IMF Macroeconomic Policies and Health Sector Budgets

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Preface

Many low-income countries suffer from ill-resourced health systems and staffing levels far below international minimum standards. A massive effort is needed to achieve the health-related Millennium Development Goals (MDGs) in time. This report focuses on the influence of the International Monetary Fund (IMF) and the macroeconomic policies it promotes on the budgets available for the health sector and the wages for health staff in low-income countries.

The IMF will be the first to point out that its programmes do not contain expenditure limits for specific sectors (including health) and that expenditures on health staff are exempted from budget ceilings. The IMF will also state that it offers support to mitigate the macroeconomic effects of increasing aid flows, and consequently calls for more aid at sustainable levels at international meetings. Finally, the IMF will – rightly – argue that governments could improve their resource allocation and make sure the money reaches the service levels.

This is all true. Then why this focus on the IMF? Because based on country studies from Ghana, Kenya, Uganda and Zambia, this report finds that although the IMF does not explicitly set limits on health spending, its overall policies and targets do limit the resources available for health and health staff.

It is important to understand the multiple ways in which macroeconomic policy recommendations can have an impact on – in this case – the health sector. A good example are the IMF-imposed budget ceilings on the wage bill in PRGF programmes. Originally intended to control total wage bill expenditure, they are everything but helpful in tackling the human resource problems in the health sector.

Overall government expenditure ceilings not only affect the ministries with the weakest bargaining position and capacity, they also provide an incentive to use project aid or other budget lines for allowances and wage payments – thus obscuring budget transparency. Ministries of health are consulted in the macroeconomic decision-making process, but their needs are often treated as shopping lists that can be granted only if the money becomes available. Beyond rhetorical IMF-statements, this report claims that too little is done to push the international donor community to make its money available in a sustainable way.

We feel that the IMF should take responsibility for the unintended side-effects of its cautious macroeconomic models, which in the end may undermine its ultimate objective: to contribute to poverty reduction and MDG-achievement. Notions such as ‘health is a prerequisite for economic development’ and ‘health is a fundamental human right’ must feature in IMF calculations. Ultimately, the benefits of macroeconomic policies should be measured in terms of whether they help improve poor people’s lives.

Nina Tellegen, Wemos director
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Acronyms and abbreviations

ADHA	Additional Duty Hours Allowance
IMF	International Monetary Fund
GDP	gross domestic product
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GHC	Ghana Cedis
GOG	government of Ghana
GOK	government of Kenya
GOU	government of Uganda
GOZ	government of Zambia
HIPC	Heavily Indebted Poor Country
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSSP	Health Sector Strategy Programme
IMR	infant mortality rate
LIC	Low Income Country
MDGs	Millennium Development Goals
MMR	maternal mortality rate
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGOs	non-governmental organisations
ODA	official development assistance
PE	personnel emoluments
PEPFAR	President's Emergency Fund for AIDS Relief
PRGF	Poverty Reduction and Growth Facility
PRS	Poverty Reduction Strategy
PRSC	Poverty Reduction Support Credit
REER	Real Effective Exchange Rate
SIDA	Swedish International Development Cooperation Agency
SSA	Sub-Saharan Africa
TB	tuberculosis
UN	United Nations
USD	United States Dollars
VAT	Value Added Taxes
WHO	World Health Organisation
ZMK	Zambian Kwacha

Executive Summary

It is widely recognised that international health goals will not be reached with current levels of health service provision. To expand provision on the scale that is necessary will require a massive, long-term injection of resources to provide staff, medical inputs and health centre facilities. In particular, employment of front line health professionals is vital given the positive relationship between the volume of medical personnel and health outcomes and impacts. At present the health sector is woefully under-staffed with staffing levels substantially below international minimum standards. However, the International Monetary Fund (IMF) policies constrain both significant increases in health spending and employment of vital staff.

The IMF does not put explicit limits on health sector spending and in some cases IMF-supported programmes even set budget floors for the sector. However, a government's overall budget is seriously constrained. Firstly, by the IMF's cautious macroeconomic policy stance, which focuses on macroeconomic stabilisation goals rather than growth objectives, and, therefore, favours minimal budget deficits financed by international rather than domestic means, sustainable levels of international and domestic debt, low rates of inflation and so on. Secondly, the IMF constrains budgets by its cautious attitude to the availability and predictability of development assistance. The implication is that health budgets are indirectly limited by the constraints imposed on a government's overall budget.

Whilst profligate spending should not be encouraged and long-term fiscal sustainability is an important consideration, the trade-off between higher budget deficits and the impacts of how these are financed needs to be properly weighed against the benefits of increased health sector spending and how this impacts on growth. In this respect, it is positive that the IMF's recently acknowledges that there is scope for allowing inflation rates to rise above the very low rates that have been targeted in Poverty Reduction and Growth Facility (PRGF) programmes, and that currency appreciation may be an acceptable consequence of higher levels of aid-financed government spending. A recent IMF and World Bank paper that recognises the need to explicitly consider the growth and poverty consequences of fiscal policy also signals a growing awareness of the need to look beyond macroeconomic stability. In the short-term, an increase in concessional aid – preferably provided as grants – is the most practical means of rapidly financing an expansion in health service provision with least impact on the macroeconomy. In this context, the IMF's support for international calls to donors to meet the 0.7% of gross domestic product (GDP) target for aid and for quality aid to be committed over the long-term is also welcome.

However, making statements is not enough. Rather than proactively pushing this agenda recent IMF publications have tended to emphasise the 'challenges' of increased aid to macroeconomic policies rather than considering the opportunities for growth. In particular, the IMF has done very little to date to provide analyses of how much additional aid could be absorbed by Low Income Countries (LICs) and has only in a few cases assisted in designing macroeconomic frameworks that help meet the Millennium Development Goals (MDGs). It should be doing much more at the country-level to push donors to harmonise and improve

the quality of the aid they give and to give more resources by providing analysis of alternative aid scenarios.

Whilst there are positive signs that the IMF is starting to respond to this need, the value of such efforts will be diminished if these are framed within the IMF's traditional view of what constitutes a stable macroeconomic position and if it simply takes aid volumes as given. At present it appears that its analysis is more concerned with identifying an appropriate macroeconomic policy approach for a given amount of aid rather than identifying how much aid can be used before seriously upsetting the macroeconomy. As a consequence debate about what are acceptable macroeconomic policy trade-offs remains constrained. To broaden its concept of what is an acceptable macroeconomic position will necessitate the IMF loosening its belief that the stability of the macroeconomy must be the foremost priority.

To facilitate a better weighing of policy and budgetary choices and their potential outcomes and impacts by LIC governments, the process of determining spending needs and setting budgets ceilings needs to be carried out jointly and collaboratively. Such a process must involve all key stakeholders. This implies a need for meaningful involvement of key sector ministries in IMF programme negotiations. Whilst this is principally a matter for governments themselves to address the IMF could do more to encourage it. Also, to facilitate the involvement of Ministry of Health officials attention needs to be given to building their capacity to negotiate for more resources, which in turn requires greater planning and budgeting capacity on their part. The role of the World Health Organisation (WHO) could be strengthened in this area.

Whilst governments should also be encouraged to improve how they prioritise and allocate their resources as another means to create fiscal space, the IMF's use of public sector wage caps to contain government spending on wages is ineffective and distorting. Caps on the wage bill do not have a significant impact on how a government employs its staff resources. Worse, though health staff is sometimes even explicitly exempted, wage spending caps can lead to the perverse outcome that desperately needed health professionals are not employed. The irony is that by capping public sector wage spending the IMF effectively prevents the expansion of the very services that are vital to tackling poverty and achieving the MDGs.

As a consequence governments and global funds have found ways to circumvent the caps, usually by keeping resources 'off budget' or using other budget items for allowances. The IMF's implicit acceptance of this makes a mockery of its and other donors' efforts to instil good governance discipline. It also suggests that the IMF is willing to turn a blind eye to the macroeconomic impacts that arise from channelling aid to the private (profit and non-profit) sector, and to the fact that vertical aid delivery mechanisms are poor means of delivering aid and distort the efficient allocation of resources.

Capping wage spending also effectively limits how much wages can increase. This means that governments are prevented from raising wages and providing addition benefits to stem the haemorrhage of health professionals who are leaving in search of better conditions, often in donor countries. Although IMF programmes do not call for sector ceilings and in some cases explicitly exempt health and education sectors, Health Ministries still have to

compete for its share of the wage bill with other sectors that have equally valid claims for higher budgets. Not all PRGF programmes allow for an automatic adjustment of the overall wage bill ceiling in the case of increases in the health wage bill.

Furthermore, the IMF's focus on the size of a government's wage bill is not obviously justified when all available resources are taken into the equation. Since aid resources are typically used to finance capital expenditures it should not be regarded as problematic that a large proportion of a government's own resources are channelled into recurrent expenditures as these tend not to be financed by donors. The implication is that measures of government wage spending against gross domestic product and as a proportion of the domestically finance budget grossly over-state the true proportion of wage spending. Moreover, determining wage spending budgets according to an average wage spending figures for Sub-Saharan Africa (SSA) is too simplistic. These provide no information about actual needs and sustainability.

