periods since 2004 without an IMF programme. The first was in 2006-08 when it went off track due to missing virtually all targets, especially as a result of rapid wage rises in a pre-electoral period. The second was in 2009-10, when IMF support was suspended due to the political crisis in Honduras which led to it being placed under international sanctions (prohibiting BWI loans). On both occasions (but more rapidly and sharply in 2009-10), it suffered from severe shortfalls of donor flows, and had to resort to additional domestic borrowing, which pushed up debt service expenditures and crowded out other spending. Mobilising donor flows has been further complicated by the fact that Honduras is no longer an IDA-only country, which means that several key health-oriented donors (eg Sweden, UK) have closed their programmes. Honduras has therefore increasingly based its planning on falling levels of aid and increased reliance on tax revenue.

#### 2. Impact on Health Expenditure and Other Anti-Poverty Expenditure (2007-2011)<sup>1</sup>

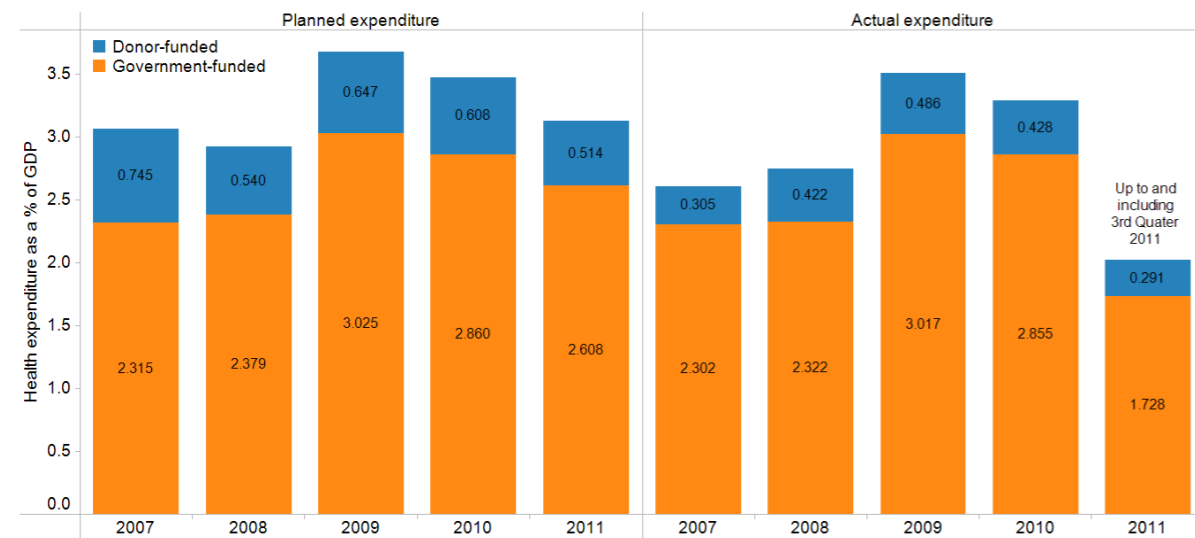
Health expenditure in Honduras has mirrored the trend in overall spending, with a sharp rise in spending in 2008-09, followed by expenditure cuts in 2010 and 2011, as shown in figures 2 and 3.

Government funded expenditures in 2007 and 2008 remained relatively even in real terms and as a % of GDP, although actual expenditure in 2007 was 0.5% of GDP less than planned, due to less than half of planned donor-funding being realised, suggesting a lack of absorption capacity due to cumbersome donor procedures.

Health expenditure in real terms and % of GDP rose in 2009, which can be seen clearly from figures 2 and 3, as a result of increased government funding going to the sector. Figure 4 shows that this increase in expenditure was channelled into recurrent expenditure, rather than capital spending. The increase in recurrent expenditure was focused on wage increases.

<sup>1</sup> Note: health expenditure is based on total expenditure by the Department for Health, which underestimates total health expenditure. This is because health expenditures are also present in the Honduran Social Investment Fund and the Finance Ministry, but it has not been possible to separate health spending made by these departments. However, as capital expenditure for the health sector is all based in the Department of Health, this suggests that the Department forms almost all of health expenditure.

**Figure 2 – Planned and Actual Health Expenditure as a % of GDP 2007-2011**

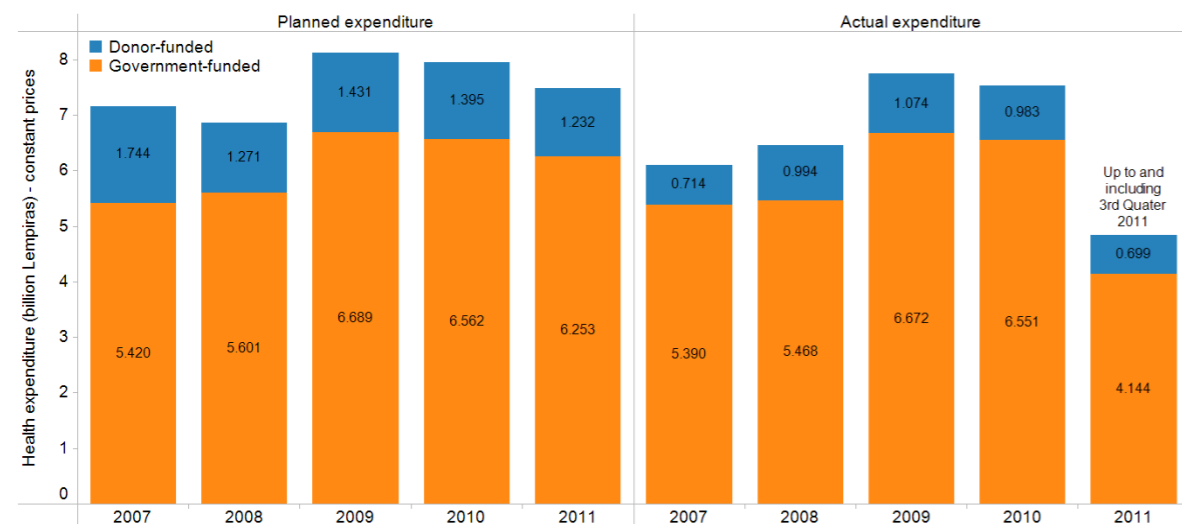


Source: Secretaria de Finanzas and IMF World Economic Outlook (Sept 2011)

In 2010, under a new presidency, it can be seen that there were cuts made to the health sector, but they were less severe than cuts to overall expenditure (see figure 1). Health expenditure levels remained well above those in 2007 and 2008, whilst overall expenditure fell below 2008 levels. This suggests that the health sector was more protected from cuts than other sectors.

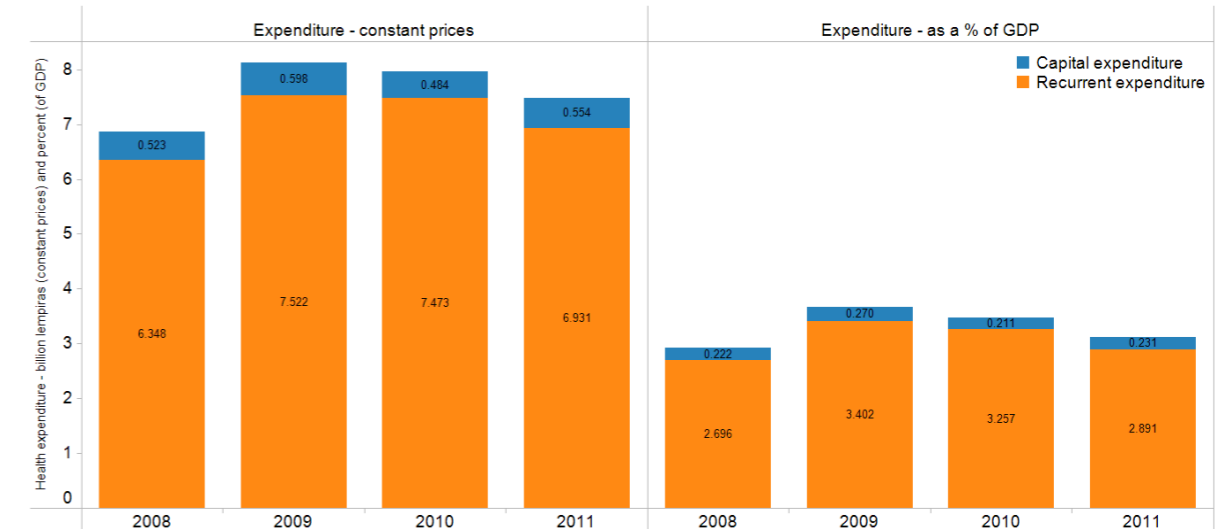
The SCF programme in 2011 has continued cuts in the health sector, with spending levels returning to those of 2007 and 2008. However, it has focused cuts on recurrent expenditure, notably wages, whilst encouraging increased capital expenditure.

**Figure 3 - Planned Health Expenditure, Honduran Lempira (constant prices)**



Source: Secretaria de Finanzas and IMF World Economic Outlook (Sept 2011)

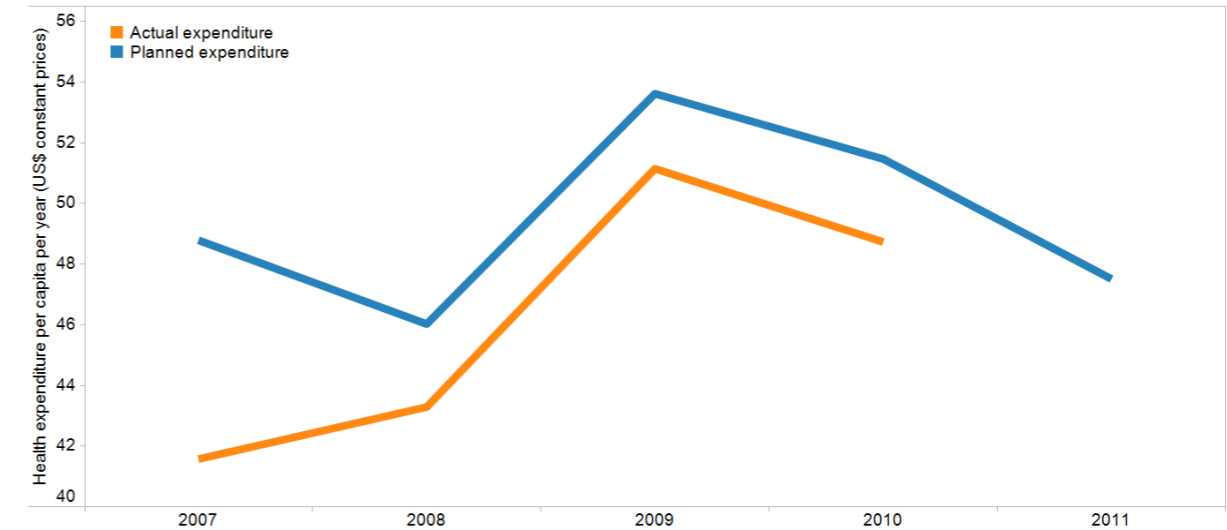
**Figure 4 – Planned Health Recurrent and Capital Expenditure 2008-11 (constant prices and % of GDP)**



Source: Secretaria de Finanzas and IMF World Economic Outlook (Sept 2011)

In per capita terms, Honduras' health expenditure in constant US\$ increased slightly in 2008 and sharply in 2009, followed by cuts in 2010 and 2011 (figure 5).

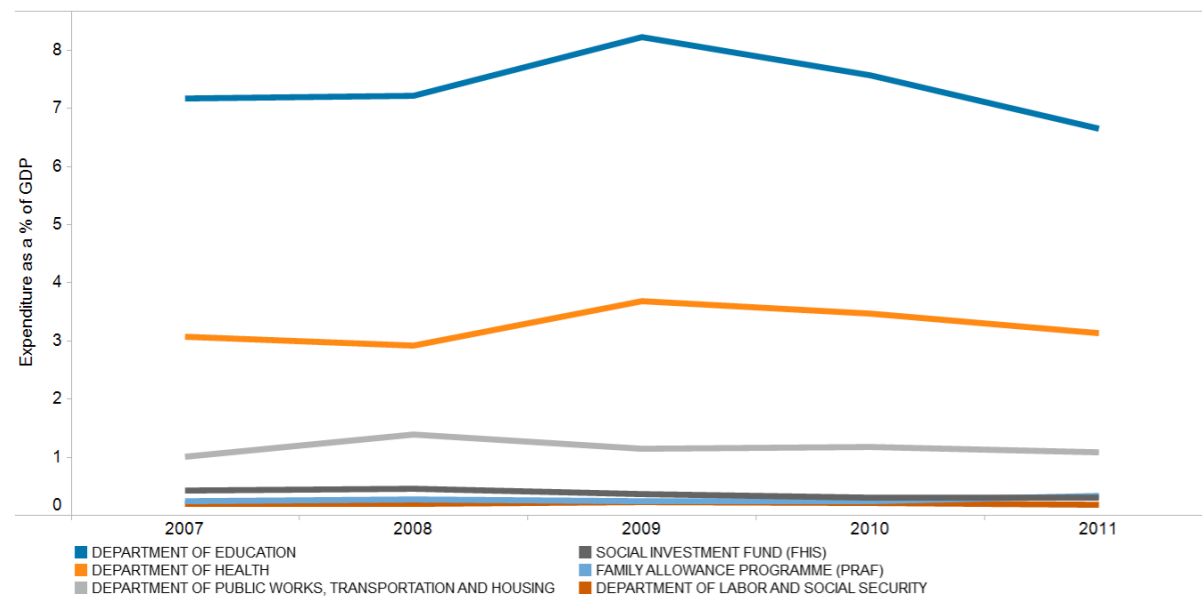
**Figure 5 - Health Expenditure Per Capita (US\$ constant prices)**



Source: Secretaria de Finanzas, www.oanda.com and IMF World Economic Outlook (Sept 2011)

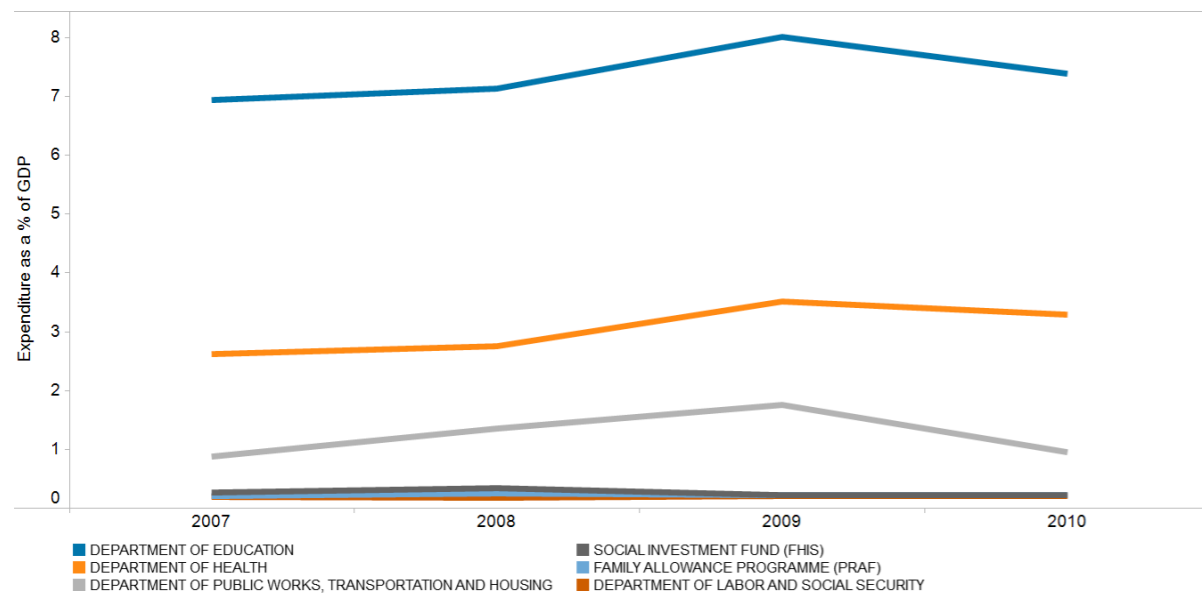
Comparing health with spending in other anti-poverty sectors, figures 6 and 7 show that other sectors have also not been immune to cuts and some sectors have been cut more than health. For example, planned and actual expenditure in education also saw increased expenditure in 2009, but cuts since then have been more severe, with planned expenditure as a % of GDP in 2011 falling below 2007. In addition, actual expenditure on Public Works and all other poverty sectors except the family allowance program have expenditure as a % of GDP below 2007 levels. Therefore, although the health sector has had significant cuts since 2009, it would appear that it has to some extent been protected from deeper cuts suffered by education and other anti-poverty sectors.

**Figure 6 - Planned Anti-Poverty Expenditure (by department/programme as a % of GDP)**



Source: Secretaria de Finanzas, www.oanda.com and IMF World Economic Outlook (Sept 2011)

**Figure 7 - Actual Anti-Poverty Expenditure (by department/programme as a % of GDP)**



Source: Secretaria de Finanzas, www.oanda.com and IMF World Economic Outlook (Sept 2011)

Government is currently focusing its anti-poverty efforts on a conditional cash transfer program, focused on rural villages which contain most of the poorest citizens. The program (Bono 10,000) provides cash in return for attendance at primary school, and nutrition and health checks, and is now covering 200,000 households. It will extend to another 100,000 households in 2012, and in the medium-term to urban households. The government has also developed sectoral strategies for water and sanitation, maternal and child health, and food security, which now account for a large proportion of the public investment programme, to accelerate progress on the Health MDGs. The cash transfer programme in particular has attracted considerable amounts of donor funding, notably from the IADB and the World

Bank, and is already increasing utilisation of health, nutrition and education services, but its impact on the MDGs is as yet unclear (see section 5 below).