Rather than cautioning governments against becoming aid dependent the IMF could be taking steps to enable LIC governments to better accommodate aid and to use aid to meet vital recurrent expenditures. Such steps include pushing aid donors to better coordinate their aid, to minimise administrative, procurement and reporting procedures that add to the transaction costs of using aid, to improve on the timing of aid delivery and, particularly importantly, to provide aid over longer time horizons. In addition, given that wage bill caps do not work to encourage governments to make tricky political decisions about civil service structures, constrain employment of vital staff and undermine good governance, they simply should not be used.

1. Introduction

The question of how to finance substantial increases in health sector spending to achieve the health-based MDGs is receiving considerable attention in the development community. Clearly, most LIC governments have too few resources of their own to boost their health budgets by the amount necessary. Thus, many non-governmental organisations (NGOs) and United Nations-based multilateral institutions have been calling for substantial increases in aid (25-70 billion United States Dollars (USD) annually), to which some bilateral donors and private foundations have responded positively.

However, the prospect of increased aid inflows has raised concerns in the IMF about the implications for macroeconomic policies and the potential impacts on the economy such as inflation, exchange rate appreciation, interest rate rises and crowding out of private investment. This has raised debate on the question of whether increased aid can be accommodated without compromising the strict macroeconomic and monetary policies advocated by the IMF, which call for low, single digit rates of inflation, low budget deficits and limiting public debt to sustainable levels, or whether the IMF's macroeconomic targets need to be loosened.

Civil society organisations and UN agencies argue that macroeconomic policy considerations are being put before the health needs of millions of people in LICs. The IMF argues that macroeconomic stability must be a government's number one priority because it is a vital factor contributing to growth, which is one of the principle means of reducing poverty. Whilst there is general agreement that macroeconomic stability is important for growth, there is also growing awareness that overly strict macroeconomic policy can be bad for growth. In between these positions lies a grey area in which there is considerable argument and debate as to when macroeconomic policy becomes too strict and how much macroeconomic policy can be loosened before growth is stifled.

The IMF is not unsympathetic to the need to find more resources – fiscal space - to increase health service delivery. However, given the potential macroeconomic impacts of most means of supplementing finance its implicit preference appears to be for additional resources to be generated by LIC governments themselves, through increased growth and revenue generation over the longer term, and increased efficiency of spending in the short term. Up to a point, increased grant assistance is also a means supported by the IMF.

To improve efficient use of government resources, the IMF has set its sights on government (overall) wage spending, which within a strict budget often crowds out government spending on other essential items necessary to run public services and maintain their quality. The IMF argues that by cutting 'excessive' wage spending resources can be freed up to invest in and maintain priority services.

Although the IMF refrains from setting sectoral limits for wage spending, in practice overall wage bill ceilings generally have a negative impact on the health sector in the countries where they are imposed. The problem is that in the health sector the volume of health

workers per population is a vital factor in terms of delivering effective health services. In LICs staffing levels are far below what is internationally considered to be the necessary minimum, thus large increases rather than restrictions on human resource spending are needed. In this context the IMF's advice appears to be undermining what it set out to achieve.

This report draws on 4 country case studies carried out in Ghana, Kenya, Uganda and Zambia in November and December 2005 and January 2006, which look at the impacts of IMF policy on health budgets and employment in the health sector, and the implications for the delivery of health services. All country statistics and country-level analyses are drawn from these case studies unless otherwise stated.[1]

Part 1 shows how IMF macroeconomic policy targets restrain a government's overall budget and the resultant impacts on health sector budgets, and examines whether health sector spending is rising in accordance with regional and international health spending and outcome targets. Part 2 looks at why the IMF is cautious about increased aid spending as a means to increase 'fiscal space' and how IMF ceilings on wage spending imposed via PRGF programmes impacts on the delivery of health services.

2. The IMF and Health Sector Budgets

The budget for health can either be determined through a 'bottom-up' process or a 'top-down' process. The former process tends to reflect spending needs, whereby sector budgets determine the size of the overall budget and macroeconomic policies are determined according to how much income the government can earn and how much additional finance it needs to generate through borrowing, donor assistance and money creation. Thus the budget ceiling (if there is one) is determined by the government's capacity or willingness to borrow (domestically and from international sources), access grant finance and create money (seinorage), which are the means by which a government can top up its revenue. With a top-down budget procedure macroeconomic policy constraints determine how much the government can borrow, access aid and create money and thus the overall size of the budget, within which the budget ceilings for the health and other sectors are set. Ideally, both spending needs and macroeconomic implications are considered and the trade-off between them carefully weighed up in determining the overall budget.

2.1. The IMF's Influence on Health Sector Budgets

The IMF does not directly determine how much of a government's budget will be allocated to health, but it indirectly plays a role by imposing ceilings on the overall budget via its macroeconomic policy conditions that promote restrictive rather than expansionary public

[1] ALMACO Management Consultants Ltd in collaboration with the African Medical and Research Foundation, *Budget Ceilings, Human Resources and Health in Kenya,* October 2005; Azeem, V., and N., Adamtey, Isodec, January 2005, *Budget Ceilings, Human Resources and Health in Ghana*; John Odaga and Peter Lochoro, Caritas Uganda, January 2006, *Budget Ceilings, Human Resources and Health in Uganda*, Chitah, M. B., CHAZ, November 2005, *Budget Ceilings, Human Resources and Health in Zambia*.

expenditure, and by its definition of what are non-discretionary and discretionary expenditures.

2.1.1. The IMF, Macroeconomic Policies, and the Overall Budget Ceiling

Many LIC governments have tended to be characterised by weak budget management observed in poor or non-existent planning and budgeting processes and profligate spending which does not relate to budgeted expenditures. In order to improve adherence to macroeconomic policy targets, and improve the efficiency and effectiveness of spending, many governments under the guidance of the IMF have taken steps to improve their budgetary and public financial management systems, an important aspect of which is compliance with budget ceilings, which specify the maximum the government as a whole or a ministry can spend.

Budget ceilings are helpful to deter profligate spending and to discipline governments to manage and monitor what they are spending. They can also help to focus the allocation of available resources on priority areas, for example, in line with Poverty Reduction Strategy (PRS) objectives, and improve project and programme implementation by ensuring sufficient resources are allocated for them. However, problems arise when ceilings are set cautiously low, and when budgetary needs far exceed budgeted allocations.

From the IMF's perspective a government's number one priority should be to achieve and maintain macroeconomic stability, which implies that the overall budget ceiling must be coherent with its macroeconomic policy targets. This 'top-down' approach to budget setting means that, given a certain capacity to earn revenue, the size of the total budget will be determined by how strict or loose the government's macroeconomic policy targets are concerning inflation rates, budget deficits, debt sustainability, private sector growth, growth in the export sector and so on.

2.1.1.1. Raising Revenue

A government's principle source of income is via taxation, tariffs and social security contributions. To remove distortions and encourage private sector-led growth the IMF has typically advised governments to: cut import and other trade tariffs, which have traditionally been important sources of government income, and to raise more revenue from value added taxes, which are relatively easy to administer and harder to avoid; rationalise (i.e. reduce the number tax bands and cut tax rates) business and income taxes; and improve tax administration. However, governments have typically not been able to raise as much revenue from Value Added Taxes (VAT) type-taxes as from import and trade taxes.

Since many LICs are yet to even reach what the IMF has established should be the minimum target for government revenue earnings – 15% of GDP – there is clearly scope for increased revenue generation. However, as the IMF itself acknowledges, it takes several years to raise revenue by a few percentage points.

2.1.1.2. Supplementing Revenue

This means that if a government is to boost its spending it must top up its revenue from other sources. However, the sources of supplementary finance available to a LIC government are also constrained by IMF conditionality and/or its policy advice, which seek

to limit their use because of the perceived harmful effects on private sector business activity and the growth potential of the economy.

For example in the IMF's view:

- money creation leads to inflation, which encourages spending and discourages saving and leads to uncertainty which is harmful for investment;
- borrowing from domestic sources can lead to rising interest rates and reduced liquidity in the domestic economy which can limit opportunities for, and discourage, domestic private investment, suck in destabilising short-term foreign capital flows, and cause the exchange rate to rise making exports less competitive;
- borrowing from both the domestic economy and overseas can lead to unsustainable debt burdens which can ultimately constrain government expenditure as debt payments consume a growing proportion of the government's budget. Furthermore, an unsustainable debt burden can discourage domestic and foreign private sector investment, for example, due to constraints on government investment in complimentary investments, such as infrastructure, and a lack of business confidence;
- aid inflows in the form of concessional loans and grants can lead to direct and indirect increases in recurrent expenditures which may not be sustainable over the long-term, particularly if increased availability of loans and grants discourages government's own revenue generation. Moreover, large increases in non-discretionary recurrent expenditures will reduce the usefulness of the budget as a fiscal tool by reducing budget flexibility. And furthermore, large inflows of aid could lead to 'Dutch Disease', that is, price inflation of non-traded goods and services which will cause the effective exchange rate to rise or if not Dutch Disease then other undesirable macroeconomic consequences.

2.1.2. Determining the Health Budget Ceiling

Within a 'top-down' budget setting framework, once the size of the government's overall budget has been determined within the chosen macroeconomic policy constraints, the next step is to allocate resources to all 'non-discretionary' items in the budget, these typically include interest payments on debt, wages, pensions and social security contributions, and any expenditures fixed by law. What is left over, after non-discretionary budget items have been covered, (ie the 'discretionary' budget) is split between the various sectors. This is the point at which the health sector budget is finally determined.

In addition to determining the overall size of the budget, the IMF also indirectly influences the health sector budget by delineating what are and what are not non-discretionary and discretionary expenditures. For example, according to the IMF, interest payments on debt are non-discretionary - these must be paid at all costs - whilst spending on the social sectors is discretionary (except social sector wage spending). Thus effectively the IMF puts creditor interests before basic human rights. For this reason, debt relief initiatives which actually reduce the volume of debt payments a government makes and thus reduce non-discretionary expenditures are vital for creating room for more health spending.

Within the (limited) discretionary budget, increased attention is being given by the IMF and World Bank to increasing allocations to the health sector. It is common for conditions contained in Heavily Indebted Poor Country (HIPC) programmes linked to debt relief and World Bank's Poverty Reduction Support Credit (PRSC) programmes to specify that a certain proportion of the discretionary budget should be allocated to the social sectors in

general, and sometimes the health sector in particular. For example the government of Kenya (GOK) agreed with the IMF to allocate 12% of its budget to the health sector.

These conditions are usually implicitly or explicitly set as 'floors' for social spending and the result of imposing them is often to raise the portion of the government's budget allocated to health. Indeed, the GOK's health budget is projected to increase incrementally until 2007/08. This is a welcome step forward. However, it appears that targets of this sort are often implicitly interpreted by governments as maxima rather than minima. For example, the GOK's overall budget for health (including donor finance) is only projected to be 11.5% of the government's total budget by 2007/08, which is still too low to finance existing Ministry of Health (MOH) programmes and is below World Bank and WHO targets for health spending. Likewise, the government of Zambia (GOZ) raised its social sector spending in line with IMF targets but failed to fully meet them.

Once the overall size of the health sector budget is known, the available resources can then be allocated between the relevant ministries in the sector, with each ministry apportioning funds to cover the recurrent and capital costs of its various health units, programmes and services and so on. In some countries, there is a bottom up planning process to establish health sector budget needs and spending priorities. However, overall spending decisions ultimately must not exceed the budget ceiling set by the Ministry of Finance (MOF), which implies that the budget ceiling determines the spending plan rather than the other way round. The implication is that health sector decision-makers must choose between competing needs within the health sector and allocate resources according to national priorities, which are increasingly determined in a PRS.

Typically a large proportion of the domestically funded health budget - that part which is funded from revenues, social security contributions, and possibly domestic borrowing and money creation - is allocated to recurrent expenditures, and a large proportion of the recurrent expenditure budget is consumed by wages and salaries (personnel emoluments – PEs). This is because: 1) donors prefer to finance capital expenditures with aid money which means that governments' resources must be used to finance recurrent expenditures; and 2) the health sector is highly labour intensive and wages are considered to be 'non-discretionary' spending.[2] This means that a large proportion of a government's recurrent health budget needs to be allocated to PEs.

Just because a government spends a high proportion of its domestic resources on recurrent expenditures, such as wages, it should not be assumed that recurrent spending is too high. When the overall budget, which includes aid resources, is considered recurrent expenditures do not usually consume an overly high proportion of the total budget. Conversely, often recurrent budgets are insufficient. Because a large proportion of governments' own resources for health are used to finance wages often little remains to

[2] The reason for this is that: 1) wages are considered a long-term expenditure; 2) unemployment has severe social consequences both for the individual, his/her family and society at large thus rapid and forced job cutting tends to be avoided which makes reducing wage budgets a long-term process; and 3) there are short term costs associated with employment cuts such as the provision of redundancy packages and pensions.

finance other operational and maintenance costs (such as provision of drugs and other medications, basic equipment, sheets and mattresses, office supplies and so on).

Although the introduction of new budgetary processes supported by the IMF has clearly improved how governments allocate and manage their resources, the problem with approaching the budget setting process from the perspective of maintaining macroeconomic stability as the ultimate priority as opposed to human development is that actual needs take second place. The implication is that health sector needs are compromised to fit the macroeconomic priorities, rather than prioritising health sector needs and looking to see where a comprise might need to be made in achieving macroeconomic targets, or how more fiscal space might be created without compromising macroeconomic targets.

The United Nations (UN) Millennium Project report observes that, "IMF program design has paid almost no systematic attention to the [Millennium Development] Goals when considering a country's budget or macroeconomic framework. In the vast number of country programs supported by the IMF since the adoption of the Goals, there has been almost no discussion about whether the strategies are consistent with achieving them."[3]

The failure to assess trade-offs between spending needs and macroeconomic targets (including competing needs from other sectors) and to come to a balanced decision concerning the two is symptomatic of the separation in the processes for determining spending ceilings and budget needs. In the case of the health sector, the former is done by the MOF and the latter by the MOH. Whilst needs and spending priorities are often determined through reasonably participatory processes, which include inputs from a range of stakeholders, it is not uncommon for budget ceilings to be set through non-participatory processes.

This is not to say that the MOH has no influence over its budget allocation. To the extent that sector allocations are determined according to PRS priorities, of which health is invariably one, then the MOH does have an opportunity to influence its budget. However, according to the UN Millennium Development Project whilst ideally budgets should be linked to the PRS via the Medium Term Expenditure Framework (MTEF), in practice this is rarely the case. Typically the forthcoming health sector budget is based on the previous year's budget.[4]

It is also usual that the MOH will have an opportunity to lobby the MOF for more resources beyond its budgeted allocation. However, whether or not the MOH eventually receives more may not depend on actual need but on how forcibly and effectively the MOH lobbies the MOF compared to other ministries. Thus the capacity of the MOH to articulate its need for more resources is vital. In practice, health ministry officials in all four countries studied for this report have indicated that they have found it difficult to influence budget ceilings handed down by the MOF. Moreover, they fear the allocation to the health sector might worsen if donors switch to provide general budget support rather than sector support.

[3] UN Millennium Project, 2005, *A Practical Plan to Achieve the Millennium Development Goals*, p193.
[4] UN Millennium Project, 2005, *A Practical Plan to Achieve the Millennium Development Goals.*

Given that macroeconomic targets set by the MOF and negotiated with the IMF are so binding on the rest of the government it is problematic that these negotiations still tend to remain closed to all but a few MOF officials. Whilst the IMF and MOF should (and in some cases do) use the PRS as a guide to determine how much of the overall budget should be allocated to health, it is unclear why the MOH is usually absent from these vital decision-making processes, particularly as the MOH is expected to adhere to the PRGF programmed agreed between the MOF and the IMF. Whilst ultimately this is a matter for national governments to address, the IMF could do more to encourage wider involvement of ministries in macro-economic policy negotiation processes, to ensure that decisions taken are based on a bigger picture and fuller awareness of what the various trade-offs will be, and to build greater ownership for the programmes it finances.

Furthermore, it is problematic that PRGF programmes appear to be negotiated without a due consideration of what the various macroeconomic options are and their potential impacts. There was no evidence in the country case-studies that the IMF presented different policy options to the governments based on a possible range of macroeconomic targets for them to consider, and it is unclear what efforts the IMF made to develop and discuss with MOF officials less strict macroeconomic scenarios. IMF excuses that there is a lack of data to provide a range of scenarios and outcomes are unconvincing and begs the question on what the IMF does base its analysis.

2.2. Increases in Health Sector Budgets

The commitment to the MDGs, prioritisation of health in PRSs and conditionality for achieving HIPC debt relief appear to have had a positive effect on health budgets, which have started to increase in nominal terms (see box 1). However, beyond the growth in nominal spending, improvements in health sector budgets appear to be limited and they remain woefully under-funded relative to what is needed to achieve the health-based MDGs, and other targets, such as the WHO's health spending target of USD 34 per capita and the 2000 Abuja Declaration target of 15% of a government's total budget for health.[5] For example:

- For Ghana to achieve the health MDGs it has been estimated that it would need to spend USD 16 per capita in 2005, USD 25 per capita in 2010 and USD 31 per capita in 2015. In comparison according to recent MOH figures total health spending per capita is USD 13.5. Despite a significant increase in the health sector budget in 2004 the ministry faced a budget shortfall of USD 70 million;
- Despite almost a 30% increase in the Kenyan MOH's budget between 2004/05 and 2005/06 from USD 293 million to USD 381 million this is way below the estimated annual health sector resource requirement of USD 638 million;
- In Uganda it is estimated that in 2003 the funding gap required to achieve the health MDGs was 3.9% of GDP.

[5] The health-related MDG goals are to: reduce the under-5 child mortality rate by two-thirds; reduce the maternal mortality rate by three-quarters; halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases. For details of the Abuja Declaration see: www.un.org/ga/aids/pdf/abuja-declaration.pdf.

Thus, the likelihood of achieving the MDG health goals by 2015 is looking almost impossible and some trends are worsening rather than improving. For example:

- In Ghana the infant mortality rate (IMR) has increased from 57 deaths in 1000 live births in 1998 to 64 in 2003 and 2004; maternal mortality (MMR) is over 200 per 1000 live births which makes the goal of reducing MMR to 54 per 100,000 by 2015 very challenging; whilst immunization coverage (as a % of children under 12 months) has increased steadily from 43% in 1993 to 75% in 2004 and malaria incidence has decreased, the incidence of HIV/AIDS continues to rise.
- In Kenya the IMR has increased from 66 per 1000 live births in 1989 to 77 in 2003; malaria, upper respiratory tract infections, HIV/AIDS, tuberculosis (TB) and fevers account for 50% of reported deaths, although HIV prevalence has declined to 6.7%;
- In Uganda between 1990 and 2000 IMR declined from 122 to 88 per 1,000 live births and MMR fell from 527 to 505 per 100,000 live births, but the percentage of deliveries taking place in health facilities has fallen from 25.2% to 25% between 1999/2000 to 20004/05; the proportion of approved posts filled by qualified health workers reached 68% exceeded the 52% target for 2004/05; immunisation coverage at 89% is also ahead of the 85% target for 2004/05.
- In Zambia the IMR is 95 per 1,000 live births; the MMR is 729 per 100,000 live births; HIV/AIDS prevalence is 16% and there are 478 cases of TB per 100,000 people.