### 3. Structural Benchmarks and Wage Bill Management

In addition to controls over overall expenditure, wage bill management has been a constant focus of IMF programmes. The 2004-06 PRGF contained a comprehensive wage reform programme, which also covered health and education sectors. All PRGF programme years contained quantitative performance criteria limiting wages, but these had little effect on spending levels, which increased especially sharply as a percentage of GDP in 2006-07, driving the overall IMF programme off track. In 2008 under the temporary standby arrangement the wage ceiling was changed from a performance criterion to a quantitative benchmark, which was met initially in 2008 but not in late 2008/early 2009, when wage expenditure spiralled upwards, resulting in wages levels rising by 4% of GDP from 2005 to 2009. To reduce wage bill expenditure the SCF programme like the programmes before it contains a wage bill ceiling quantitative criterion, which aims to reduce spending by 1% of GDP in 2010-11. This has been implemented through a nominal wage freeze and met in December 2010.

As well as quantitative criteria on overall wage levels, various IMF programmes have contained structural benchmark actions to control wages, including comprehensive reforms in 2004-06, and a verification exercise for health and education employees in 2010-11. In years when structural reform actions have not been specified, this has typically been because the budget (approval of which was a structural action) contained very detailed expenditure control measures including on wage controls (for example a census and audit of health employees in 2008; and no nominal increases in wages in 2010-11). There has been no specific donor-funded programme targeted to increasing health sector wages or employment levels.

### 4. Poverty Reduction/Social Investment Expenditure Floors

Honduras has had poverty reduction spending floors in all its PRGF, SBA and SBA/SCF programmes. Government has even insisted on maintaining these throughout the period because it has regarded them as useful in pushing parliament and government to meet its anti-poverty spending commitments.

However, the definition of anti-poverty spending has narrowed considerably. In 2004-07 it included most social sector (health and education) spending under the PRGF (8% of GDP rising to 10% in the medium term). In 2010-11 it is limited in the SBA/SCF to a relatively narrow set of programmes which are felt to be more closely targeted on the poor, principally the Bono 10,000 programme (see above) but also the Honduran Social Investment Fund (FHIS), community education, family allowances, free school meals, and various scholarships and transport allowances. As a result, the amount of anti-poverty spending which has been "protected" in 2010-11 has remained relatively small. Though it has risen sharply from 1% to 1.5% of GDP, and all the targets set have been considerably exceeded, virtually none of it is direct health expenditure (though the cash transfer programme should increase use of health services, and some other programmes help the poorest to increase health indicators).

### 5. MDG Performance

Honduras has made considerable progress towards the MDGs since the mid-1990s, reducing infant mortality by 37%, and maternal mortality by 41%. However, wide disparities remain (especially between urban and rural areas) in access to health services, and therefore in health indicators. Honduras has already met its target for malaria incidence, and may well meet its target for TB prevalence. In addition, as of 2010 it was on track to meet its child mortality target (see table 1) and as of 2008 was on track to meeting targets on access to improved water and sanitation facilities. However, it will not meet the other health MDGs including maternal mortality or HIV prevalence.

**Table 1 – Selected MDG Target Indicators**

MDG indicator/Year	1990	1991	1993	1995	1997	1999	2001	2003	2005	2007	2008	2009	2010	2015 target
Population below national poverty line, total, percentage	..	74.8	67.5	67.8	65.8	65.9	64.4	63.5	65.8	60.2	59.6	58.8	60	42
Children under five mortality rate per 1,000 live births	58	55	51	47	43	39	36	33	30	27	26	25	24	20
Infant mortality rate (0-1 year) per 1,000 live births	45	43	40	37	35	32	29	27	25	23	22	21	20	..

However, whilst Honduras seems on track with some health related MDG indicators, the latest available data are from 2010, with many from 2008 or before. Therefore, it is not possible to judge what the likely impact on MDG performance has been in light of expenditure cuts from 2009. Moreover, the vast majority of non-health MDGs was also unlikely to be met even before Honduras’ political crisis. Added to this, the population below the national poverty line increased by 100,000 from 2009 to 2010, as a result of the declining economic situation. With declining expenditures on health and education, there is therefore a strong possibility that MDG indicators may go further off track – in relation to health and other sectors.

**6. Conclusions**

Over the last 12 years, Honduras has for the majority of that time been under IMF programmes, from the PRGF’s (1999 to 2002 and 2004 to 2007), the temporary SBA in 2008 and finally the SCF in 2010. Over that time, IMF programmes have been synonymous with deficit reduction, principally through reducing expenditure. However, they have not managed to reduce wage expenditure significantly. In addition, the periods without an IMF programme before late 2009 have been categorised by increased spending, focused on wage bill increases (indeed wage increases were among the main reasons why Honduras went off-track with its IMF programmes). Health spending therefore broadly increased (especially in 2009) and MDG indicators improved.

However, since mid-2009 the Governments of both Roberto Micheletti and President Lobo focused on reducing government expenditure, even before the SCF was in place, partly due to large cuts in donor inflows. The SCF programme that started in late 2010 contained many of the facets of previous programmes and has continued the programme of deficit reduction and expenditure cuts from late 2009. The expenditure cuts since 2010 have seen spending in all poverty related sectors reduced, although the health sector has been comparatively less cut in real terms and as a percentage of GDP, especially compared to education. Whilst the cuts in the health sector in 2010 hit both recurrent and capital expenditures, the SCF in 2011 appears to have focussed on cutting recurrent expenditures, through wage reduction in the health and education sectors. It could be argued that the SCF programme has cut expenditure more than the PRGF/SBA, but this appears to reflect the policy of a new government, the lack of donor funding and the perceived need to reduce the deficit from 2009 levels, rather than any change of policy by the IMF.

Whilst the central features of the IMF programmes have remained largely the same from PRGF to SCF, one feature that has changed quite significantly in content is the social/poverty expenditure floors. Under the PRGF, the poverty related floor included the majority of poverty spending (8-10% of GDP), and the PRGF had a strong focus on meeting those targets to reduce poverty and meet MDG targets. However, under the SCF the poverty floor has changed to a social investment floor, which measures only expenditure in a few very specific programmes with a poverty focus, amounting to between 1-1.5% of GDP. This would seem to suggest that the SCF programme is much less focused on measuring and maintaining overall levels of poverty expenditure. Given lower economic growth and rising poverty in 2010, the broader declines in spending on key anti-poverty sectors (health and education), and narrower coverage of spending floors in the IMF programme, progress towards the health MDGs might decelerate in Honduras in the next few years.

**Annex 1b: Malawi Case Study**

**THE IMF AND THE HEALTH SECTOR:  
MALAWI CASE STUDY**

Malawi has had continuous IMF-supported PRGF and PRGT programmes since the inception of the PRGF in late 1999. The first PRGF programme ran from 2000 to 2004, which was followed by a second PRGF programme from 2005 to 2008, with a PRGF-ESF programme running from 2008 to 2009. Leading on from the ESF, in February 2010 the government adopted the government adopted a 3-year PRGT-ECF programme.

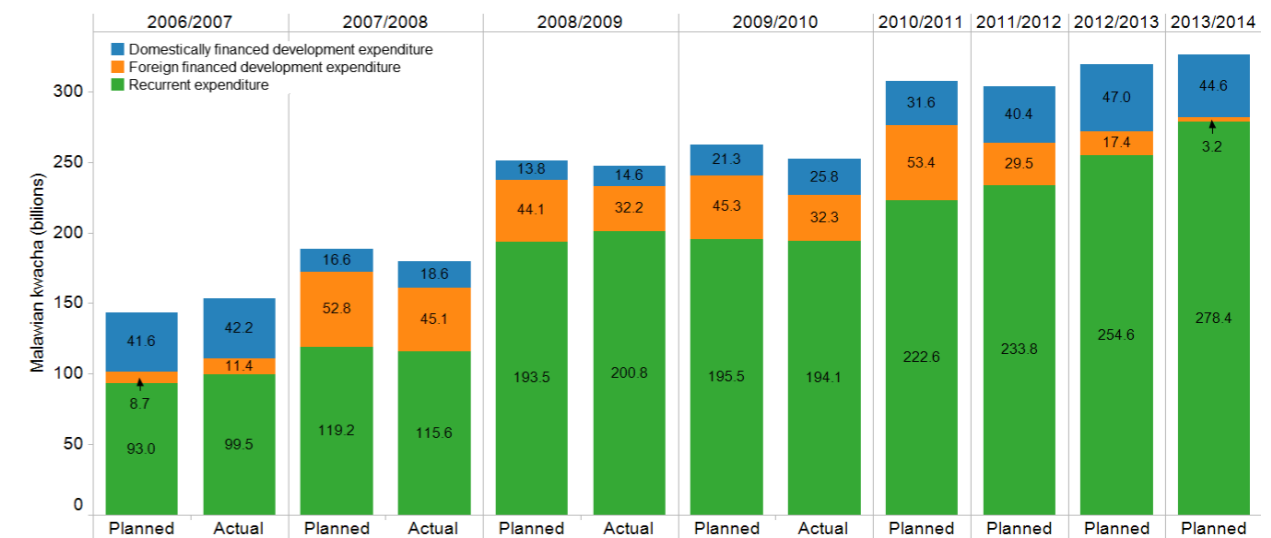
**1. Macroeconomic Framework and Impact on Overall Expenditure**

The first PRGF programme (2001-2004) was largely unsuccessful in improving fiscal performance as well increasing investment in the country, which lead to increasing levels domestic debt and a poor outlook for the economy. One of the key features of the first and the subsequent PRGF/PRGT programmes has been to tackle levels (repay) of domestic debt. This focus on domestic debt reduction is further emphasised by the continued quantitative criterion of a ceiling on government discretionary expenditure.

**1.1 Trends in government expenditure**

Figure 1 and 2 outline the Government planned and actual expenditure trends from 2006/2007 to 2013/14 in Malawi.

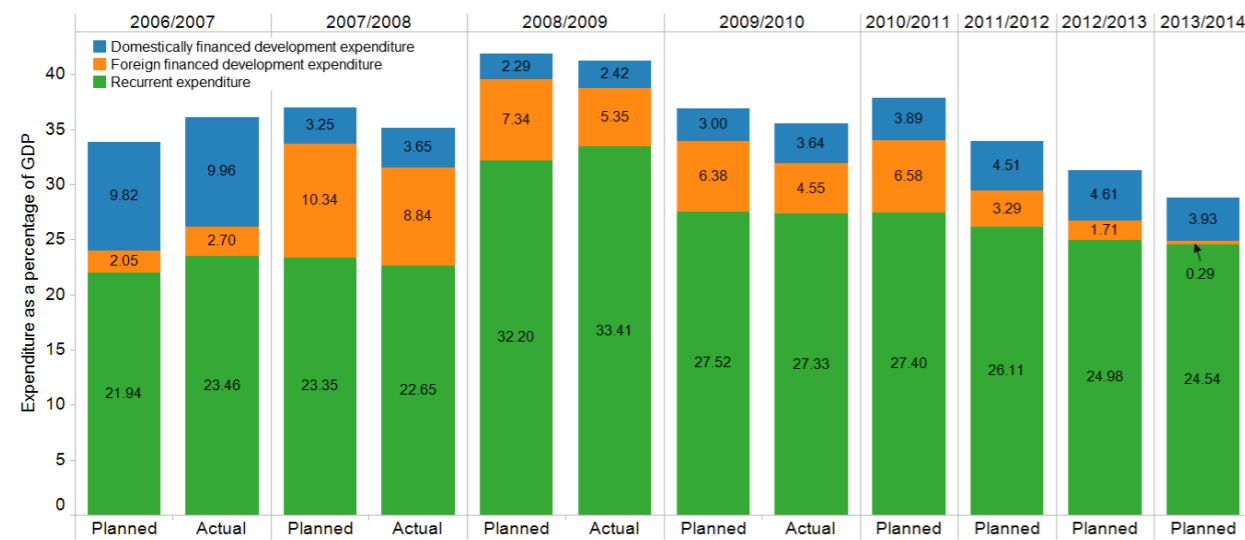
**Figure 1 – Government expenditure trends 2006/07 to 2013/14 (current prices)**



Source: Government of Malawi Economic reports, IMF WEO (September 2011) and IMF review documents of Malawi.



**Figure 2 - Government expenditure trends 2006/07 to 2013/14 (percent of GDP)**



Source: Government of Malawi Economic reports, IMF WEO (September 2011) and IMF review documents of Malawi.

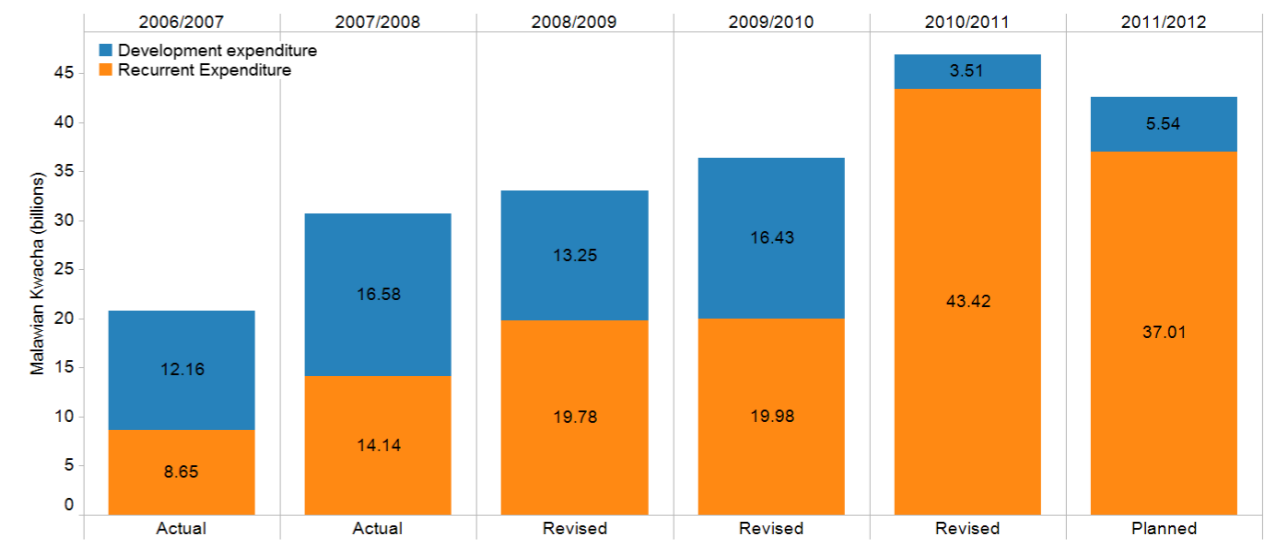
Expenditure under the 2<sup>nd</sup> PRGF programme remained relatively constant, although in 2006/2007 the target on discretionary expenditure was missed, which is highlighted by the higher actual expenditure than planned. In 2007/2008 it can be seen that there was a significant shift of focus towards financing of development expenditure towards foreign sources.

In 2008/2009, during the one year ESF there can be seen to have been a large increase in expenditure, particularly recurrent expenditure (see figures 1 and 2). This growth in expenditure was fuelled by increased domestic borrowing in the run up to elections in mid 2009. This meant that targets on domestic debt and reserves under the ESF were missed by a large margin. However, after the elections and into 2009/2010 the conditions under ESF appear to have constrained expenditure, back to similar percentage of GDP levels of 2007/2008. The PRGT-ECF programme included the same quantitative criteria as the ESF and PRGF's, with domestic debt reduction and expenditure constraint still at the forefront. Under the ECF in 2010/2011 planned expenditure remained constant compared to 2009/2010 as a percentage of GDP, although planned expenditure in the future is projected by the Government to drop significantly, due to a sharp reduction in foreign finance development expenditure, due to the stalled ECF programme, and several key donor countries decision to freeze aid to Malawi.

## 2. Impact on Health Expenditure and Other Anti-Poverty Expenditure (2007-2011)

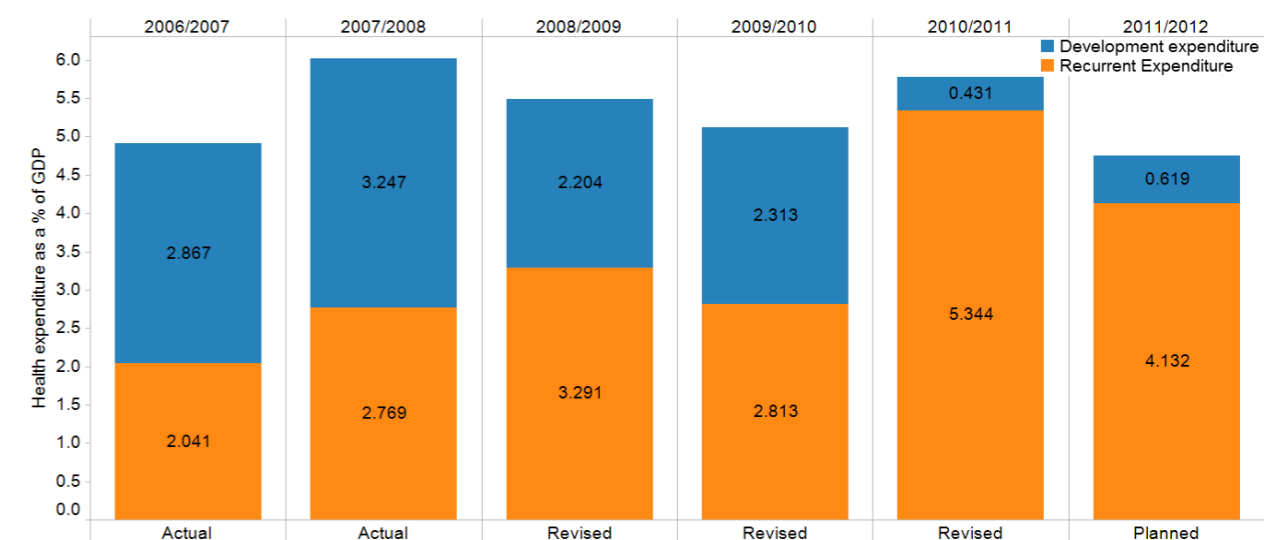
In terms of absolute numbers the health expenditure has been increasing from MK20.81 billion in 2006/2007 to around MK36.41 billion in 2009/2010, although the budgeted expenditure has decreased in 2011/2012 to 42.55 billion (see figures 3 and 4).

**Figure 3: Health budget in Billions of Malawi Kwacha**



Source: Government of Malawi Economic reports (2009, 2010 and 2011)

**Figure 4: Health budget as a percentage of GDP**

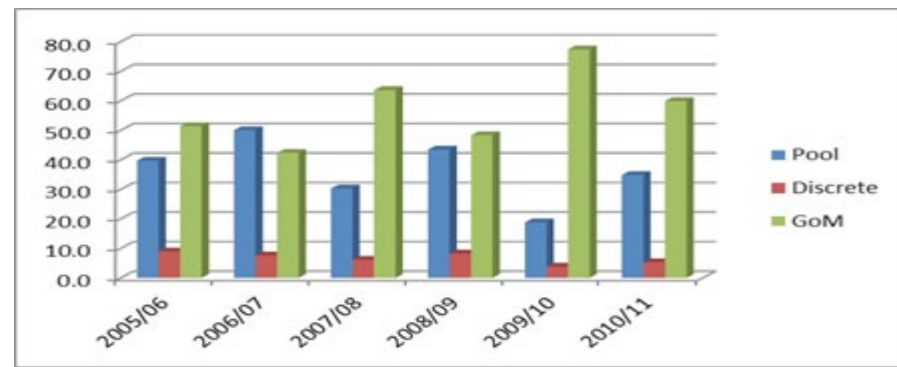


Source: Government of Malawi Economic reports (2009, 2010 and 2011)

### 2.1 The Financing of the Health Budget

The Malawi Health SWAp is financed by development partners and government. The modes of financing for the SWAp are pooled funds, discrete funds and Malawi government funds. A group of development partners came together and formed a basket of pooled funds to finance programmes of work in accordance with Health SWAp design. However, there are some partners who are not in a position to commingle their funds with other donors. The mode of funding of this group is categorised as discrete funding. Lastly, there are Malawi Government contributions towards the implementation of the health sector budget. The contribution of discrete funding has been consistent as shown in Figure 5. However, the pattern of the pool funding and government funding is somewhat mixed. The government contribution to the Malawi Health SWAp has been over 50 percent except 2006/07 fiscal year. In most cases the health expenditures are pre-financed by Treasury, then Treasury gets reimbursements from various donors in accordance with their pledges and programme of work.

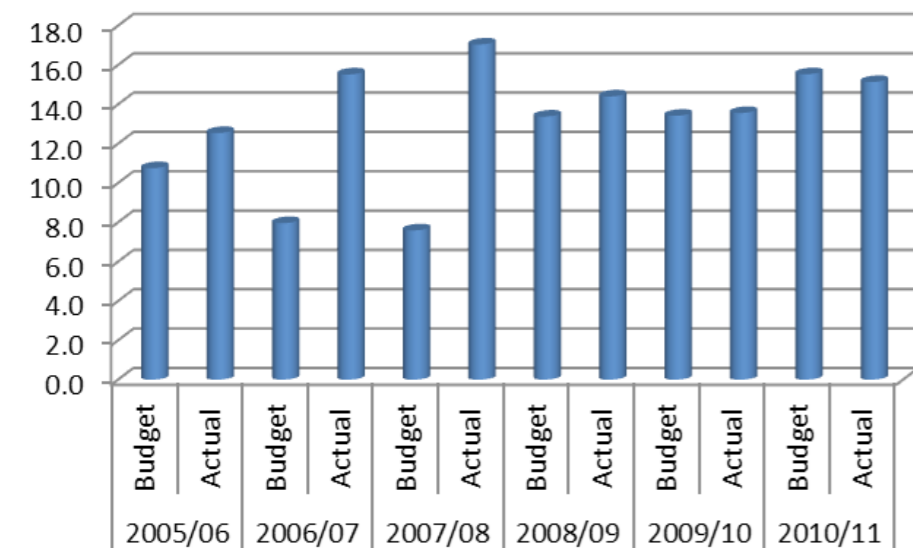
**Figure 5: Analysis of Financial Flows into Health Sector in US\$**



Source: Draft Annual Report of Malawi Health SWAp 2011

The budgeted Total Health Expenditure as percentage of Total Government Expenditure does not match the actual health expenditure as shown in Figure 6 below. The actual health expenditure has been more than budgeted in all years since 2005/06 except 2010/11. This outcome has been as a result of the way health sector is being funded by various players in the SWAp, with increasing commitments reflecting growing partner confidence in Government delivery capacity, as well as an impressive record of absorbing donor funds and claiming reimbursements rapidly. The key lesson being derived from this outcome is that the country is able to use all resources allocated to the health sector.

**Figure 6: Total Health Expenditure as a Percentage of Total Government Expenditure**

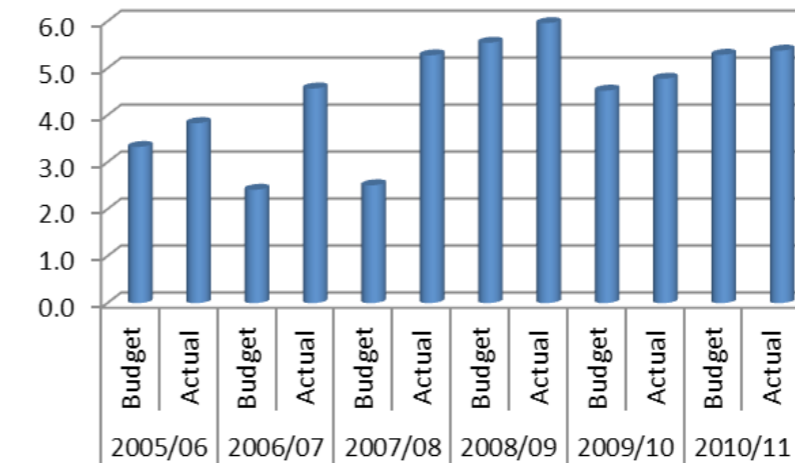


Source: Government of Malawi Economic Reports 2005-2011

The analysis of actual health expenditure shows steady increase and then abrupt decrease in the fiscal year 2008/09 as shown in the Figure 6 above. The health expenditure SWAp went under review and reorganisation during this period, and at the same time, the country was going through a political campaign for the 2009 Presidential and Parliamentary General Elections. After the 2009 general election, the actual expenditures on health care system have steadily been increasing as share of the total government expenditure.

Expressed as percentage of total government expenditure, actual health expenditure reached 17.0 percent in 2007/08 while health expenditure as a percentage of Gross Domestic Product reached 6.0 percent in 2008/09 as shown in Figure 7. The Abuja declaration recommends a minimum of 15 percent of the total government expenditure to go towards health sector. However, Malawi failed to sustain the ratio having attained it in 2006/07 fiscal year. It is worth noting that in 2010/11 fiscal year, the government has once again attained the Abuja recommendation by ensuring that the expenditure to health sector is above 15 percent.

**Figure 7: Total Health Expenditure as a percentage of GDP**



Source: Government of Malawi Economic Reports 2005-2011

### 2.2 The Analysis of Recurrent Health Expenditure

The actual recurrent expenditures on the health sector are above the budgeted recurrent expenditure for the entire analysis period. The contraction is not evident in the actual recurrent health expenditure in terms of what was budgeted and what was actually spent. However, from year to year there is noticeable variation on the actual recurrent health expenditure as shown in Figure 8 overleaf. The recurrent expenditure includes the money spent on paying salaries for the workers. It also includes money spent on the purchase of drugs and other pieces of surgical equipment.

### 2.3 Health Sector Wages

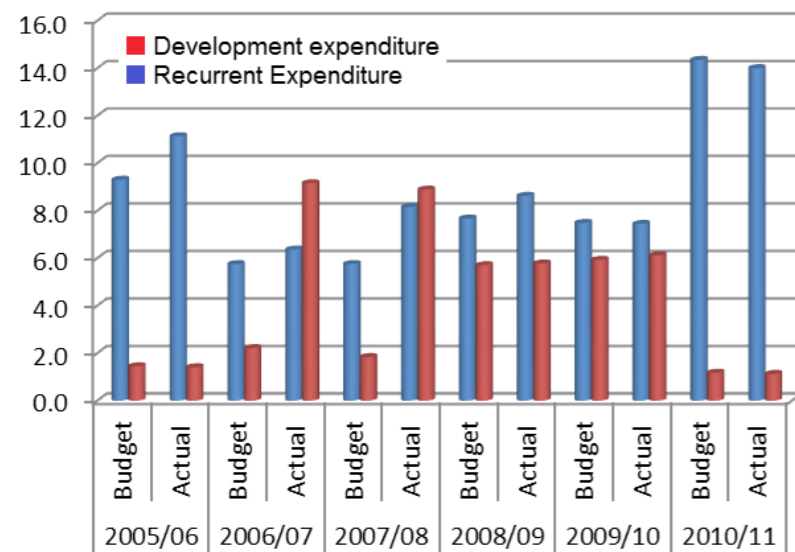
The health sector has faced a lot of challenges in the delivery of its services. One key challenge has been the high turnover of medical personnel due to poor wages. Under the Health SWAp, the government was able to put in measures to increase employment and improve pay packages with funding from donors like DFID. The development of Malawi Health SWAp included (apart from the Essential Health Package) an 'Emergency Human Resource Programme' (EHRP) which addressed the human resource crisis in the health sector.<sup>2</sup> The EHRP successfully accomplished its primary goal of increasing the number of professional health workers in the Ministry of Health. Across the 11 priority cadres, the total number of professional health workers increased by 53%, from 5,453 in 2004 to 8,369 in 2009. The achievement is due to donors' willingness to support a system where wages for professional staff such as doctors working in the public health sector were different from other civil service workers. The doctors, clinical officers and nurses received 52% salary top-ups, in order to retain more of the doctors and nursing professionals within the country rather than seeing them emigrate. However, though there has been a significant improvement in staffing levels, staff members are still not able to keep pace with the increased workload.

<sup>2</sup> Malawi had 1.6 physicians per a population of 100,000 and 28.6 nurses per a population of 100,000

### 2.4 The Analysis of Development Health Expenditure

It is noted in Figure 8 that actual development health expenditure is either equal to or higher than budgeted for. It means therefore that during this period what was budgeted for development expenditure in the health sector was spent for that purpose. The health development expenditure involves the construction of district hospitals as well as rural clinics. Due to major refurbishments and construction work of district hospitals, the development expenditures surpassed recurrent expenditures between 2006/07 and 2007/08 fiscal years as shown in Figure 8 below. In 2010/11 fiscal year, the expenditure on development health budget in the health sector has dramatically gone down. This may reflect the fiscal stance the government has adopted on the zero deficit budget in the face of the donor pull out on the budgetary support.

**Figure 8: Health recurrent and development expenditure, as a percentage of total government expenditure**



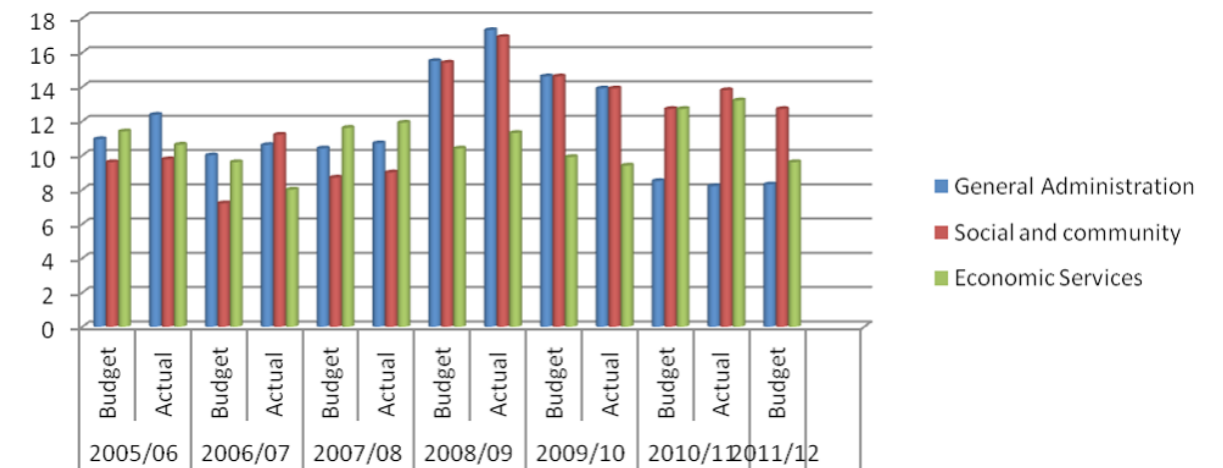
Source: Government of Malawi Economic Reports 2005-2011

### 3. Comparative Analysis of the Social sector and other sectors

Under the ECF agreement, the Government and the IMF have agreed to set a social spending floor. Though the precise amounts have not been published in IMF documents, they are based on the definition of priority social expenditure in the budget, which is analysed below. The definition of social expenditure takes into account central government expenditure on health, education, social services and the agricultural fertilizer/input subsidy programme. Has this had a major impact on maintaining social expenditure levels?

In terms of overall allocation of government expenditure between social and other sectors, there has been a considerable decline in the allocation of resources towards general administration as shown in Figure 9 below. This reflects enhanced development partner and government funding for both the social and economic services sectors. Indeed, there was a sharp increase in economic services spending in 2010/11, due to road construction and expenditures towards development of "Green Belt Initiative" in the agriculture sector. As a result of these expenditures, the proportion allocated to social spending in the budgets declined in the 2010/11 and 2011/12 financial years compared to 2009/10. In 2011/12 this decline also reflects lower support for the SWAp.

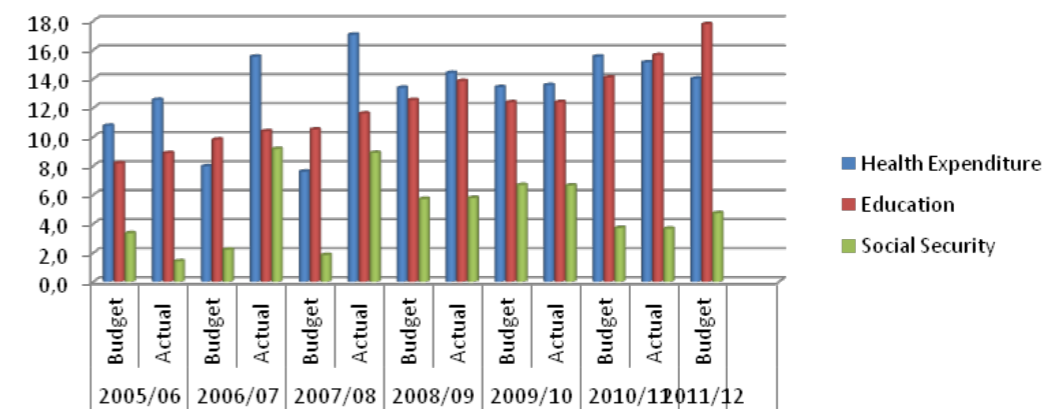
**Figure 9: Comparative Analysis of Broad Sectors of Government Expenditure**



Source: Government of Malawi Economic Reports 2005-2011

To look at spending in more details, we have limited our analysis of social sector to mean health, education and social services. The Figure 10 below shows that actual expenditures on education and health were above planned expenditures throughout 2005/10. However, actual health expenditures did not meet planned levels in 2010/11, and planned expenditures on health for 2011/12 are below planned and actual 2010/11 levels, due to suspension of the IMF programme and withdrawal of budgetary support.