Box 1: Trends in Health Sector Spending

Ghana

In Ghana total (government and donor resources) per capita spending on health increased from USD 6.3 in 2001 to USD 13.5 in 2004, and the total health budget was projected to increase from Ghana Cedis (GHC) 1.2 million in 2003 to GHC 2.5 million in 2005 to GHC 4.8 million in 2006. The Government of Ghana's (GOG) own contribution to the health budget increased from USD 3.1 per capita in 2001 to USD 5.7 in 2004. In 2003 the health sector was allocated 12% of the government's budget.

The increase in funds to the health sector has largely been used to pay higher wages and provide incentives to halt the brain-drain and encourage health professionals into rural areas, although he government has taken steps to increase the share of non-wage recurrent expenditure, which has risen from 10.5% in 2002 to 12% of recurrent expenditure in 2004.

Kenya

The GOK allocation to the MOH has grown each year between 2000/01 to 2004/05 from USD 161 million to USD 315 million, with a substantial increase of 44% between 2003/04 and 2004/05. This has led to an increase in per capita spending from USD 5 per person in 2000/01 to USD 9 per person in 2004/05.

However, another picture emerges when one looks at the volume of GOK expenditure on health as a proportion of total GOK expenditure. In 2004/05 the proportion was only marginally higher at 7.7% than in 2000/01 when it amounted to 7.2%, and had fallen from a high of 9% in 2001/02. Similarly, looking at MOH expenditure as a proportion of GDP there is considerable fluctuation from year to year rising to a high of 1.9% in 2004/05. Both as a proportion of total GOK expenditure and as a percentage of GDP recurrent spending rose between 2000/01 and 2003/04 but fell back in 2004/05 to below 2000/01 levels.

Looking forward, 2004/05 health spending was projected to be 8.62 % of the GOK's total expenditure and future projections for 2005/06, 2006/07 and 2007/08 are 9.9%, 10.30% and 10.7% respectively.[1] However, total government expenditure is only expected to increase by 1.3% of GDP between the period 2004/05 to 2007/08, which suggests that increases in health sector spending will probably mostly be achieved by reductions in other sectors such as public administration and national security.

Uganda

In Uganda the government's contribution (including donor projects) to the health sector in 2000/01 was USD 8 per capita, which is far less than the estimated USD 30-40 needed (including anti-retroviral treatments and pentavalent vaccine). Only 31% of the first Health Sector Strategy Programme (HSSP), which ran from 2000/01 to 2004/05 was funded. However, the health sector budget has been growing as a percentage of the total government budget, from 7.6% in 2000/01 to 10.3% in 2004/05, although in real terms the budget has stayed more or less constant and is expected to decline in coming years. Moreover, funding for the second year of HSSP2, which runs from 2005/06, is projected to fall short by 34% compared to estimated, conservative funding needs. Of the total health sector budget for 2005/06, 21.6% is allocated for recurrent wage expenditure, 19.9% is allocated for non-wage recurrent expenditure, 5.9% is domestically financed capital expenditure, and 52.3% is donor financed capital expenditure.

Zambia

In Zambia total health expenditure (which includes government, donor and households expenditure on health) was Zambian Kwacha (ZMK) 950 billion (USD 211 million) in 2002, which is a nearly 6-fold increase from 1995.[1] However, total health expenditure as a percentage of GDP has barely increased over the same period: fluctuating from a low of 5.4% in 1995 to a high of 6.6% in 1998 and dropping again to 5.8% in 2002 and averaging 5.8% of GDP per year. Whilst government per capita expenditure on health has declined over this period, from USD 8.1 in 1995 to USD 7.5 in 2002, and government health expenditure as a proportion of total government expenditure has barely changed between 1995 and 2002 rising from 6.5% to 6.7%, with a yearly average of 6.7%. Recently, the budget allocation to health shows a rising trend. The 2006 budget allocates 10.7% of the total government budget to the health sector, or 18% of the discretionary budget.

3. Increasing 'Fiscal Space': Aid or Wage Ceilings?

IMF and World Bank staff members recognise that many countries are unlikely to achieve the health MDGs by 2015: "On current trends, most regions will fall short on goals for reducing child and maternity mortality, and the number of people infected with HIV/AIDS continues to grow." And acknowledge that "…achieving the human development MDGs will require a major expansion of education and health services."[6] So the IMF implicitly accepts that spending needs to increase. The question is how can a government finance a massive expansion in health services if the IMF's PRGF programmes and policy advice constrain governments from raising their budget ceilings?

The IMF's answer to this problem is to find 'fiscal space' in the budget without impacting on macroeconomic policy goals. A broad IMF definition of fiscal space is: "the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position."[7] Given IMF programme restrictions, the few options available to LIC governments for creating fiscal space are: raising more domestic revenue either through generating more growth, or increasing and expanding taxation and improving tax collection; improving the efficiency of government spending and switching expenditure from low priority to high priority expenditures; and using aid - preferably grants - and debt relief.

The most sustainable means of creating fiscal space, which has least impact on the macro-economy and, therefore, is implicitly favoured by the IMF, is via revenue generation and improving efficiency of expenditure. As mentioned previously, given that revenue levels in LICs are generally low there is scope for increasing revenue generation, but doing so takes a long-time. This implies that in the short-term the most likely source of 'domestically created' fiscal space will be from improved efficiency of expenditure.

For low LICs the viable sources of 'external' finance to generate fiscal space are debt relief and aid. Debt relief is more sustainable because flows are certain and it is guaranteed over the long-term, although it is limited in volume and to the number of countries that can access it, which implies that aid will be the principle source of externally provided fiscal space. The World Bank and IMF (2005) report that "…even the most conservative estimates of the external financing gap [to reach the MDGs] indicate the need to double or triple current levels of official development assistance (ODA) for health and primary education."[8]

However, whilst the IMF supports the use of aid to create fiscal space, particularly grants that do not add to debt burdens, even the use of aid is constrained because of the short- and long-term impacts it can have on fiscal stability, the potential macroeconomic impacts of large aid inflows, and the marginal returns to aid.

[6] Berg, A. And Z. Qureshi, 2005, The MDGs: Building Momentum, *Finance and Development*, Vol. 42 No.3.
[7] Heller, P., 2005, *Understanding Fiscal Space*, IMF Policy Discussion Paper PDP/05/4.
[8] World Bank and IMF, 2005, *Global Monitoring Report*, p91.

3.1. The Potential Macroeconomic Impacts of Aid[9]

In the past year, the IMF has started to engage more positively with efforts to increase aid. For example in recent reports such as *The Macroeconomics of Managing Increased Aid Inflows: Experiences of Low-Income Countries and Policy Implications* and *"Pity The Finance Minister": Issues in Managing a Substantial Scaling up of Aid Flows*, it has begun to examine the potential macroeconomic impacts of increased aid so as to be better positioned to advise governments what the macroeconomic and wider economic trade-offs might be and how macroeconomic policy can be used to ameliorate them.

However, whilst the IMF accepts that donors are going to provide more aid and that countries should be helped to manage increased aid flows its approach to this agenda remains cautious and reactive. Typically the IMF takes aid quality as given and demands that LIC governments adjust to the uncertainties of aid, with the implication that they may well be incorporating less aid into their spending plans and budgets than they could do. Beyond inserting references to the need for improved aid quality in some of its reports it appears to be doing relatively little in either Washington or at the country-level to actively encourage donors to increase aid volumes and aid quality, although this might be about to change since the April 2006 *Managing Director's Report on Implementing the Fund's Medium-Term Strategy* proposed that, "The Fund should inform donors when there is scope for more aid to be absorbed and, conversely, when it judges that expected aid flows put macroeconomic stability at risk."[10]

Moreover, although recently there have been some positive signals of willingness to allow some flexibility into the macroeconomic agenda, the IMF's analysis of aid how much aid can be sustainably used is tightly framed within the IMF's concept of macroeconomic stability, which continues to be given priority over growth objectives. A recent IMF and World Bank publication which recognises the need to take account of the growth consequences of fiscal policy is a welcome sign that this emphasis might be beginning to change.[11]

3.1.1. Aid and Budget Flexibility

The IMF takes a cautious view of how much aid will actually be made available to LIC governments within a fiscal year, based on past experience which has shown that donors often commit to provide more aid than they eventually disburse and that there tend to be large swings in aid from year to year which makes it hard to anticipate how much a country can expect to receive. This can create budgetary problems for a government if it makes spending decisions based on overly optimistic assumptions about the aid it will receive and plans this money into its budget, since if not all the aid is forthcoming the government may be left with sizeable holes in its budget. These gaps must either be filled by additional borrowing (or money creation), which might impact on macroeconomic stability, or by making rapid expenditure cuts (usually planned investment projects or discretionary recurrent expenditure, such as medicinal supplies). Preferring to avoid either of these options, the IMF tends to allow governments to factor into their budgets only those donor

[9] This section draws on Heller, P., 2005, *Understanding Fiscal Space*, IMF Policy Discussion Paper PDP/05/4.
[10] p8.
[11] World Bank and IMF, 2006, *Fiscal Policy and Growth for Development: An Interim Report*.

resources that are guaranteed to be disbursed, which implies that budget ceilings may be set lower than they need be.