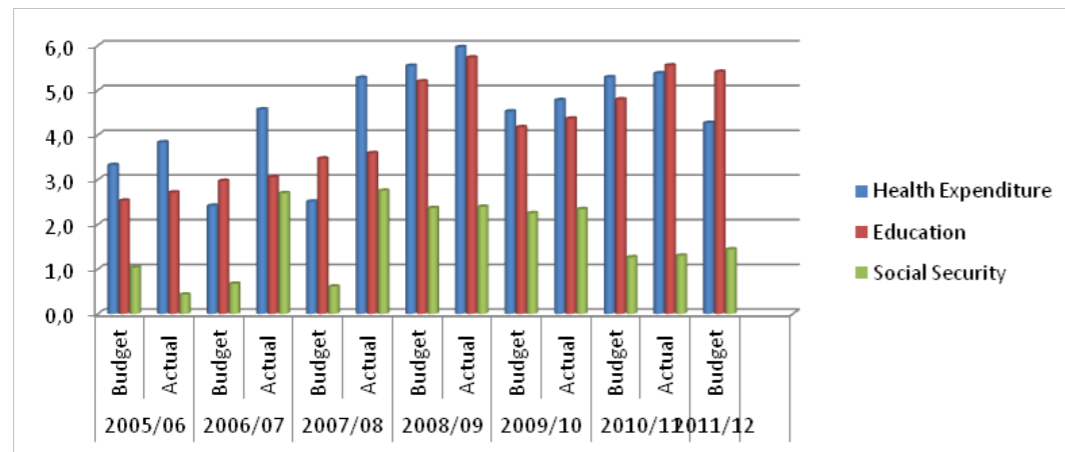
**Figure 10: Analysis of Social Spending in percent of total Government expenditure**



Source: Government of Malawi Economic Reports 2005-2011

In terms of social spending as a percentage of GDP, health spending rose faster in 2005/09, but there was a sharp rise in education in 2008/09. Both sectors suffered equally from cuts in 2009/10, and rose somewhat in 2010/11, but health has been cut sharply in 2011/12, falling back to below 2006/07 levels, as shown in Figure 11 below.

**Figure 11: Analysis of Social Spending in Percent of GDP**



Source: Government of Malawi Economic Reports 2005-2011

#### 4. The Effect of the IMF-Supported Programme on the Health Sector

Under the PRGF agreement, there were several quantitative performance criteria and indicative targets, which constrained government spending, including an indicative target ceiling on central government discretionary expenditures and a quantitative criterion of a ceiling on central government's net domestic borrowing. However, the performance criteria and indicative targets were subject to adjusters, notably an adjuster on donor funded health expenditure, with an upward adjustment if there was an increase in donor flows relative to program assumptions. For example, in the sixth review under the PRGF (June 2008), the ceiling on central government discretionary expenditures was increased by 7.7% due to an increase in donor funded health expenditure.

In addition, the PRGF agreement also had structural benchmarks aimed at managing government spending, which included wage adjustments by grade (met in September 2005) and the communication of spending ceilings to Ministries and assemblies (January 2008 - not completed). These obviously influenced overall wage expenditures and sector/decentralised expenditure levels but, as discussed in earlier sections, are not felt by the government to have compressed health spending during 2005/08, given that they allowed considerable rises in real and GDP terms.

Under the ESF agreement, adjusters remained in place for the quantitative criteria (although there were fewer of them) and included donor-funded health expenditure, and there were no structural benchmarks. Due to increased spending and domestic borrowing, targets set under the ESF were missed by wide margins, even allowing for the adjusters. There were therefore sharper spending cuts in the year when Malawi was not on an IMF programme and saw reductions in overall and sector budget support: even domestic borrowing was unable to fund higher spending. Therefore, the ECF agreement was based around a plan to reduce the fiscal deficit sharply, allowing a reduction in domestic debt.

The ECF agreement has the same quantitative criteria and indicative targets as the ESF, although an indicative target on social spending has been added (see next section for details), together with a restriction on non-concessional borrowing. The adjusters also remained in place, with a liquidity reserve requirement added to provide space to offset revenue or aid shortfalls without needing to increase domestic borrowing.

At the start of the ECF agreement, the Government recognised the need to restrain expenditure, but assumed that expenditure would grow due to continued IMF and donor support. It particularly targeted the preservation of social and poverty-reducing spending (including health), and aimed to cut other sectors if necessary to ensure that domestic debt was reduced. As a result, in 2010, due to the government's insistence on maintaining poverty reduction under the ECF, increased donor flows under the health SWAp (helped by the donor health adjuster), and despite a tightening fiscal position, health expenditure in Malawi has not been limited by the IMF programme.

However, after completing the first review of the ECF in December 2010 (though with waivers for non-observance of performance criteria), in 2010-11 Malawi has gradually fallen off track with the IMF programme targets, resulting in suspension of IMF and donor support. In mid 2011, the IMF and Malawi failed to conclude the second ECF review. This combined with other political factors led to the UK, German and other bilateral partners in assessing and halting assistance. Donor assistance is only expected to return after the second review is complete, and in its place the government has been raising revenue through increased taxation and duties, which has exacerbated inflation in the country.

Health spending cannot be sustained and remains vulnerable in the event that donors pull out of the budgetary support. This has resulted in challenges for the health sector that have included problems in purchasing drugs as well as improving capital investment in the health sector. It is expected that there will be general shrinkage in the expenditure of the government. Gains in the Expanded Programme of Immunisation (EPI), malaria prevention, HIV testing, counseling and treatment and Prevention of Mother to Child Transmission (PMTCT) may be lost and even reversed without continued donor support. After several years of predictable and rising funding, Malawi has seen once again that its progress towards the health MDGs remains over-dependent on donor support, exacerbating uncertainty as regards long-term funding. In addition, rapid inflation (due in part to drought and higher food prices) and increased government borrowing in 2010/12 have reduced the ability of Government to make its contribution to health expenditure.

#### 5. The Impact of the SWAp on MDGs and Health Planning

Since the introduction of the health SWAp, there has been an improvement in health planning, budgeting and outcomes, due in considerable part to stable delivery of funding. The Initiatives under the Programme of Work have resulted in strengthened planning and budgeting at District Health Management Team (DHMT) level. It has promoted institutionalisation of District planning and use of tools that were developed for planning and budgeting. There is now a resource allocation formula being used which allows for needs-based approach to resource allocation and is relevant to the devolution of health services to district assemblies. The formula is now part of the district planning process.

As already discussed, the SWAp has also helped the government to fulfil its commitment to the Abuja Declaration of committing 15 percent of the total government budget to the health sector, and to increase absorptive capacity to the point where it is able to spend more than planned provided additional resources are available.

Despite these improvements, the Government still faces challenges because there is still inadequate capacity to formulate policy, coordinate implementation, monitor progress, and capacity to support district health services. There are still gaps in coverage of health services which results in poor access. This has negative impact on women, children and poor households. Poor staff attitudes, drug shortages, and poor physical infrastructure continue to be a problem.

In terms of results for the Millennium Development Goals (MDGs), the Programme of work for the SWAp was developed in compliance with the MDGs. It is difficult to link a line expenditure item to precise achievements in maternal health or child health programmes. However, the increased funding in malaria as well as HIV and AIDS programmes has resulted in improved maternal health and child health indicators as shown in Table 1. Nevertheless, the progress is not enough for Malawi to achieve all the

health MDGs. It might achieve the U5MR, but is off-track to achieve the Maternal Mortality Ratio (MMR) target because the Programme of Work was resource-based and not needs-based and therefore provided for too few resources to achieve the MDGs. In addition, drug and health supply procurement systems have not been addressed adequately, with bulk procurement of drugs still handled by United Nations Children Fund (UNICEF). The distribution of drugs on a needs basis poses a challenge to sustain the gains made in the delivery of health care system.

## 6. Conclusion

Overall, Malawi has made major progress in health indicators during 2005-10, with all indicators showing positive developments, in contrast to the previous five-year period. Even the maternal mortality ratio is steadily coming down, from the peak of 1120 deaths per 10,000 women to around 560. The Malawi Health SWAp has been the main reason for improving delivery of health services. As discussed, it has dramatically increased development partner and Government funding for the sector, as well as planning, budgeting and delivery. It has also allowed a dramatic increase in health service personnel numbers (doctors and nurses) due to salary supplements, though extra work is required in this area to have comparable ratios with regional neighbour countries. The prior commitment by various partners to funding the implementation of health SWAp has assisted in the predictability of resources in the health sector, and assisted the government to protect health-related expenditure in the overall budget.

**Table 1: Progress Against key Health Outcome Targets**

Indicator	Baseline	Progress July 08-June 09	Target (2010-11)
- IMR	76/1000 (2000-2004)	72/1000 (MICS 2006)	48/1000 by 2011
-U5MR	133/1000 (2000-2004)	122/1000 (MICS 2006)	76/ 1000 by 2011
- MMR	984/ 100,000 (2000-2004 )	807/100000 (MICS 2006)	560/ 100,000 by 2011
-Life expectancy (at birth)	40 yrs (NSO, 2005)	-	45 by 2011
- Prevalence of HIV among 15-24 year old pregnant women attending ANC	14.28% (2005)	12.3%	<12% by 2011
- % of infants born to HIV- positive mothers who are infected	21% (2005)	Not Estimated	13%
- Malaria In-Patient Case Fatality rate	7%	3.95%	3%
-% of children that are under weight	18% (2005)	16% (2008)	7%

Source: Review of the SWAp

The presence of the IMF programme has generally not constrained health sector spending, because the IMF has been flexible in allowing it to increase in line with donor funding. Indeed, to the degree that budget support has been encouraged by compliance with the IMF programme, it may have helped somewhat to increase health spending. However, there have been exceptions to this picture in three

of the last seven years. In 2009/10, there were sharp cuts in health spending/GDP as part of a broader effort to reduce expenditure to achieve budget balance (partly also because the SWAp was being re-designed), after a sharp increase in spending in 2008/09. In addition, the suspension of the IMF programme and withdrawal of budget support in 2010/11 has led to a considerable cut in planned health spending in the 2011/12 budget.

As 2010/11/12 have been during the ESF and ECF programme, it might seem logical to ascribe spending cuts to the ECF. However, there has been no notable change in IMF policy under the ECF. Instead, the 2009/10 cuts were mainly a reaction to sharp increases in expenditure in 2008/09 (and later the lack of an IMF programme), and the social sector including health was not spared. In 2010/12, there was an intention to protect social spending, but given the broader breakdown of the IMF programme and other governance issues leading donors to suspend budget support, measures such as the social spending floors in the ECF programme may have helped to protect social spending slightly in 2010/11, but have failed to do so in 2011/12.

Though the health SWAp has played a critical role in increasing spending and delivery in the health sector, this has fallen back in the 2011/12 budget by 1% of GDP to only just above 4%: while the SWAp has been able to prevent a collapse of social sector spending, it has not stopped a sharp fall due to the suspension of the IMF programme. Overall, Malawi remains excessively dependent on donor funding for delivery of the health MDGs, which in turn is too dependent on macroeconomic developments (both exogenous shocks such as drought and global food prices, and failure to meet IMF programme fiscal and monetary criteria). These factors, in so far as they lead to unstable and inadequate health spending, may well prevent Malawi from reaching the health MDGs.

## ANNEX

### Financial Contributions to Health SWAp

	Financial Year					
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Pool Donors	US\$	US\$	US\$	US\$	US\$	US\$
DFID	16,288,788	26,132,199	31,842,404	18030435	28204379	23914420
	<b>19389362</b>	17559150	19671529	29814147	11385937	6477703
Norway	-	-	-	6775648	3513109	-
KfW	200,000	100,000	200,000	300,000	300,000	300,000
	-	-	-	-	2753400	1362000
UNFPA	4999985	866275	-	2999970	-	-
Flanders	6363507	14521325	1879898	33869706	4177255	57930826
World Bank	<b>47,241,632</b>	<b>59178949</b>	<b>53593831</b>	<b>91789906</b>	<b>50334020</b>	<b>89984949</b>
Global Fund						
Pool Donors						
Discrete	10,650,000	8,985,714	10,835,714	17,407,143	10,206,667	13,570,993
GoM	61,157,143	50,121,429	112,585,714	102,050,000	207,120,000	154,639,647
Grand Totals	<b>119,048,775</b>	<b>118,286,092</b>	<b>177,015,260</b>	<b>211,247,049</b>	<b>267,660,687</b>	<b>258,195,590</b>

Source: Annual report of the Work of Malawi Health Sector

#### References

Malawi Government Annual Economic Reports: 2005-2011

International Monetary Fund, Technical Memorandum of Understanding

Malawi Government, Annual Reports of the Health sector 2006-2011

DFID Impact Evaluation of the Sector Wide Approach

Final Evaluation of the Health Sector Programme of work 2004-2010

### Annex 1c: Sierra Leone Case Study

## THE IMF AND THE HEALTH SECTOR:

### SIERRA LEONE CASE STUDY

Since 2001, Sierra Leone has been under almost continuous IMF-supported PRGF and PRGT programmes. There have been two periods under PRGF programmes, from 2001-2005 and 2006 to 2010. Following the completion of the second PRGF, programme the Sierra Leonean Government and the IMF agreed a three year PRGT-ECF programme, planned to end in June 2013.

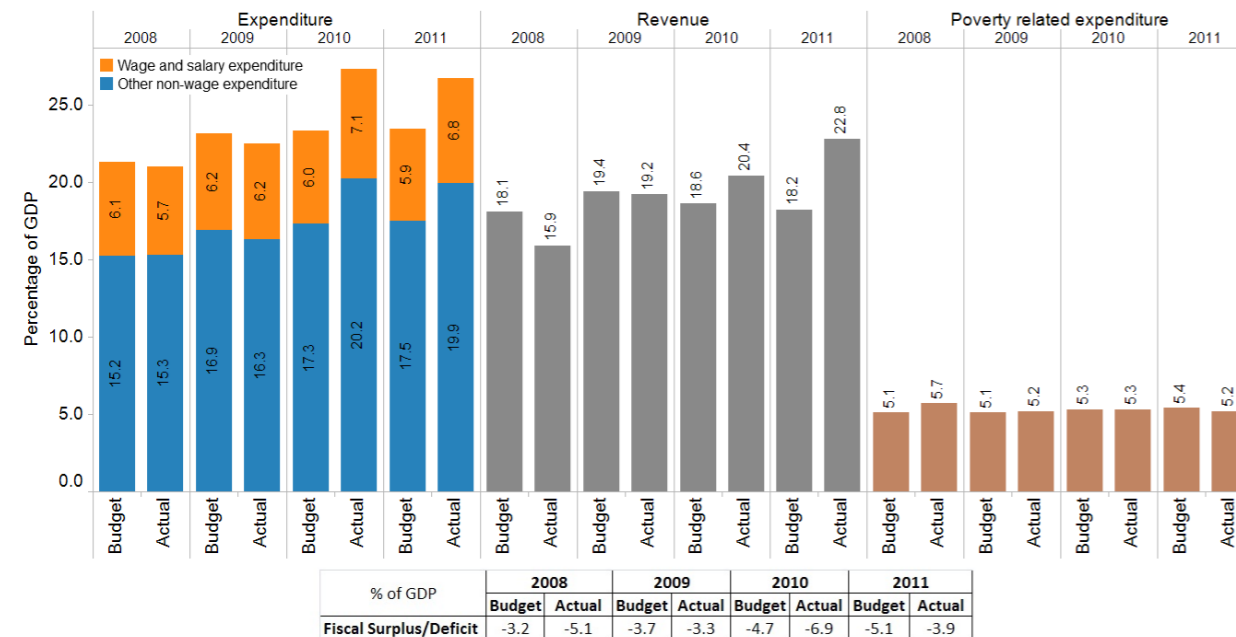
#### 1. Macro-fiscal Framework

During the last four years starting in 2008, the government of Sierra Leone has pursued policies aimed at achieving the priorities articulated in the country's second generation PRSP. The thrust of the macro-fiscal framework has consistently been aimed at macroeconomic stability through the pursuit of prudent fiscal, monetary and exchange rate policies geared towards low inflation. However, the government has had to balance this objective against its poverty reducing objectives of (i) accelerating economic growth by scaling up investment in agriculture and economic and social infrastructure, and improving the business climate, and (ii) improving the delivery of basic social services in order to accelerate progress towards achieving the Millennium Development Goals (MDGs). Budgetary allocations have been consistently and progressively skewed towards achieving these priorities. However, allocations have remained constrained by the key fiscal policy objective of reducing the domestic primary budget deficit.

The approach of the government has been to use a combination of improved domestic revenue collection and prudent expenditure management, on the assumption of regular and predictable external support in the form of budget support and project loans and grants.

Figure 1 compares budgeted revenues and expenditures over the period 2008 – 2011. The budgeted figures reflect conclusions reached between the government and the IMF on an annual basis, and during the successive reviews of the country's programme with the Fund. The table shows relative flexibility in the programme as shown by a modestly expansionary tendency going from 2008 - 2009, with relative tightening in the last two years. Total programme expenditure increased from 21.3 percent of GDP in 2008 to 23.1 percent of GDP in 2009, and has increased by only 0.3 percentage points of GDP in the last three years. Some programming flexibility is however evident from the programmed overall deficit increasing from 3.2 percent of GDP in 2008 to 5.1 percent of GDP in 2011.

**Figure 1 – Actual Budget Revenue and Expenditure Compared to Budget - 2008-2011 (% of GDP)**



Source: Ministry of Finance and Economic Development

Figure 1 also shows that the poverty related budget and actual outlays have been maintained relatively stable at an average of about 5.4 percent of GDP over the years 2008-2011. Variations from the budgeted figures have been minimal, but generally positive, with actual outlays generally exceeding budget.

Table 1 is an analysis of the variations of actual expenditures from the programme budget numbers in figure 1. It can be seen that expenditure has been constrained largely by shortfalls in domestic revenues and external budgetary resource flows. This notion is borne out by the Public Expenditure and Financial Accountability Assessment (PEFA) of 2010, which revealed that whereas there has been little progress in the effectiveness of domestic revenue collection since 2007, the predictability of direct budget support had actually deteriorated (see table 2 below).

Figure 1 reveals a sustained underperformance in respect of both the domestic revenue targets and the basic primary balance during the period under review. This suggests that the programme (both PRGF and ECF) targets for both of these indicators may have been unrealistic especially during 2008-2010. On the other hand, even though domestic revenue performance exceeded target in 2010, and is likely to do so in 2011, we note significant underperformance in the domestic primary balance in 2009 and 2010. This indicates a progressive tightening of programme targets. It is clear that expenditure tightening has been excessive relative to the recovery in domestic revenue performance.