The IMF's concession is to encourage governments to prepare supplementary budgets should more aid or domestic resources become available than was budgeted for or the country face a crisis which demands emergency spending and to include 'adjusters' in PRGF programme targets. Preparation of supplementary budgets is common in Kenya and Ghana, which suggests that budget ceilings in these countries are possibly being set too cautiously and that the MOH budget is routinely under-financed, although it also demonstrates that there is some flexibility in budget ceilings and the overall budget deficit.

However, whilst such a process might ensure holes in the budget are avoided, delays in the use of aid resources may lead to them being withdrawn if they cannot be used within the time-frame specified by the donor. This might occur if the government does not have ready provisional plans for increased spending, or if delays in allocating aid to the budget are compounded by aid absorption problems, which mean that the aid cannot be disbursed and used sufficiently quickly. The use of supplementary budgets may also obstruct efficient planning and resource allocation.

The IMF argues that it cannot be blamed for a government failing to have a supplementary spending plan. However, if donors honoured their aid commitments there would be no need for one. But rather than push donors to improve aid mechanisms the IMF requires LIC governments to adjust to the unpredictability of aid. Whilst the latter may be realistic it is reactive, the easy option and far from optimal. For example, an IMF report looking at five countries with large increases in aid found that prediction errors were common, and that in one case there was a systematic pattern of under-prediction.[12]

Even if the MOH has a ready plan it may not be able to accept donor resources if it is not able to match donor funding with sufficient counter-part funds. This has been the case in Kenya.[13] Counter-part funds may be restricted because the government is either unable to free-up resources within its existing budget (possibly because a large proportion of the budget is spent on non-discretionary items) or because IMF conditionality restricts it from borrowing domestically. In these cases, budget ceilings may effectively be inflexible.

Moreover, some governments may be very strict in adhering to the budget ceilings agreed with the IMF. For example, in Uganda, the MOF has determined that there should be no flexibility in its budget ceilings. Thus any additional donor finance made available for health is accommodated in the health sector budget by cutting back on the government's own contribution, implying no overall change in the budget ceiling. This strict policy stance appears to have been adopted by the MOF and not imposed by the IMF, possibly motivated by a political desire to reduce aid dependency rather than concerns about the macroeconomic impacts of greater aid-financed expenditure.

[12] IMF, 2005, *The Macroeconomics of Managing Increased Aid Inflows: Experiences of Low-Income Countries and Policy Implications*.

[13] In some cases, delays in providing counterpart funds have led to some donors cancelling projects already planned into the MOH's programme. Improved budget management processes and donor harmonisation might help prevent this in the future.

However, IMF conditionality often constrains governments from spending increased aid and raising their budget deficits. This is typically the case in those countries that have not achieved sufficient macroeconomic stability. Instead, IMF conditionality may require LIC governments to use aid to cut back on domestic borrowing, pay off debts and build up reserves. Thus the emphasis is on supplanting rather than supplementing existing government resources.

For instance, the IMF in its 2005 report, *The Macroeconomics of Managing Increased Aid Inflows: Experiences of Low-Income Countries and Policy Implications,* found that the governments of Ghana and Ethiopia both spent little of the anticipated incremental aid they received. Instead they increased reserves and reduce domestic debt. In Ghana, between 2001 to 2003 the IMF's PRGF programme allowed only partial spending of the aid increase with the remainder used to reduce domestic borrowing, and in Ethiopia the IMF's PRGF programme for fiscal year 2001-02 required the government to use aid to cut back on monetary financing of the fiscal deficit and to reduce the fiscal deficit. In other years, the governments' decisions not to spend all of the increased aid could not be directly attributed to PRGF programme conditionality, although it is not known what the staff's advice was.

Moreover, contrary to the IMF's assertion that it supports the use of supplementary budgets, the report found that unanticipated aid flows were also often used to supplant a government's own resources: "The PRGF-supported programs generally dealt with aid surprises more cautiously than with expected changes in aid. In the case of positive aid surprises, PRGF-supported programs limited the spending of aid in excess of projections via reducing the ceiling on net domestic financing of the government in three of the five countries…Such an adjustment in the ceilings sets an implicit limit on the fiscal deficit. When actual program aid exceeded the level projected under the program, net domestic financing of [the] government budget was reduced by the full amount of the excess aid." [14]

Whilst using aid in this way may contribute to macroeconomic goals this is not what the aid was intended. In particular stockpiling aid as reserves to smooth volatility of aid flows rather than using it as an additional resource is problematic. Whilst this is ultimately an issue for donors to address the IMF should be responsible for pushing them to do so.

3.1.2. Long-term budget sustainability and budget as a macroeconomic tool

The IMF is also concerned about long-term budget sustainability and, therefore, is cautious about governments using aid to increase expenditures in the present that generate long-term (i.e., recurrent) spending commitments. For example, using aid to finance higher wages or more employment in a priority sector or to provide essential services, such as the provision of anti-retro viral drugs for treatment of HIV, that once provided cannot be withdrawn.

The IMF argues that decisions to use grants or other means to increase spending in the short term should be based on an ability either to meet these costs in the long term from a

[14] IMF, 2005, *The Macroeconomics of Managing Increased Aid Inflows: Experiences of Low-Income Countries and Policy Implications,* p33.

government's own resources or to scale back expenditures in line with future levels of finance. If a government expects aid to be available only over the short- to medium-term this is likely to have implications for how much aid it will be willing to use, unless there are strong indications that government revenue will increase sufficiently to cover expected aid cuts.

Whilst the IMF's concern is understandable it is problematic because health service provision requires a significant amount of inputs particularly labour. Increasing the number of health sector staff and the wages paid to them is a pressing issue which demands an increase in recurrent expenditure now. The World Bank and IMF themselves note that, "The financing gaps in health and education are for core budget expenses—largely local costs, largely recurrent, and largely for personnel."[15] Many LIC governments' recurrent budgets are already so under-financed that they are unable to hire the necessary personnel to staff existing services and there is no likelihood of them employing new staff on the scale that is needed; and then there are drug and other operational costs to consider.

Another reason why the IMF may discourage using aid to hire more nurses and doctors now is that it is also concerned that if aid is used to fund increased non-discretionary recurrent expenditure then the usefulness of the budget as a macroeconomic policy tool i.e., to respond to unanticipated fiscal challenges, may diminish. This could arise because 'non-discretionary' expenditure can neither be easily nor rapidly cut back. However, it should be seriously questioned whether forfeiting employment of frontline service staff to maintain budget flexibility is indeed desirable. As the IMF itself notes, most industrialised country budgets are spent on non-discretionary expenditures.[16]

3.1.3. 'Dutch Disease' and the Macroeconomic Impacts of Large Aid Flows

Beyond fiscal instability, the IMF has also raised concerns about the possibility of 'Dutch Disease', which is a situation in which a rise in the exchange rate is caused by a rise in the price of non-traded domestic goods and services, which in turn is caused by large flows of aid into an economy. An appreciating exchange rate could damage a country's growth potential by reducing its international competitiveness and thus its ability to export. The implication is that governments might be encouraged to forego aid in order to maintain competitiveness: "In choosing such a strategy [substantially increasing the use of aid], countries must be mindful of the downside risk that the continuity of aid flows is not sustained. In the meantime, the competitiveness of the tradable goods sector would have been weakened, increasing a country's vulnerability to such aid shocks. This suggests that without clear guarantees, a country may wish to be cautious in limiting the scale of its aid dependency."[17]

Whilst an IMF study examining the impact of large aid flows in five African countries found no evidence of Dutch Disease problems it is evident that some governments managed their economies so as to prevent an increase in the exchange rate: "In all three countries – Uganda, Mozambique and Tanzania – concerns about the negative impact of a Real

[15] World Bank and IMF, 2005, *Global Monitoring Report*, p92.
[16] Heller, P., 2005, *Understanding Fiscal Space*, IMF Policy Discussion Paper PDP/05/4.
[17] Heller, P., 2005, *"Pity the Finance Minister": Issues in Managing a Substantial Scaling Up of Aid Flows*, p6.

Effective Exchange Rate (REER) appreciation on competitiveness dictated the pattern of aid absorption and the monetary response."[18] Ironically, these cases suggest that the macroeconomic effects of trying to prevent an increase in the exchange rate might actually be worse, for example, if aid is not used to buy imports but is sterilised by selling government bonds it could lead to an interest rate rise, raise government debt stocks and crowd out the private investment.

Consequently, the IMF has become more vocal in its support for exchange rate rises, although one wonders if this has come too late as previous IMF warnings about the potential negative competitiveness impacts and "challenges" seem to have taken root in policy makers' minds. What recent IMF papers reveal is that whilst there is a presumption that aid will increase it can be expected that the IMF's advice in relation to it will be cautious and that it will be weighted towards maintaining relatively strict macroeconomic stability. This is evident in the emphasis given to the potential negative macroeconomic impacts large aid flows could have, with little if any attention given to the potential growth enhancing effects.