**Table 1: Analysis of Actual Revenue and Expenditure Variations from Budget - 2008-2011 [% of Budget]**

	2008	2009	2010	2011
	[Percentage Variation of Actual from Budget]			
<b>Total Revenue and Grants</b>	<b>-12.2</b>	<b>-0.8</b>	9.9	24.9
Domestic Revenue	-6.5	-10.3	14.0	23.3
Grants	-27.0	17.5	-4.2	28.2
<b>Total Expenditure and NL</b>	<b>-1.4</b>	<b>-2.3</b>	17.1	14.2
Total Recurrent Expenditure	-5.1	-0.1	19.8	15.3
Non-Salary, Non-Interest Recurrent	-5.5	7.6	22.4	9.6
Wages and Salaries	-6.1	0.3	18.2	14.8
Development Expenditure (Total)	7.7	-7.1	13.0	12.6
Development Expenditure (Ext Support)	6.3	-14.9	-12.7	16.4
Poverty-related Expenditures	11.8	2.1	0.0	-3.2

Source: Ministry of Finance and Economic Development

**Table 2: Sierra Leone – Comparison of PEFA Indicators of Budgetary Performance (2010 Relative to 2007)**

Relevant PEFA Indicator	2007 Score	2010 Score
PI-1 Aggregate expenditure out-turn compared to original approved budget	B	B
PI-2. Composition of expenditure out-turn compared to original approved budget	C	C
PI-3. Aggregate revenue out-turn compared to original approved budget	B	C
PI-13 Transparency of Taxpayer Obligations and Liabilities	C+	B
PI-14 Effectiveness of measures for taxpayer registration and tax assessment	C	B
PI-15 Effectiveness in collection of tax payments	D+	D+
PI-16. Predictability in the availability of funds for commitment of expenditures	C+	C+
D-1 Predictability of Direct Budget Support	C+	D
D-2 Financial information provided by donors for budgeting and reporting on project and programme aid	D+	D+
D-3 Proportion of aid that is managed by use of national procedures	D	D

## 2. Recent Trends in Health Expenditure

Health sector budget performance in Sierra Leone during the past four years can be divided into two 2-year periods: the situation prior to the launch of the country's Free Health Care Initiative in early 2010 (see later), and the period 2010 – 2011. Table 3 clearly depicts the trends. It can be said that the health sector budget and expenditure profile generally mirrors the overall national profile, and both reflect the domestic revenue performance, external support and the allocative emphasis on the national priorities of the poverty reduction strategy for the period 2008-2012.

Table 3 shows progressive reductions in the variation of actual health sector expenditures from budget, as depicted in the overall ratio of health sector expenditure to total government expenditure. Whereas the 2008 budget earmarked 7.2 percent of total allocation to health, the actual expenditure outturn was less than 4 percent. This is a reflection of both budgetary shortfalls in that year (including a 1.7 percent of GDP shortfall in external resource inflows) and a significant 0.8 percent of GDP shortfall in domestic revenues. It can be seen that the situation has significantly improved since. However, it is also clear from the table that the share of the health sector in recurrent expenditure outlays continues to depart from budgetary allocations, while fluctuating from year to year. Several factors seem to explain this phenomenon:

1. Weak absorptive capacities in the health sector (see section III);
2. Weak domestic revenue mobilization capacity in the face of high requirements for investment in infrastructure, and in some cases delays in the release of funds by development partners, including budget support funds;
3. The ongoing devolution of functions under the decentralization programme – transfers to local councils increased from about 0.7 to 0.9 percent of GDP between 2008 and 2011, with health accounting for progressively increasing shares of the transfers

**Table 3: GoSL Health Sector Budget and Out-Turns 2008 – 2011**

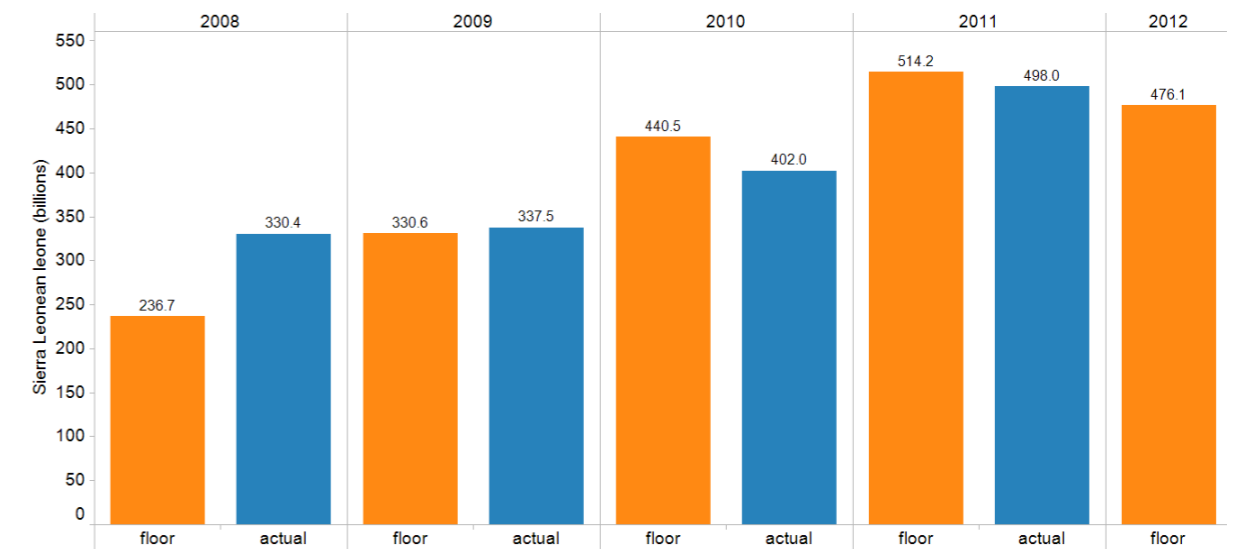
	2008		2009		2010		2011
	Budget	Actual	Budget	Actual	Budget	Actual	Budget
	<i>(in % of corresponding national aggregate expenditure line)</i>						
<b>Total Budget/Expenditure</b>	7.2	3.9	6.2	5.3	6.5	6.3	8.6
Recurrent Expenditure	2.6	1.7	4.0	3.3	4.1	2.3	2.4
Wages and Salaries	6.4	4.9	5.0	4.9	4.1	11.8	14.5
Development Expenditure	7.3	6.7	3.4	4.2	5.4	5.5	5.3
Transfers to Local Councils	31.7	36.9	25.7	34.7	22.3	32.3	41.5
	<i>(in % of GDP)</i>						
<b>Total Budget/Expenditure</b>	1.52	0.82	1.42	1.19	1.52	1.71	2.02
Recurrent Expenditure	0.40	0.25	0.62	0.52	0.57	0.38	0.33
Wages and Salaries	0.39	0.28	0.31	0.31	0.24	0.83	0.86
Development Expenditure	0.42	0.41	0.25	0.29	0.50	0.57	0.49
Transfers to Local Councils	0.31	0.27	0.24	0.31	0.21	0.33	0.34

Source: Ministry of Finance and Economic Development

In real terms, Table 3 shows that actual expenditure on health more than doubled between 2008 and 2010, with total health expenditure increasing from 0.8 percent of GDP in 2008 to 1.7 percent of GDP in 2010. The budgetary figure for 2011 is over 2 percent of GDP or 8.6 percent of the 2011 total expenditure allocation. Actual outlays have shown a progressive increase from 3.9 percent of GDP in 2008 to 6.3 percent of GDP in 2010. The predictability of resources has also improved considerably, as depicted by the narrowing gap between the budgetary allocations and the actual outturns.

Figures 2 and 3 profile the distribution of poverty-related expenditures (actual and budgeted) for 2008 to 2012. The figures suggest a shift in emphasis of poverty-related expenditure allocations towards the health and infrastructure sectors and, to some extent, away from other social sectors, including education. This is explained by lower absorptive capacities (especially in education) and an increasing emphasis on economic infrastructure (energy, water and roads), the latter varying with expenditure requirements of sector projects. The phenomenon demonstrates the wisdom of fixing poverty expenditure floors at the global level, which guarantees protection and improvements in poverty expenditure allocations while at the same time allowing for appropriate reallocations towards needy and/or priority areas of public policy. In any case, the evidence shows that a rising poverty expenditure floor against low levels of revenue performance and constrained foreign inflows could constrain the government's ability to enhance or even protect salaries, including in the poverty sectors themselves. We note from figure 1 earlier, for instance, that the salaries budget has been maintained at a relatively fixed 6 percent of GDP, but that that budget has been consistently breached especially under the ECF programme, and after the health sector pay increases.

**Figure 2 - Actual (2009-2011) and Planned (2012) Poverty Expenditures Against Programme Floor**

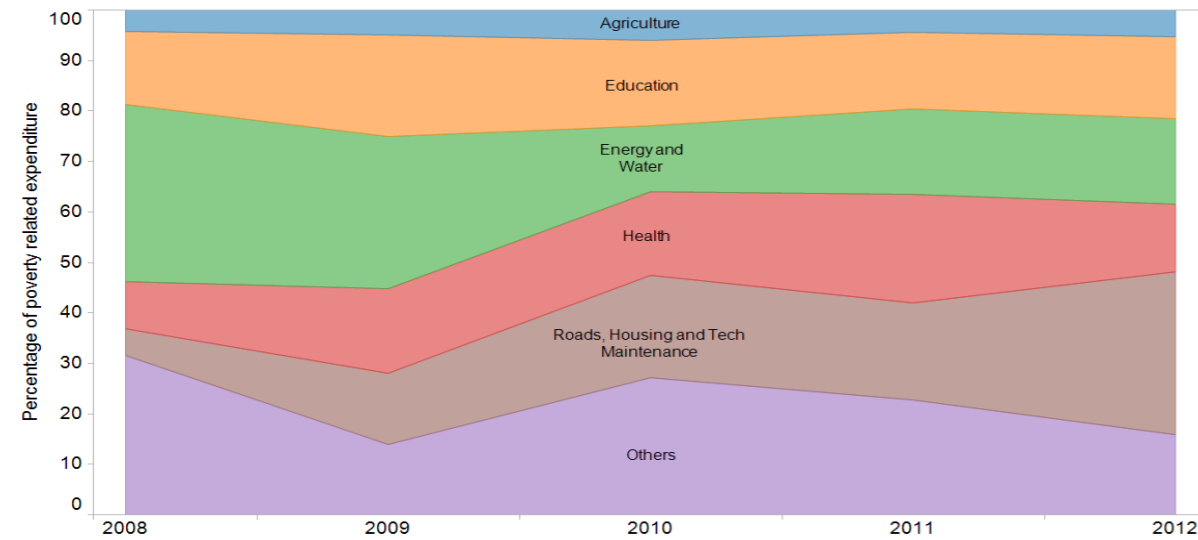


Source: Ministry of Finance and Economic Development

Note: 2011 data is projected actual expenditure and 2012 is planned expenditure.



**Figure 3 - Distribution of Actual (2009-2011) and Planned (2012) Poverty Related Expenditures**



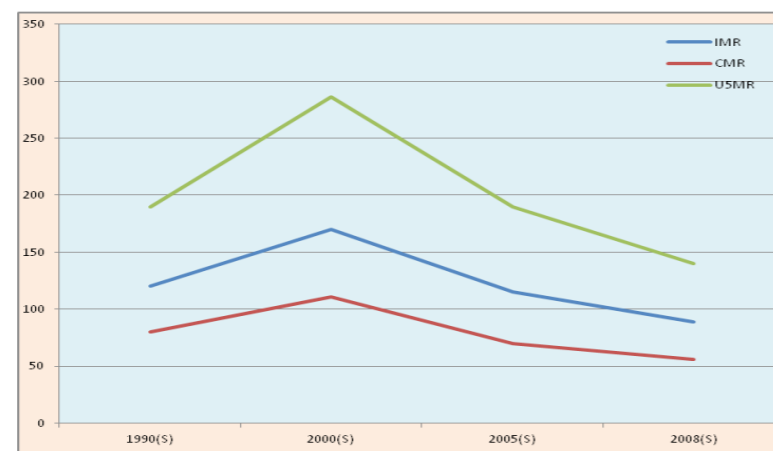
Source: Ministry of Finance and Economic Development. Note: 2011 data is projected actual expenditure

### 3. Prospects for Attaining the Health MDGs in Sierra Leone

Sierra Leone emerged from a brutal eleven-year civil conflict in January 2002. The conflict resulted in considerable loss of lives and property, massive displacements in the population, destruction of the country's economic and social infrastructure, and erosion of its economic base. A large part of the population was plunged deeper into poverty, with massive deterioration of living standards.

At the beginning of the conflict in 1991, Under-Five mortality had been successfully reduced from over 360/1000 live births in the mid 1980s to 190/1000 live births in 1990. Maternal and infant mortality had fallen in similar proportions, with maternal mortality estimated at 450/100,000 live births in 1990, and infant mortality down to 120/1000 live births. The conflict led to a reversal of this progress and constituted eleven years of lost opportunities in terms of the MDGs. Thus by the end of the conflict in 2002, Under-Five and infant mortality were respectively 286 and 170 per 1000 live births (see Figure 4 for trends); while maternal mortality was 1800/100,000 live births. However, the chart reveals that despite the above reversals, considerable progress has been made with respect to the health MDGs since the end of the conflict. Under-five mortality was reduced from 286/1000 in 2000 - 2005 to 140/1000 in 2008, infant mortality was brought down from 170/1000 live births to 89/1000 live births, while maternal mortality fell from 1,800/100,000 to under 900/100,000 over the same period.

**Figure 4: Sierra Leone: Trends in Infant, Child and Under-5 Mortality 1990-2008**



Source: As indicated by x-axis

Note to x-axis: C-Census based; S-Survey-based - (Surveys include DHS and, MICS series)

Acronyms: IMR – Infant Mortality rate; CMR – Child Mortality rate; USMR – Under-five Mortality rate

**Table 4: Trends in Selected Key Indicators of Maternal and Child Survival, Health and Nutrition**

Indicator	2000 (MICS2)	2005 (MICS3)	2008 (DHS)	2015 MDG
Infant Mortality (per 1000 live births)	170	170	89	50
Under-Five Mortality (per 1000 live births)	286	286	140	95
Maternal Mortality (per 100,000)	na	1300	857	600
Under-weight prevalence (2SD/3SD)	na	31/9	21/3.5	
Stunting (2SD/3SD)	34/16	40/20	36/21	
Wasting (2SD/3SD)	na	na	10.2/4.2	
Under-Fives sleeping under Treated Bed Nets (%)	2	5	26	75
Exclusive Breast Feeding (0-5 months) (%)	na	8	11.2	
Immunization Coverage (Penta 3) (%)	46	63	54.6	
Full Immunization (% of all children aged 13-24 months)	39	54	40	90
Institutional Deliveries (% of all deliveries)	na	19	24.6	
Skilled Attendant at Delivery (% of all deliveries)	42	43	42.4	

Source: Survey Reports indicated in table column headings

The above remarkable progress notwithstanding, the health situation was still unacceptable by end 2008. The health sector remained a poor performer as a result of the conflict and fragility background, weak capacities and inadequate facilities and services. Thus even at the levels depicted in table 4, maternal, infant and child mortality were considered high in a situation of high disease prevalence. Systemic and institutional capacity weaknesses and constraints persisted in the health service delivery system, including weak management and referral systems, a dearth of diagnostic facilities; weak stores, inventory and supply management; and acute skills gaps. Service utilisation rates remained low for even the limited services due predominantly to a barrier posed by user fees. Consequently, it was recognized that achieving the health MDGs remained a significant challenge.

In response, the government and its development partners renewed their commitment to accelerating progress towards universal access to health care and the attainment of the MDGs in Sierra Leone. The second generation PRSP - the **Agenda for Change (2008-2012)** - clearly articulated that commitment by closely aligning Sierra Leone's health sector policies and priorities to MDGs 4, 5, 6, 1c and 7c. In November 2009, the government announced a **Free Health Care Initiative (FHCI)** aimed at the universal delivery of free health care to pregnant women and lactating mothers, and for under-five children. The initiative was rolled out in early 2010, with significant support from DFID, UNICEF and other development partners. At the same time the government, again with support from DFID, substantially increased health sector pay effective April 2010 to improve on staff attraction, retention and motivation in that sector, while launching several other initiatives aimed at streamlining recruitment and selection, continuing staff development, and addressing other human resource issues which hitherto hamper effective health service delivery. Professional/technical and frontline staffing in the sector has almost doubled from just over 3000 before the launch of the FCHI to more than 6000 by mid 2011.

Table 5 below shows the FHCI had already made a significant impact after only one year of implementation.

**Table 5: Impact of the Free Health Care Initiative (a Pre-and Post-Launch Comparison)**

Indicator	Pre-Launch	Post Launch	Change	Change (%)
	2009 - 2010	2010 - 2011		
Under-five consultations (in '000s)	933	2,929	1,996	214
No of U5 malaria cases treated with Artesunate (in '000s)	348	1,160	8,812	233
No of U5s given Vitamin A supplementation (in '000s)	308	386	79	26
% of children under 12 months fully immunized	76.0	88.0	12.0	16
No of antenatal care visits by pregnant women (in '000s)	555	810	255	46
No of institutional deliveries ('000s)	87.3	126.5	39.2	45
No of facility-managed maternal complications (in '000s)	8.1	20.2	12.1	151
Maternal case fatality rate (in % of admissions)	2.8	1.1	-1.7	-61
No of postnatal care consultations (in '000s)	110	235	125.0	115

Source: Ministry of Health & Sanitation – Assessment of the Impact of the FHCI after 12 months of Implementation. April 2011

The GoSL, in collaboration with development partners, conducted an evaluation of the country's progress toward the MDGs in 2010. The Progress Report concluded that MDGs 1, 2, 3 and 7 will not be met; MDGs 6 and 8 may be partially met; but that 'with sustained effort', MDGs 4 and 5 could be met, thus making the health MDGs the most advanced in terms of progress (see Table 6 for summary of the conclusions)

**Table 6: Sierra Leone - Feasibility of Achieving the MDGs Based on 2010 Assessment**

Goal	Feasibility of Achieving Goal
Eradicate extreme poverty and hunger	Will not be met
Achieve universal primary education	Inconclusive
Promote gender equality and empower women	Will not be met
Reduce child mortality	May be met with increased and sustained effort
Improve maternal health	May be met with increased and sustained effort
Combat HIV and AIDS, malaria and other diseases	Likely to be met, but only with regard to HIV/AIDS. Malaria and TB will lag behind
Ensure environmental sustainability	Will not be met
Develop global partnership for development	Global goal, may be met locally with, sustained effort.

Source: Republic of Sierra Leone – Millennium Development Goals Progress Report 2010

#### 4. Conclusion

In the Sierra Leone context, it can be said that the IMF has broadly struck a balance between the maintenance of macroeconomic stability, protecting social and poverty reducing expenditures and other competing priorities, with due cognizance of the ongoing investment in infrastructure in the context of the country's post-conflict reconstruction requirements. However, the analysis shows that the Fund's flexibility was restrained with preference being for low inflation, in some cases at the expense of other competing priorities. During the Fund's mission of February 2010, it was clear that intensified efforts were needed in the health sector for the acceleration of progress towards the MDGs, and that there was a need for a significant adjustment in health workers' pay. The Fund agreed to an adjustment in the wage bill allocation only to the extent of the required adjustment for the health sector, and only against guaranteed funding of the initiative from development partners led by DFID. Of course, the reality of looming pressures for parity treatment from other sectors was recognized by all parties. There is also the lesson here that development partners' guaranteed support is crucial in these circumstances.

In this case study, even given a commitment to accelerating progress towards universal access to health care, three aspects have been highlighted as crucial to making significant progress towards the attainment of the MDGs: improving sector institutional and absorptive capacities; improving performance in the domestic revenue mobilization front; and significant and predictable development partner support. However, it should be obvious that adequate domestic resource mobilization capacity presents an assurance of sustained progress in the indicators beyond their attainment, post 2015.

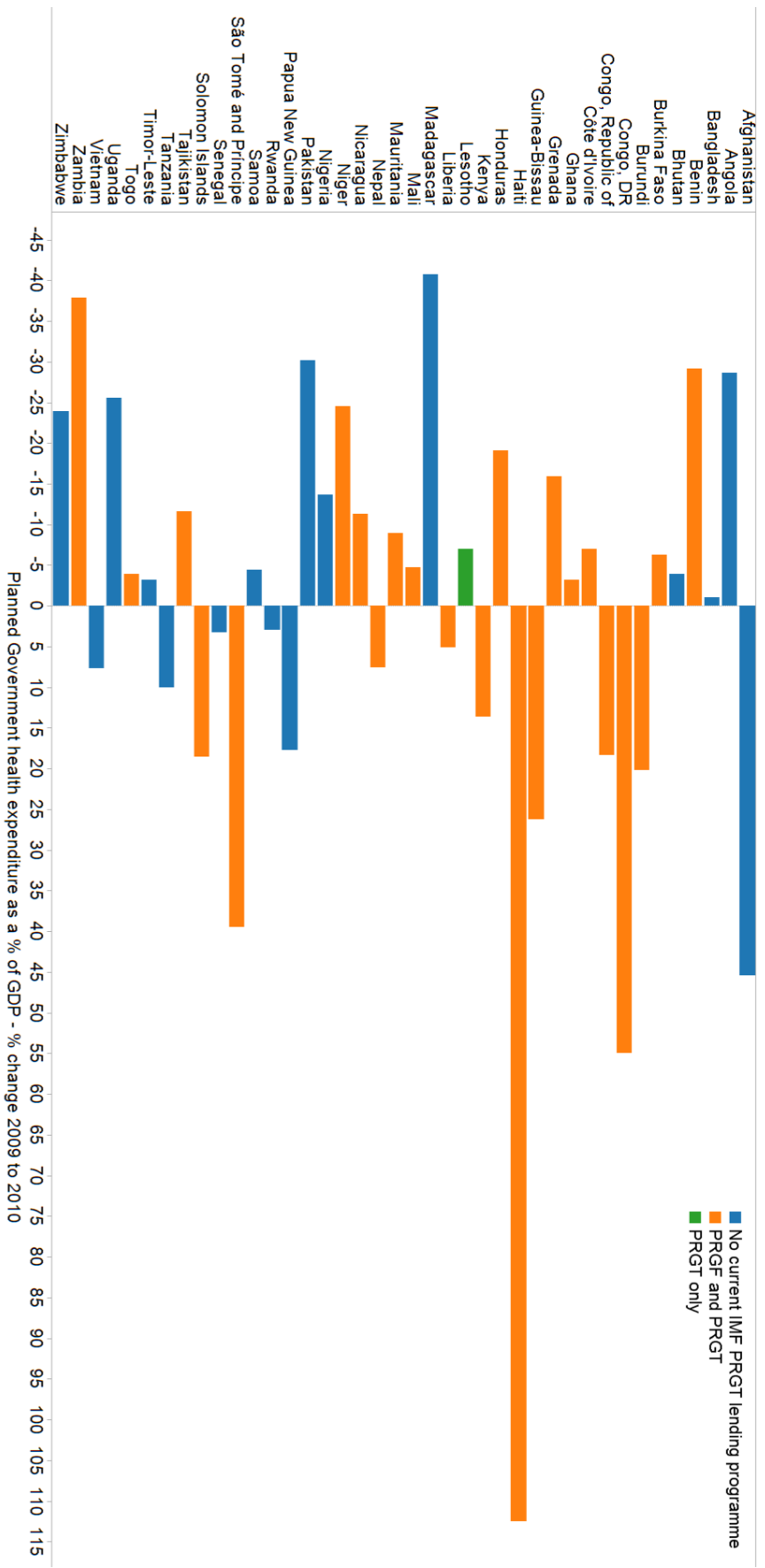
Finally, there is an inherent risk that intensive focus on a particular sector in a situation of acute resource limitations could crowd out other priority sectors, unless the intensified focus is accompanied by additional (new) resources.

#### Recommendations

Based on the Sierra Leone case study, the following recommendations are in order:

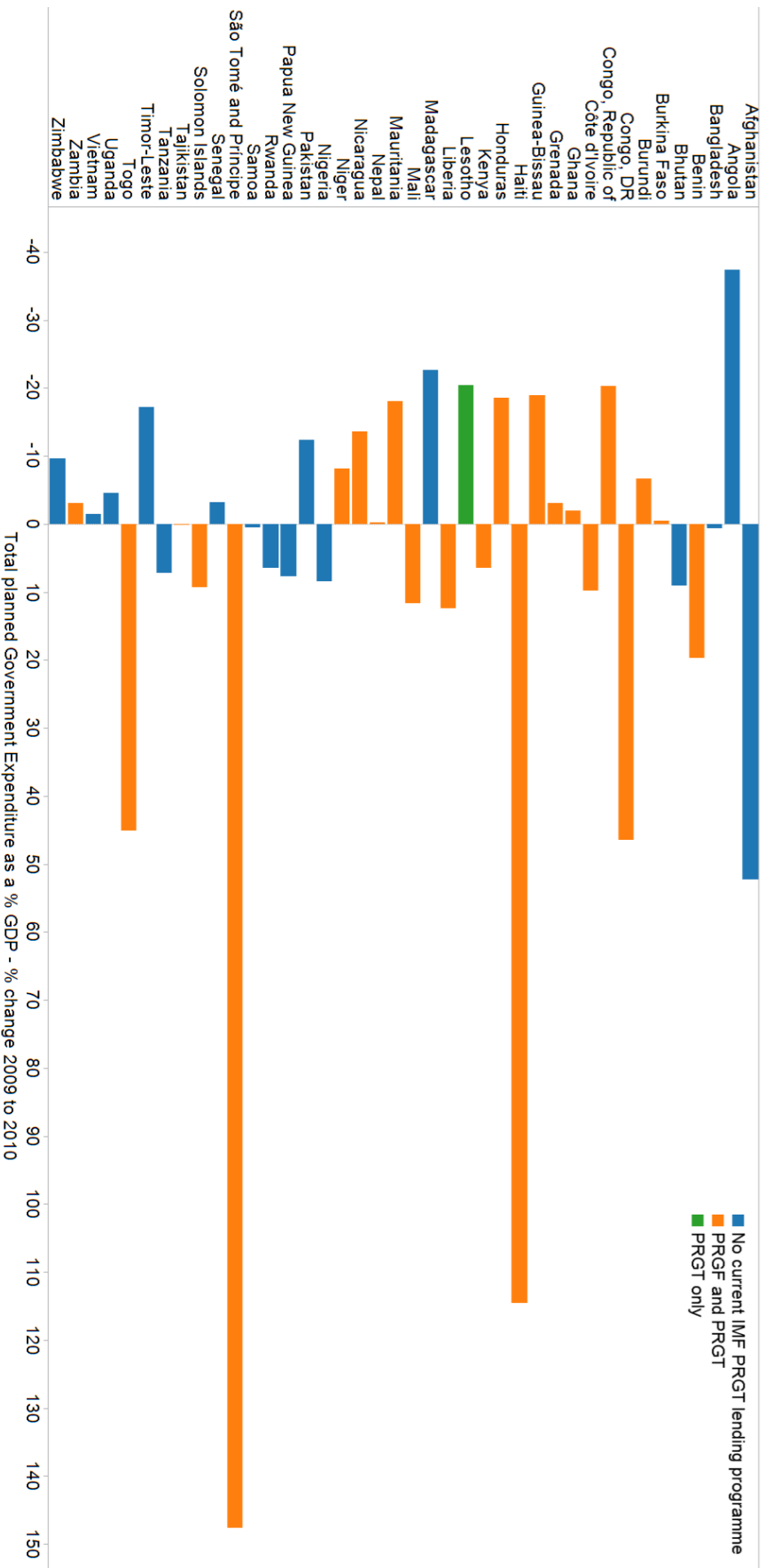
- i. The IMF needs to demonstrate greater sensitivity to events in the global economic environment and to country-specific circumstances in the design of country programmes. It does not suffice to leave the mitigation of the adverse consequences of these shocks to other bilateral and multilateral partners. Granted, there is an absolute need for maintaining macroeconomic stability in Fund country programmes. However, there is a need especially where domestic or external shocks threaten to halt or reverse gains made in poverty reduction and/or the attainment of the MDGs, and there is an equally absolute need for commensurate flexibility.
- ii. To help strike the appropriate balance between short-term macro-stability and sustained poverty reduction, development partners should strive towards greater adherence to the Paris Declaration on Aid Effectiveness in developing countries. The Sierra Leone case study demonstrates a need for improved predictability of aid flows, and this should be particularly viewed against the fact that most bilateral and multilateral aid flows are based on signals from the IMF.

Health expenditure percentage change from 2009 to 2010 as a percentage of GDP

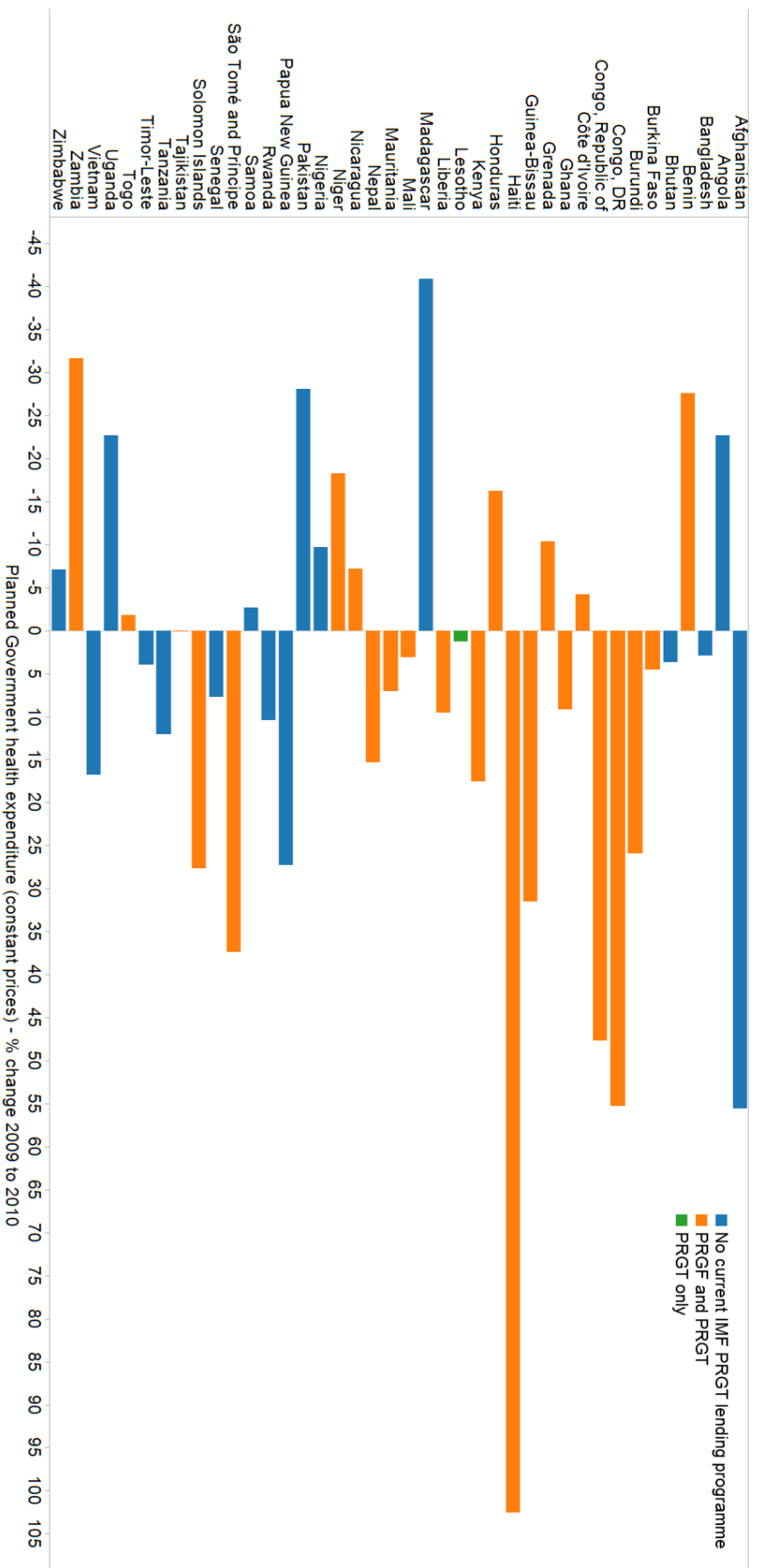


**ANNEX 2: 2009 TO 2010 – PRGF PROGRAM EXPENDITURE CHANGES**

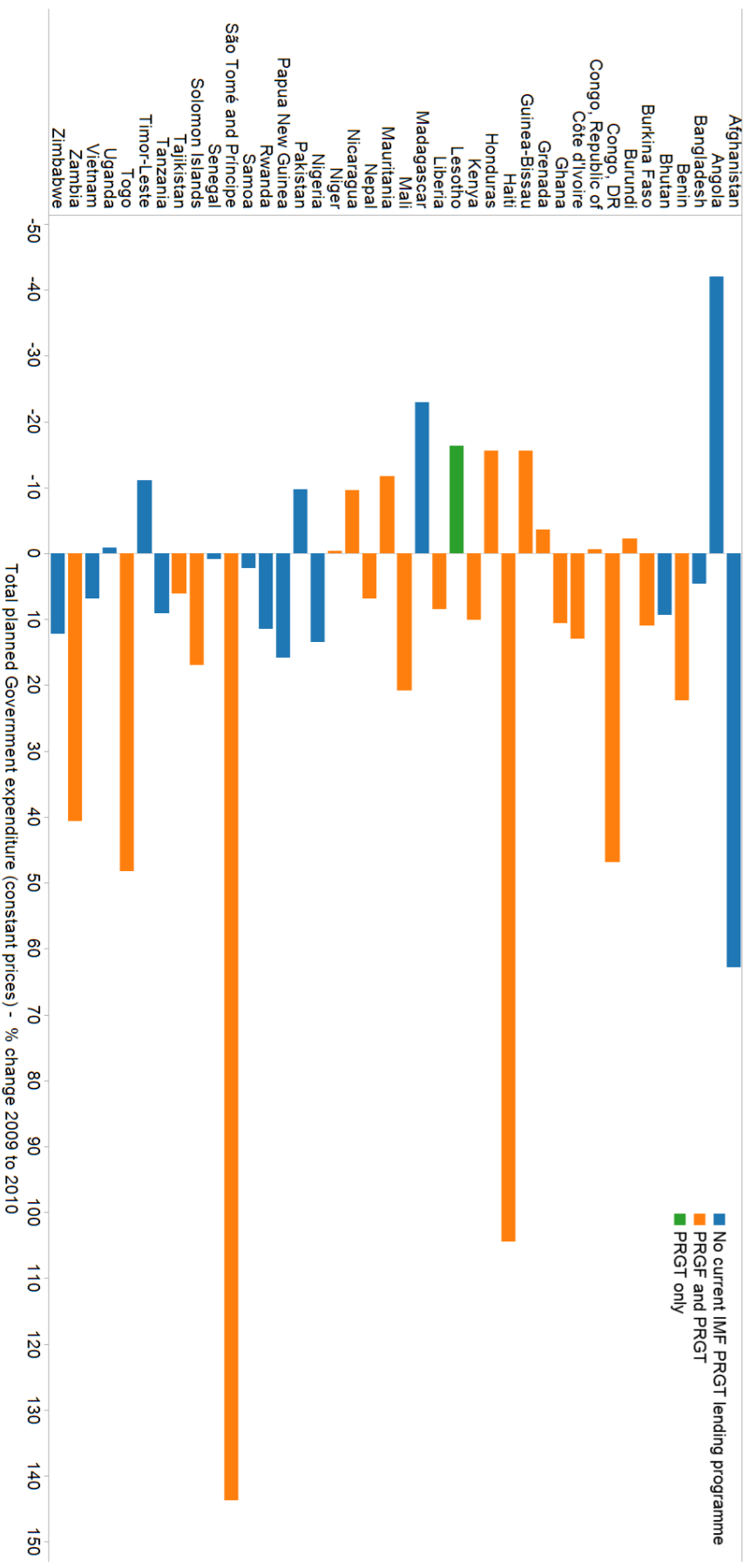
Total expenditure percentage change from 2009 to 2010 as a percentage of GDP