3.1.4. Government Absorptive Capacity

However, once factored into the budget there is no guarantee it can be spent. Although Tanzania's scaling up of primary education and Uganda's accelerated expansion of poor people's access to primary health care and HIV/AIDS programmes demonstrate some governments can absorb larger quantities of aid, a number of LIC governments are not managing to spend even the moderate amount of aid they already receive.

The problem is that some governments have limited capacity to disburse aid once it is received, and once disbursed there may be limited capacity to actually spend the aid. A government's limited administrative capacity is very quickly drained the more donors there are in a sector, which means a multitude of procedures must be followed, schedules adhered to, programmes implemented and reports produced. And its ability to spend aid is increasingly limited when donors ear-mark for what purposes their money is to be used and demand that complicated reporting procedures are followed. The problem is that if the aid cannot be spent for the specified purpose, for example because contractors cannot be hired in time, then often it cannot be reallocated for other purposes for which it could be spent.

The implication is that it is not unusual for government budgets to be under-spent. For example, only about 50% of SIDA's funds provided to the GOK for the health sector are absorbed, whilst only 80% of the WHO's funds to the GOK are used. A 2004 Financial Disbursement Assessment by the MOH found that on average as much as 60% of donor funding for health programmes is not spent. However, under-spending is typically a problem with donor money rather than with a government's own resources which have few transaction costs and are relatively flexible.
These problems are well known to donors who have committed to take steps to harmonise and streamline their procedures and work plans and to provide more budget and

[18] IMF, 2005, *The Macroeconomics of Managing Increased Aid Inflows: Experiences of Low-Income Countries and Policy Implications*, p43.

programme support as opposed to project aid and technical assistance. However, progress with harmonisation is proceeding too slowly. Whilst steps are being taken to develop governments' administrative capacity this is also a slow process.

3.1.5. Improving the Quality of Aid

It is self-evident that current growth rates and revenue raising capacity are too low to generate the resources on a scale necessary to boost health expenditure. This is acknowledged in the 2005 World Bank and IMF *Global Monitoring Report*, "Although low-income countries eventually need to be able to sustain their education, health, and water and sanitation systems with domestic resources—avoiding developing long-term dependency on aid—that goal can be achieved only gradually in most countries, with economic growth and deepening of fiscal capacity."[19] Berg and Oureshi (2005) concur - "Even with stronger efforts to mobilise domestic resources and attract private capital inflows, these countries [Sub-Saharan Africa] will need a substantial increase in ODA to improve their prospects for achieving the MDGs"[20] – and suggest that aid needs to be doubled within the next five years.

Not only must aid commitments be increased, they must be lengthened too. Short-term aid is not appropriate for scaling up recurrent expenditure: "the scaling up of expenditure that is required in low-income aid dependent countries will only be sustainable if the increased aid is maintained for many years, well beyond the planning horizon of most aid programmes."[21]

The IMF is right to be concerned about the unpredictability of aid and its short- and long-term impacts on budgets and other parts of the macro-economy. However, the answer is not to limit the use of aid but to improve its quality: "While official development assistance (ODA) needs to rise, the nature of donor support must also change. There is often a disconnect between the types of expenditures that countries need to finance to increase education and health services (recurrent local costs that largely go to pay for personnel) and what bilateral donors provide (in-kind financing and technical assistance)."[22]

Improving aid quality means: 1) committing aid for longer time periods; 2) fully honouring aid commitments; 3) providing budget or sector programme support rather than project support and technical assistance; 4) donor harmonisation around a core, limited set of monitorable targets/actions, which will facilitate joint monitoring and reporting; 5) negotiating these targets/actions with the government so that they are owned, thereby reducing the likelihood of non-compliance and having a phase out period for aid if there is non-compliance to limit 'stop-start' financing; and 6) working with governments to develop plans to generate higher revenues over the long-term and phase out aid.

Whilst donor rhetoric clearly expresses the right sentiments there is foot-dragging in putting this into practice. Given the macroeconomic problems and inefficiencies that ensue from aid unpredictability, and that the IMF's role as an advisor to governments on their budgets and related macroeconomic policy issues is made more problematic because of aid uncertainty,

[19] World Bank and IMF, 2005, *Global Monitoring Report*, p94
[20] Berg, A., and Z., Qureshi, 2005, The MDGs: Building Momentum, *Finance and Development*, Vol. 42 No. 3.
[21] *High Level Forum on Health MDGs*, 2005, p3.
[22] Berg, A., and Z., Qureshi, 2005, The MDGs: Building Momentum, *Finance and Development*, Vol. 42 No. 3.

the IMF has a responsibility and is one of the institutions best placed to hold donors to account to their aid harmonisation commitments. It is negligent for not doing so.

The IMF's failure to engage proactively with the issue of scaling up and improving aid beyond adding its voice to international calls to increase aid levels, is visible in its cautious analysis of aid's impact on the macroeconomy. The result of which may well be to discourage donors to provide more funding and governments from using more of the aid available to them. The IMF's emphasis on constraining aid use and on stockpiling it to smooth aid volatility is a reactive and cautious response to uncertainty. Instead it should take a proactive approach and push donors to take steps to make the aid more predictable and to commit aid for longer, rather than demanding that LIC governments make adjustments to deal with these problems.

Whilst many donors are not yet able to make definitive long-term commitments many do anticipate providing finance to the LICs for a considerable time to come. Thus whilst they might not be able to indicate on what scale it does suggest that LIC governments and the IMF could make more positive assumptions about the longevity of aid flows, whilst bearing in mind that aid levels will likely fluctuate from year to year.

3.2. The IMF, Wage Ceilings and Health Workers

Because aid is uncertain and might be quickly cut back and because it is not committed over the long term, donors and the IMF prefer that it is used to finance capital investments that can be quickly scaled back rather than recurrent costs, particularly wages, that are long-term costs. However, aid used to build health centres is worthless if a government cannot finance the running costs. If more aid is to be invested in health this implies a need for more government resources too, the question is where to find these extra resources if a government's own are limited.

The IMF's answer is to reorganise government spending by switching expenditure from low priority areas to high priority areas, increase the efficiency of spending and cut out waste.

3.2.1. The IMF and Wage Ceilings (budget restrictions)

One area of government spending that has concerned the IMF for many years, and which it considers ripe for reallocation, is wage spending. The IMF advocates wage spending ceilings for three reasons. Firstly, wage budgets are excessive due to inappropriate staff levels and skills composition, inappropriate civil service structures, and mismanagement that has led to payment of 'ghost' workers. For example, in Zambia it is argued that there are too many administrative and support staff compared to health professionals in the health sector. Secondly, since wages consume a large portion of a government's budget, any increase in wage expenditure can rapidly raise budget deficit levels. Thirdly, increased spending on wages in the present puts a burden on budgets in the future (especially if associated social security and pension costs are also factored in), which may constrain budget flexibility and a future government's choice as to how to prioritise its expenditure.

Therefore to improve the efficiency of wage spending and preserve the flexibility of the budget, the IMF is focused on eliminating 'ghost workers' from the government's payroll,[23] restructuring (rationalising) the civil service so that more staff can be employed in priority sectors such as education and health (with fewer employed in low-priority sectors), prioritising employment of staff providing front-line services rather than administrative support, and restraining wage increases.[24]

According to the IMF, average spending on wages across SSA countries ranges between 6-8% of GDP. Thus, wage spending over 8% of GDP is considered excessive. Wage budgets in Ghana, Kenya and Zambia are at the top end of this range or above, and consequently their wage budgets have been capped, and all three governments have committed to reduce their wage budgets as a proportion of GDP.[25]

The GOG's total wage bill was projected to be nearly 9% of GDP in 2005 but it agreed to cut it back to 8.5%, meaning that new health staff could not be employed nor wages or allowances increased without prior approval from the MOF. However, some officials within the GOG do not support the policy, and are sympathetic to health workers' wage demands. They report that the Ghanaian authorities tried to convince the IMF that agreed wage increases were needed to attract and retain qualified personnel and to curb migration. According to the GOG, paying appropriate wages and incentives is a strategic decision to ensure appropriate levels of staffing and thus provision of necessary health care services. It rejects the IMF's argument that higher wage spending would lead to inflation and erode macroeconomic gains.

A lack of ownership of this policy might explain why the GOG has found it difficult to stick to wage bill targets agreed with the IMF. In 2002 the GOG's PRGF programme was declared 'off-track' by the IMF because of serious wage bill overruns, and in 2004 a wage bill condition was waived (that is the wage bill was allowed to overrun its ceiling). Even so, the wage ceilings have had an impact. For example, the GOG suspended agreed increases in its Additional Duty Hours Allowance (ADHA), and could not honour in full a wage agreement with registered nurses and other civil servants.

Overrunning wage ceilings may be a way for a government to signal its lack of ownership of a policy but it can cause problems if going off-track with the IMF causes a halt in other donor flows. As more donors switch to budget support governments may have little option but to stick to wage ceilings, since it is likely that they will be included as a condition in budget support agreements, as was the case in Ghana.

The GOK has agreed to reduce its wage bill from 9% of GDP in 2004 to 8.5% by 2005/06 and finally to 7.2% by 2007/08. It hopes to achieve this through a voluntary retirement scheme, with a total reduction in public sector staff of 21,000 over the medium-term.

[23] Often it is argued that substantial wage savings can be made by eliminating 'ghost' workers. However, during the course of civil service reform, which has been going on (slowly) in many countries for several years now, many ghost workers have already been eliminated from employment records. For example, in Kenya, a recent head count of MOH employed staff found only about 250 ghost workers.
[24] Heller, 2005.
[25] There is no wage budget ceiling in Uganda.

In Zambia, budget overruns caused the budget deficit to rise to about 5% of GDP in 2002, which according to the IMF was unsustainable. The IMF attributed the budget overruns to payments of higher PEs that were not budgeted for. By 2002/03 PEs were absorbing about 60% of GOZ revenues and 11% of GDP. In the programme signed in 2002 with the IMF, the GOZ agreed to a ceiling of 8% of GDP on the wage bill, implying a significant cut back in wage spending. In addition this agreement called for an overall recruitment freeze for the civil service in 2003. Although health and education staff were officially excluded from the recruitment freeze, these sectors experienced a de-facto freeze as a result of wage spending restrictions. [26] Furthermore, in 2004 the GOZ cut its discretionary spending in order to reduce the budget deficit from 5.1% to 2.2%, which resulted in a fall in the discretionary budget spent on health of 1% of GDP. While the 2006 budget showed a rise in the MOH budget as a share of the total budget, the wage bill allocated to the health sector decreased from 11.6% in 2005 to 10.4% in 2006.[27]

The IMF is quick to defend that it does not impose wage ceilings in the health sector specifically, nor does it determine where a government must limit or cut its wage spending. These decisions must be taken by the government itself. Indeed, the health sector is often exempt from hiring bans. However, before new staff can be hired approval must often be sought, for example, from the MOF, and staff can only be hired if there are resources available in the MOH's budget. Given that the MOH's budget is constrained this effectively means there is a limit on hiring personnel, unless resources are can be freed up by making cuts elsewhere in the budget, or staff costs can be reorganised either within the Health Ministry or the public sector as a whole.

For example, in Kenya the MOH was given approval to hire an additional 2000 nurses and 100 drivers, but it was unable to because it could not find the necessary resources. Overall, the MOF has approved the employment of 45,000 health workers but only 34,840 have actually been employed.[28] Yet, it is estimated that the MOH needs at least another 600 doctors, 2000 clinical officers and 7000 nurses.[29]

The problem with wage ceilings is that whilst they might be useful at containing budget overruns they are seemingly ineffective at pushing a government to restructure its civil service i.e., at improving the allocation and efficiency of government spending. Job cuts are always a politically contentious issue, thus faced with a political 'hot-potato', governments often shy away from making them. The implication is that if there is no reorganisation and restructuring within the civil service, the government is not able to save the necessary resources from low priority sectors in order to improve wages or staffing levels in priority sectors, such as health and education. Thus wage ceilings are implicitly imposed on the

[26] Originally the wage bill target in this programme was set at 8% of GDP, but was raised after NGO protests that this would curb the employment of teachers. The 0.1% increase in the ceiling allowed the government to employ 2000 more staff in the education sector after it received funding from the Netherlands government to pay benefits to retired staff, thereby removing them from the payroll. See Wood, A., 2005, *Back to Square One IMF Wage Freeze Leaves Zambian Teachers Out in the Cold. Again,* Global Campaign for Education: http://www.campaignforeducation.org/resources/Jun2005/back_to_square_one_tcm8-4743.pdf

[27] MTEF 2005 budget and 2006-2008 projections, Ministry of Finance, Zambia

[28] The number of 'approved' health workers is not the same as the number of 'required' health workers.

[29] Moreover, GOK is still implementing a 2000-2002 retrenchment plan that proposed to retrench 10,273 health workers and employ only 4,719 new staff, implying an overall loss to the health sector of 5,554 workers.

health sector. Moreover, even if governments respond to wage ceilings by making cuts, it is doubtful that sufficient resources can be saved by these means to employ the health professionals that are needed let alone the additional staff needed in other priority poverty-reducing sectors, such as teachers. [30]

Furthermore, whilst attention needs to be given to hiring front-line health professionals cutting back aggressively on administrative staff may simply generate further financing problems as capacity to access and disburse aid becomes even more constrained.

Whilst there are grave doubts about the effectiveness of wage ceilings, there is also a question about whether in fact wage budgets are too high. It seems that the problem of health sector wage bills might be overemphasised: they appear much more reasonable if calculated in relation to a government's total health sector budget rather the domestic budget. For example:

- In Ghana, the budget for wages and allowances amounted to 82% of the GOG's health sector expenditure in 2003 and 2004, and the proportion was expected to rise to 86% in 2005 and to 89% in 2006. However, as a proportion of the total health sector budget (i.e., including aid) wages accounted for 64% in 2003, 58% in 2004 and were projected to consume 54% and 36% in 2005 and 2006 respectively;[31]
- In Zambia, the health sector wage bill amounted to ZMK 280 billion (USD 62 million) in 2003 ZMK 308 billion (USD 68 million) in 2004, equivalent to 52% and 48% of total health sector expenditure respectively, and 1% of GDP;[32]
- In Kenya, although as a percentage of GDP the wage bill was 8.2% in 2003/04, as a percentage of the total recurrent expenditure budget it is only projected to be 47.5% in 2005/06, and as a percentage of the GOK's total budget it is only 35.46% in 2005/06. The MOH's wage bill as a percentage of its recurrent health budget is only 47.2% and as a percentage of the GOK's total expenditure it is less than 3% in 2005/06.

The IMF's preference for calculating the wage burden in relation to GDP again presumably arises from its assumption that donor contributions are at best medium-term and cannot be guaranteed beyond that. The implication is that to ensure governments can afford to pay public sector wages (and other non-discretional payments) they must be able to find sufficient resources out of their own revenues, which reflect the level of GDP. However, once again we see the IMF taking a very cautious approach, which assumes that aid levels and commitment periods are 'given'. If it were to do more to persuade donors of the benefits of providing longer-term, higher quality aid to LICs governments would be on firmer ground to include aid into their recurrent budget calculations. Its efforts in this regard appear to be minimal.

Moreover, using a regional average of wage spending to GDP to determine wage budget limits is not helpful if the average does not reflect ability to meet human resource needs in the public sector. Whilst spending 6-8% of GDP on public sector wages might sound

[30] This is not to say that budget ceilings have not had an effect on allocative efficiency. In some cases they are, but the implication is that the efficiency is being achieved within sectors rather than across sectors, which is what wage budgets are intended to achieve.
[31] See Azeem and Adamtey, 2005, Tables 4 and 5. In 2006 the government expects to raise substantial additional resources for health from the National Health Insurance Scheme.
[32] Chitah, 2005, Table 7.

reasonable given the competing demands on government resources, it must be borne in mind that levels of GDP in LICs are very low, thus in nominal terms spending on wages is actually low. Furthermore, if all countries are under-spending on wages (i.e., staff numbers and salary levels in the public sector are generally too low), then it makes little sense to base wage budget decisions on such an average. Instead, wage budget needs should be calculated on a country by country basis, taking into consideration necessary staffing levels, appropriate wage rates and the government's capacity to finance wage spending over the medium- to long-term (including using aid resources), and determined by the MOF in consultation with each ministry.[33]

3.2.2. Human Resources for Health (budget demands)

Azeem and Adamtey argue that in Ghana "the most important constraint of the health sector is the lack of health workers of the right type, in the right numbers and at the right places and the sector's inability to retain and equitably deploy nationwide the qualified health personnel available." The need for more health personnel is not lost on the IMF who, along with the World Bank, recognise that doctors and nurses are the most essential input for effective health service delivery,[34] and that there is a "…desperate need for large numbers of skilled doctors and nurses."[35] World Bank and Fund staff estimate that in Sub-Saharan Africa the health workforce will need to triple by 2015, adding more than a million workers.[36]

Not only is the health sector labour intensive which means a lack of health personnel constrains the delivery of health services, there is also a significant, positive relationship between the volume of medical personnel and health outcomes and impacts, which means that the more health personnel there are the greater the positive impact on health outcomes.

The World Health Organisation has calculated that to achieve the MDGs and provide reasonable health care coverage health worker density should be no less than 2.5 workers per 1000 population (equivalent to 1 health worker per 400 people), with a doctor to population ratio of 1:5000. The World Bank and IMF note that "Countries with fewer than 1.5 health workers per 1,000 people are highly unlikely to have a measles immunization rate of 80 percent, whereas this rate is almost assured in countries with a health worker density of more than 2.5. Countries with fewer than 2.5 health workers per 1,000 people are also less likely to have at least 80 percent of births attended by skilled personnel."[37] They also recognise that "The number of skilled providers is also important for health outcomes. A recent study of 83 countries found that a 10 percent increase in the number of trained health workers (doctors, nurses, midwives) per population unit is associated with a 2–5 percent decline in mortality, controlling for per capita income, poverty, and female literacy."[38] However, the health worker density in the countries examined for this report is far below what the WHO deems necessary (see box 2).

[33] There is a tendency to base wage budget calculations on the existing complement of staff rather than on needs.
[34] World Bank and IMF, 2005, *Global Monitoring Report*: http://siteresources.worldbank.org/GLOBALMONITORINGEXT/Resources/complete.pdf
[35] The World Bank and IMF Respond to Gorik Ooms and Ted Schrecker, published in *The Lancet*, June 2005: http://www.imf.org/external/np/vc/2005/061805.htm
[36] Berg, A., and Z., Qureshi, 2005, The MDGs: Building Momentum, *Finance and Development*, Vol. 42 No. 3.
[37] World Bank and IMF, 2005, *Global Monitoring Report*, p79.
[38] World Bank and IMF, 2005, *Global Monitoring Report*, p80

Herein lies the paradox in the IMF's logic. The IMF argues that wage spending must be cut to create resources to spend on fighting poverty. However, one of the most effective means to fight poverty is to employ more health workers, but they cannot be employed because IMF wage ceilings inadvertently restrict the hiring of health professionals.