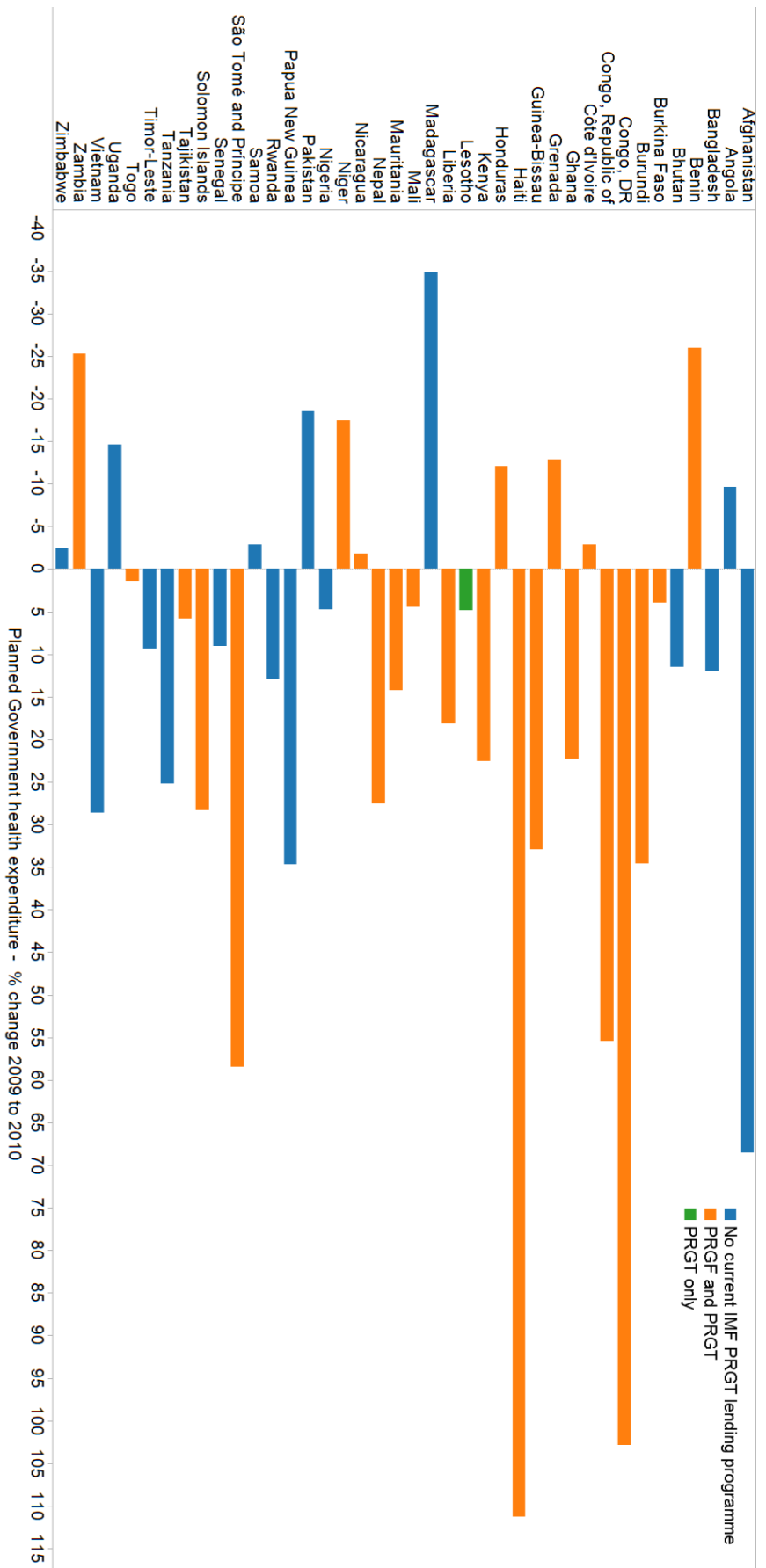
Percentage change in planned health expenditure from 2009 to 2010 (constant prices)



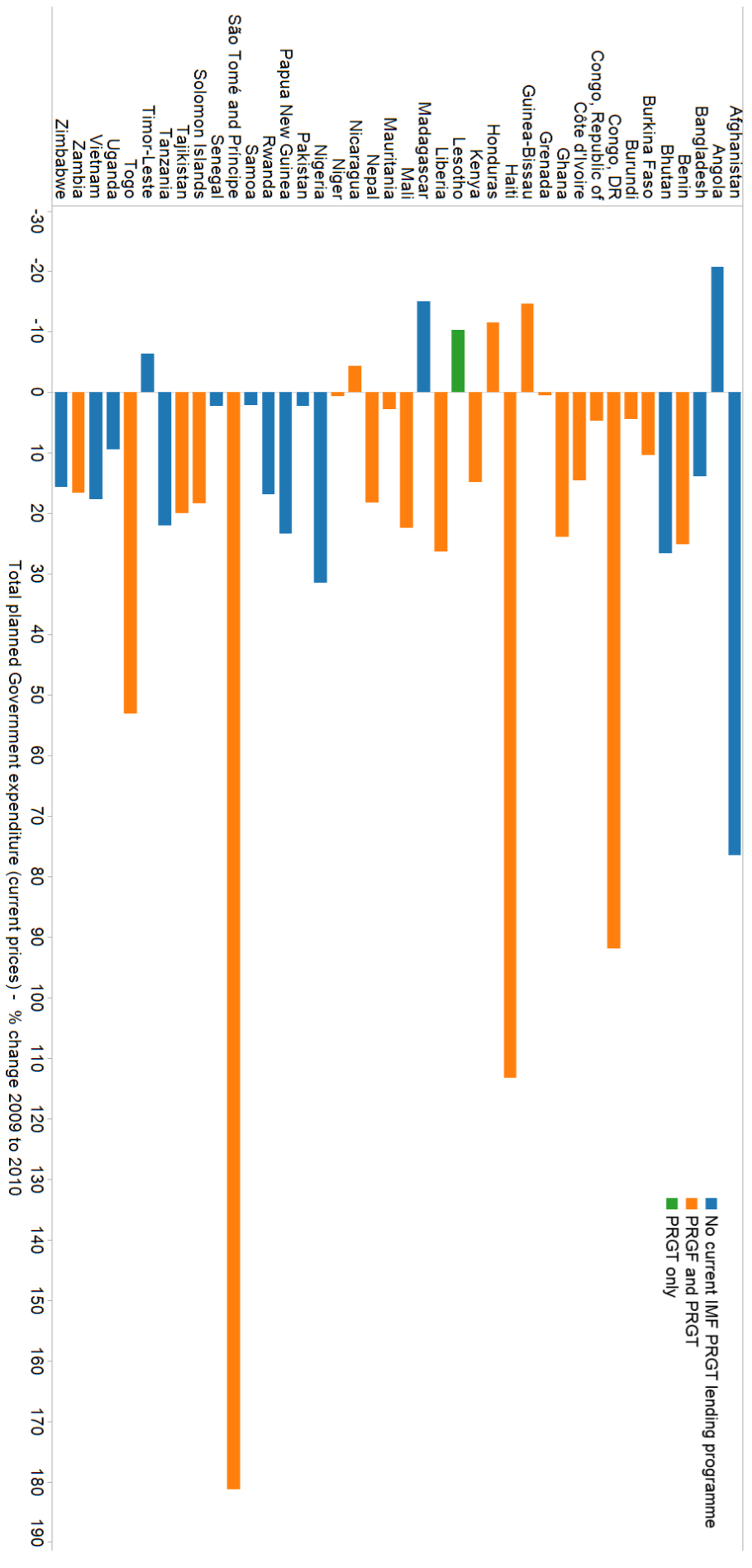
Percentage change in planned total expenditure from 2009 to 2010 (constant prices)



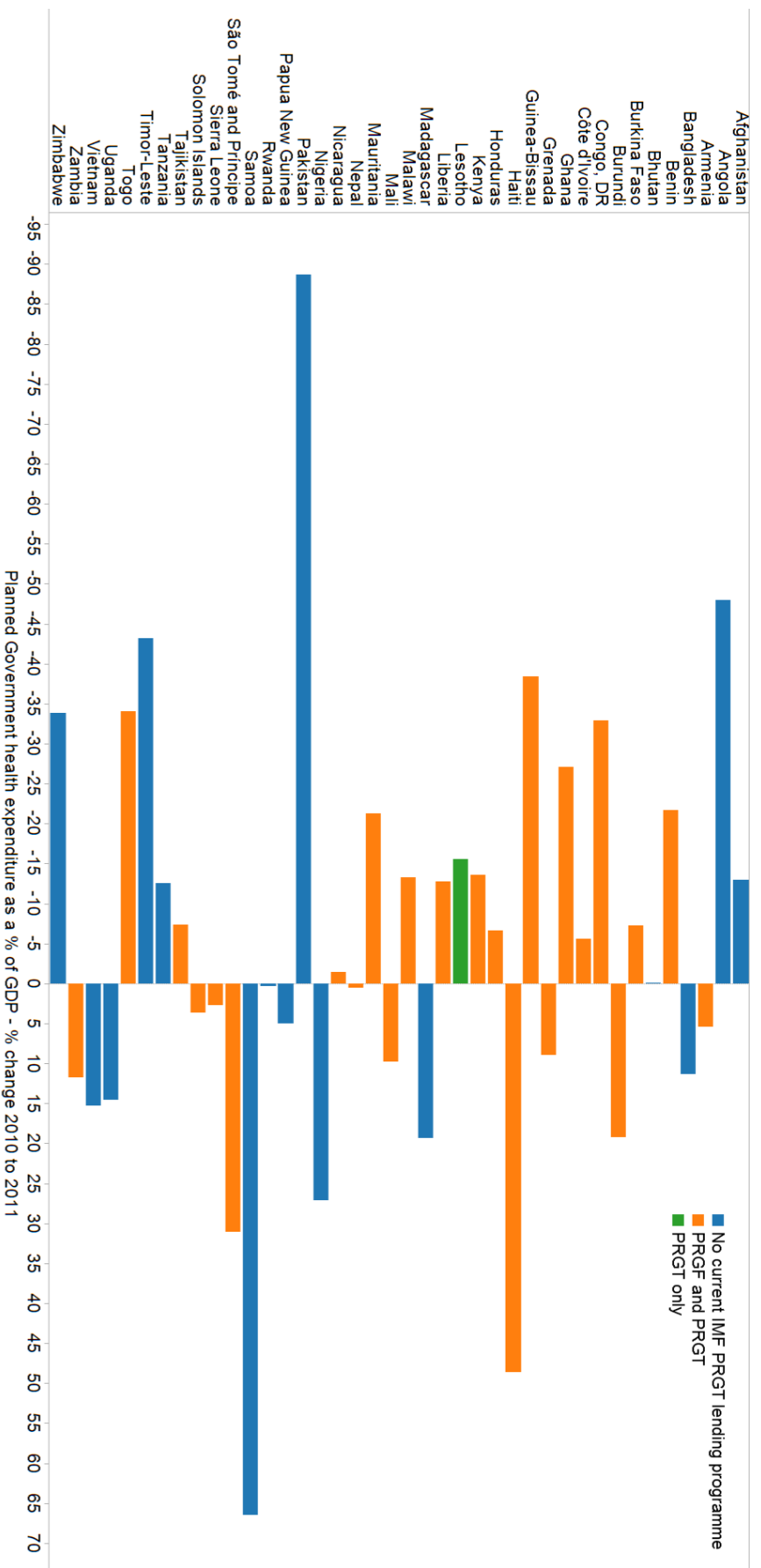
Percentage change in health expenditure from 2009 to 2010 (current prices)



Percentage change in total expenditure from 2009 to 2010 (current prices)

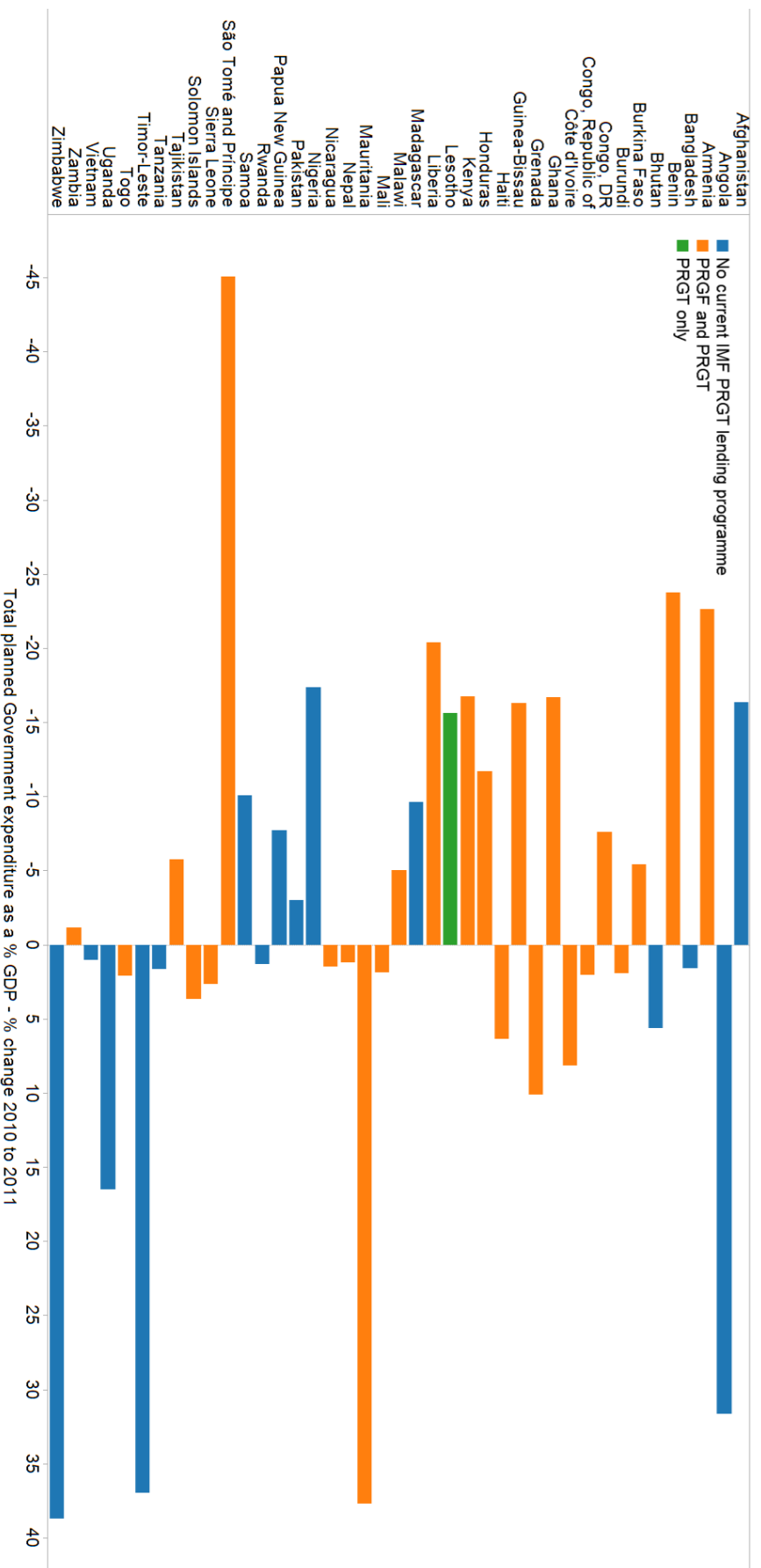


Health expenditure percentage change from 2010 to 2011 as a percentage of GDP

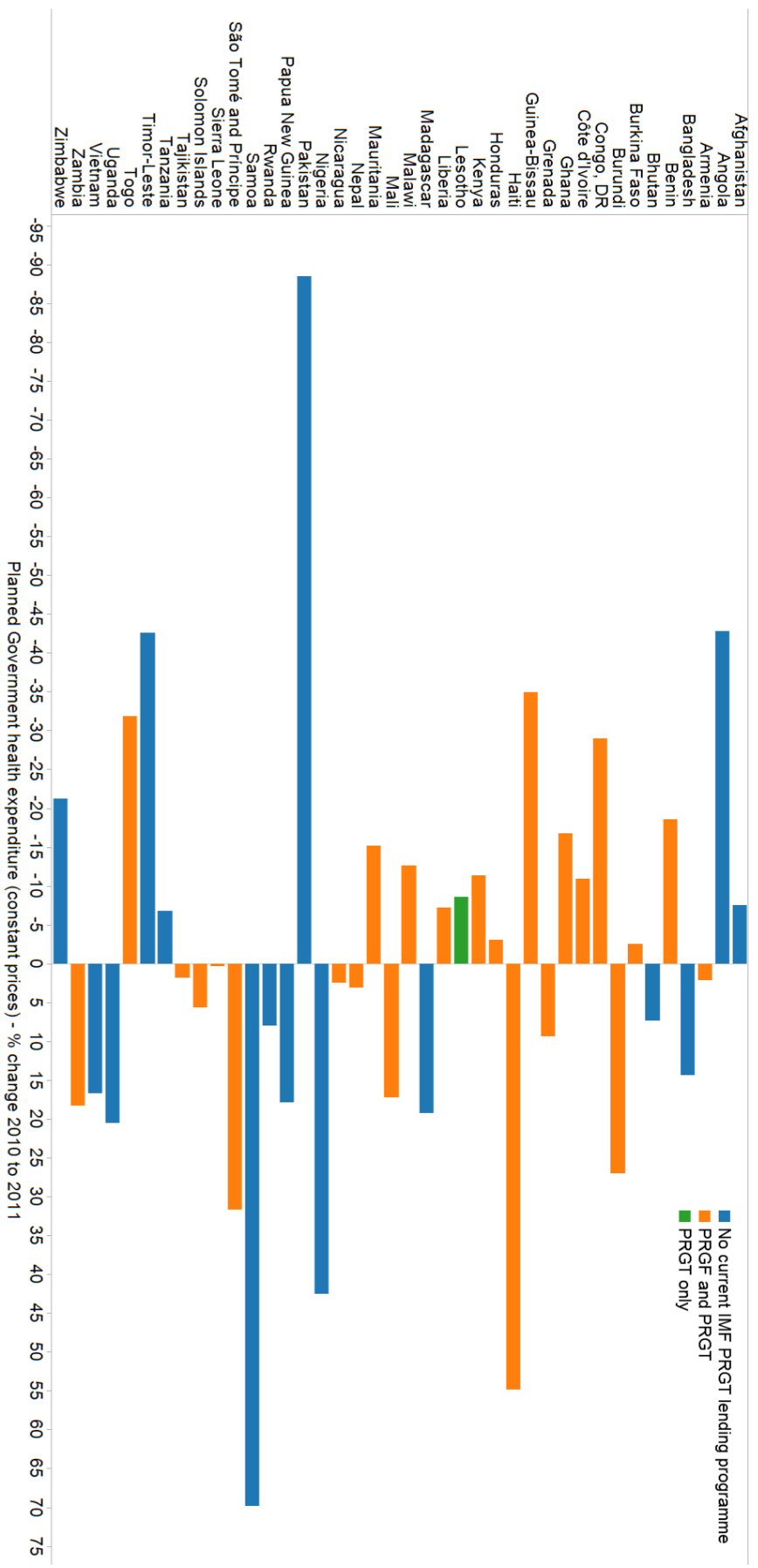


ANNEX 3: 2010 TO 2011 – PRGT PROGRAM EXPENDITURE CHANGES

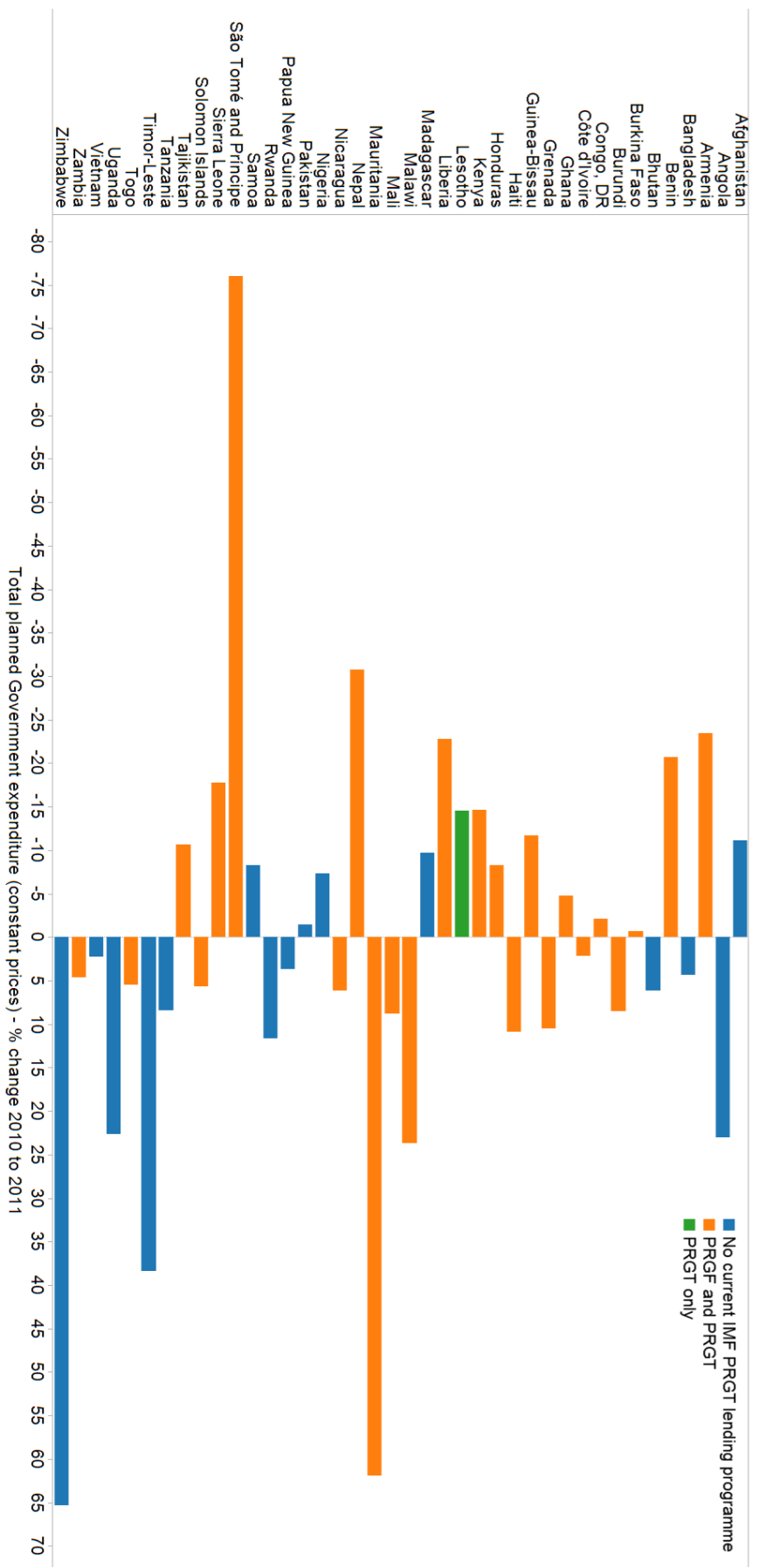
Total expenditure percentage change from 2010 to 2011 as a percentage of GDP



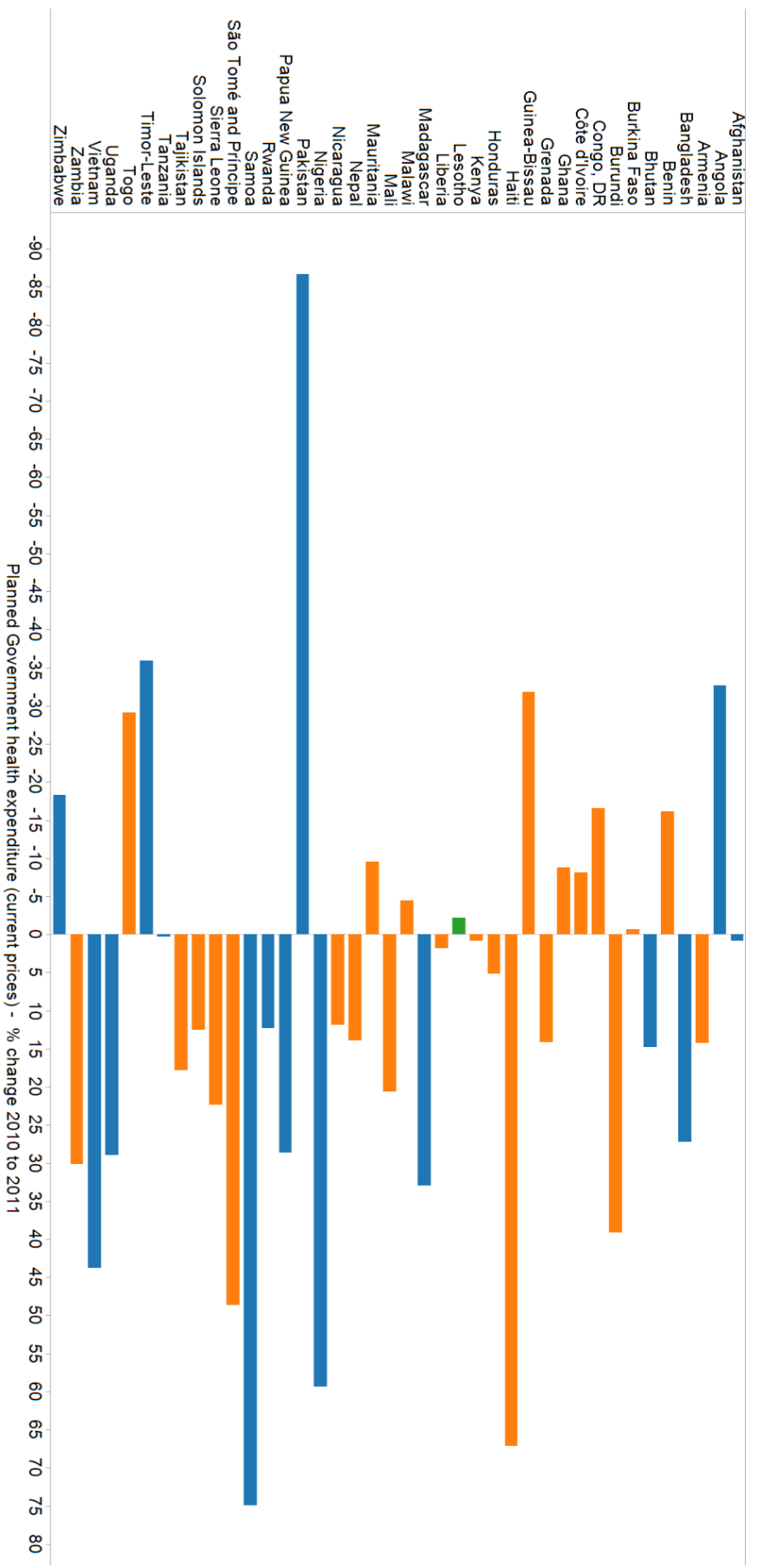
Percentage change in health expenditure from 2010 to 2011 (constant prices)



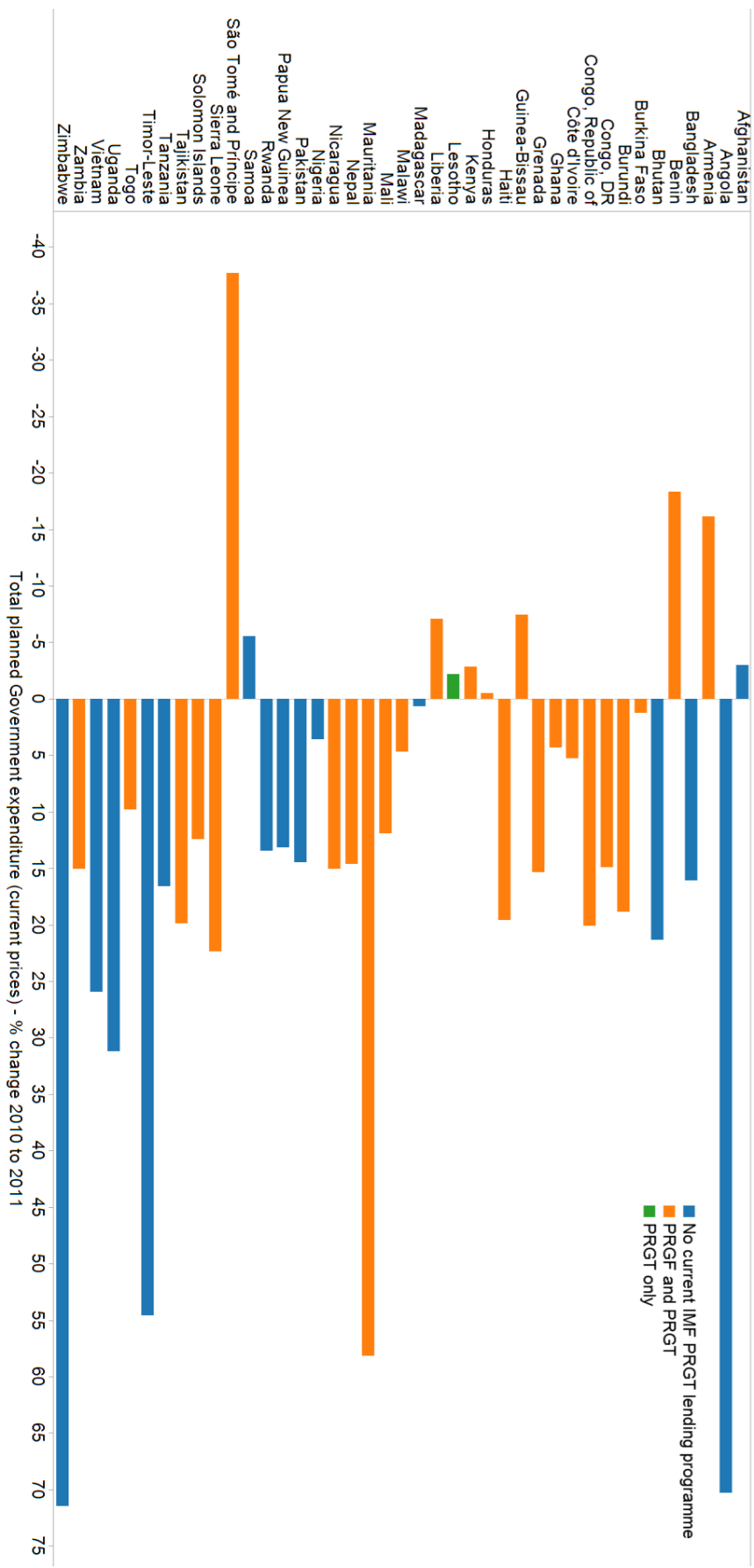
Percentage change in total expenditure from 2010 to 2011 (constant prices)



Percentage change in health expenditure from 2010 to 2011 (current prices)



Percentage change in total expenditure from 2010 to 2011 (current prices)





## ANNEX 4 – CONSOLIDATED EXPENDITURE DATA FROM ANNEX 1 AND 2

	Increase in % change		Decrease or an increase of less than 1% of % change	
	PRGT Countries	Other LICs	PRGT Countries	Other LICs
<b>Total expenditure 2009 to 2010</b>				
% of GDP change	10 (43%)	6 (35%)	13 (57%)	9 (65%)
% of change constant prices	15 (65%)	10 (59%)	8 (35%)	5 (41%)
% of change current prices	18 (78%)	13 (76%)	5 (22%)	4 (24%)
<b>Total expenditure 2010 to 2011</b>				
% of GDP change	12 (46%)	9 (60%)	14 (54%)	6 (40%)
% of change constant prices	12 (56%)	10 (67%)	14 (44%)	5 (33%)
% of change current prices	18 (69%)	12 (80%)	8 (31%)	3 (20%)
<b>Health expenditure 2009 to 2010</b>				
% of GDP change	10 (43%)	6 (35%)	13 (57%)	11 (65%)
% of change constant prices	14 (61%)	10 (59%)	9 (39%)	7 (41%)
% of change current prices	16 (70%)	11 (65%)	7 (30%)	6 (35%)
<b>Health expenditure 2010 to 2011</b>				
% of GDP change	9 (36%)	7 (47%)	16 (64%)	8 (53%)
% of change constant prices	12 (48%)	9 (60%)	13 (52%)	6 (40%)
% of change current prices	15 (60%)	9 (60%)	10 (40%)	6 (40%)
Sources: Government Budget Documents; IMF World Economic Outlook				
Total number of countries analysed - 64 (o/w 35 are PRGT countries and 29 other LICs)*				
Breakdown of the 29 other LICs - no data for 13 countries, 16 analysed for 2009-2010, 15 analysed for 2010-2011				
Breakdown of the 35 PRGT - no data for 7 countries, 24 analysed for 2009-2010, 26 analysed for 2010-2011 (25 for health)				
*note that yemen and lesotho were analysed as other LICs in 2009-2010 and as PRGT in 2010-2011, as they were not under a PRGF previously				