Box 2 Ratio of Health Professionals to Population

Ghana

In Ghana, the doctor to population ratio improved from 1:22,811 in 2001 to 1:17,489 in 2003, however, in 2004 it worsened to 1:17,615. This ratio is already very poor and is made worse by the fact that the majority of doctors are in the south of the country, leaving the poor northern regions woefully under-served. The nurse to population ratio is 1:1513.

Kenya

Between 1998 and 2004 the number of registered doctors increased from 4,282 to 5,016, however, over the same period, the doctor density only grew from 14.2 doctors per 100,000 people (equivalent to 1:7,042) to 16 doctors per 100,000 people (equivalent to 1:6,250). Whilst, the nurse population (enrolled and registered) grew from 34,139 in 1998 to 35,515 in 2004. This is equivalent to an increase from 114.7 nurses per 100,000 people (equivalent to 1:872) in 1998 to 128 nurses per 100,000 people (equivalent to 1:781) in 2004.

Uganda

In Uganda, the doctor to population ratio is 4.7 per 100,000 people (equivalent to 1:21,277) and the nurse to population ratio is 5.6 per 100,000 (equivalent to 1:17,857). The health worker to population ratio is 1.5 staff per 1000 people. The government of Uganda (GOU) estimates that a further 6289 medical staff are needed to meet its HSSP goals and another 1741 medical staff are needed to achieve Anti-Retroviral Therapy scale-up goals for 2005. Thus a total of 8030 additional staff members are needed. Achieving the MDGs will require even more staff. Currently only 68% of approved posts are filled with qualified staff; the target for 2009/10 is 90%.

Zambia

In Zambia there is 1 health worker (all medical staff) per 1,039 people, 1 enrolled nurse per 2,293 people and 1 doctor per 17,589 people. These ratios vary from region to region. For example the doctor to population ration ranges from 1 doctor per 6,250 people in Lusaka province to 1 doctor per 66,000 people in Northern Province. Increasing health sector employment to 2 health professionals per 1000 people (which is still below the desirable minimum international standard) would mean that the total health sector wage bill cost to the GOZ would rise to 2.3% of GDP, currently it amounts to 1% of GDP.

3.2.3. Brain Drain

Resources are not only needed to employ more staff, they are also needed to pay higher salaries in order to stem migration.[39] 'Brain drain', that is, out migration of health professionals to other countries - either neighbouring countries such as South Africa, Botswana and Namibia or industrialised countries such as Australia, the United Kingdom and United States – is a significant cost to many SSA countries. All four of the case study countries are affected by the problem, particularly Ghana, Kenya and Uganda.

For example:

- In Ghana it is estimated that 50% of medical school graduates emigrate within 4½ years of graduating and 75% within 9½ years. Another estimate puts the attrition rate for doctors at 74% in 2003 up from 66% in 2002. In addition, about 400 nurses leave annually;

[39] High Level Forum on the Health MDGs, 2005, *Fiscal Space and Sustainability: Towards a Solution for the Health Sector*.

- In Kenya the MOH estimates that the country loses 20 nurses per week or 1040 per year. Furthermore, there are too many health staff in lower cadres and a deficit of professional health staff which is symptomatic of the problem of migration;
- In Uganda, there are no official figures but one source suggested that as many as three-quarters of the recently qualified nurses and midwives in one hospital applied for jobs outside the country.

Frequently cited factors fuelling migration include: low wages, which do not reflect long work hours and high risks; lack of continuing education and training possibilities; lack of retirement and other benefits, including health insurance; and poor working conditions and a lack of equipment.

3.2.4. Deployment of Staff

Whilst average staffing levels in relation to the overall population are bad generally, they are totally unacceptable in rural areas whilst just about acceptable in many urban areas. In many countries, health workers are discouraged to move to rural areas due to the lack of basic services such as schools, water, electricity, poor transport connections, and poor promotional prospects. The problem is that new investment in the provision of health facilities in rural areas is pointless if there is insufficient staff to provide services.

The implication is that it is not enough to simply employing more health professionals, due consideration must also be given to where they are most needed. Thus the problem is not just a question of finding resources to pay more staff but also finding ways to attract and retain staff to rural areas.

3.2.5. Incentive Packages

Additional incentives are needed to retain health professionals within the sector and to attract staff to work in rural areas. To stem migration health professionals need to be offered wages, benefits and working environments that are sufficiently attractive to compensate them for not migrating. To attract health staff to rural areas requires action to address the problems of a lack of housing, basic facilities and amenities, and poor prospects for career development. Health sector wages are often not sufficient by themselves to compensate health workers to forgo these basic necessities.

The GOG has raised wages and offered a range of incentives to try to retain health staff in the country, including offering an Additional Duty Hours Allowance (ADHA), which compensates health workers for the long hours they must work due to staff shortages. However, views on the effectiveness of such policies in stemming migration are mixed. The doctor to population ratio has worsened in 2004 after improving between 2001 and 2003 (see box 2). Likewise, to attract workers into rural areas, the GOG provides cars for personnel on hire purchase, offers promotions and additional training, and provides additional allowances (such as the Deprived Area Incentive Allowance) and higher salaries. It is also considering the option of establishing housing-loan systems and land banks for sale to health personnel.
The GOZ is considering a similar package of incentives, including provision of houses, improved living conditions through the provision of water and electricity (solar power), medical insurance schemes and loans for houses and motor vehicles.

However, whilst there is a clear need to provide incentives to health workers to move to deprived, rural areas, ensuring incentive schemes are effectively targeted is problematic. In Ghana, the incentive schemes have not been well administered and urban-based health workers have often benefited from them. For example, cars meant for health staff in rural areas have gone to those living in urban areas and MOH staff. This is an inefficient use of resources. Moreover, additional allowances, particularly those which are proportional to wage rates, are costly. For example the cost of the ADHA to the GOG has grown substantially from GHC 17 billion in 1999 when it was introduced to GHC 810 billion in 2005. Additional allowances and incentives constitute between 40-50% of the GOG's wage bill. Furthermore, providing allowances as a means to compensate for low wages could lead to inefficiency in the use of resources and a lack of transparency.

Where wage ceilings are in place, it is argued that providing more 'non-wage' incentives could compensate for a government's inability to raise wages. However, Chitah argues that in Zambia, improving non-wage incentives is not an alternative to raising wages. Both are needed, particularly given that improving infrastructure, such as provision of electricity, roads and water, cannot be done quickly and is very costly in sparsely populated rural areas.

3.2.6. Training

Beyond the problem of finding the resources to pay wages and provide non-wage incentives to employ more health professionals on the scale that is needed, there is the additional problem of finding enough trained professionals to hire. Training enough health professionals is a problem in both Ghana and Uganda, which is made worse by the brain drain. The latter also reduces government incentives to pour more resources into increasing training places.

Resources are needed to increase the number of training places within existing colleges, to build new colleges, and to provide student allowances. Health budget ceilings constrain MOHs from providing allowances to trainee nurses, doctors and other health professionals, which may impact on the number of people entering training. For example, in Uganda, "the training of post-graduates has been severely affected, with the number the Ministry of Health can sponsor falling dramatically each year."

Azeem and Adamtey propose that donors should fund training costs and/or compensate Ghana for the brain drain they encourage. Indeed, the UN Millennium Project has chastised donors for not doing enough to increase funding for training: "even though worker shortage are often the major bottleneck for countries trying to deliver basic social services, donors do not systematically invest in long-term preservice training of health, education and other key workers." [40]

3.2.7. Aid and Wages

Some donors are already taking positive steps to provide both general budget support and to finance programmes specifically focused on increasing employment of health

[40] UN Millennium Project, 2005, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, p196.

professionals and improving their coverage throughout a country. For example, in Zambia the Dutch government is providing non-wage incentives to health sector employees with the aim of improving retention and distribution of staff between rural and urban areas (this is off-budget). Similarly, in Ghana, increased donor resources to fund the second Plan of Work in the health sector have been used to raise wages to stem the brain drain and provide incentive packages to encourage health workers to move to rural areas.

This is a welcome step forward. However, tight budget and wage spending ceilings and a lack of action on the part of many bilateral donors to make long-term aid commitments which would allow governments to contract (even if only for a limited period) more health workers, are encouraging governments to turn to the 'vertical funds' as sources of plentiful, off-budget aid. These include the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM), President's Emergency Fund for AIDS Relief (PEPFAR), and the Clinton Foundation.

These donors are more than willing to facilitate governments to hire additional health workers. For example, the GFATM and the Clinton Foundation have agreed to support the GOK to employ accountants and nurses. The GFATM has already hired 1,800 nurses on contract and is planning to hire 4,000 more. However, the money used to hire these nurses will not be reflected in the MOH budget to avoid exceeding the budget ceiling. Whilst this might seem a practical way of circumventing the IMF's conditions, it makes a mockery of the IMF's wage ceilings, undermines good governance an aim of which is to bring donor resources on-budget to improve budget management, and could prevent the government from improving its planning for and oversight of the sector.[41]

In relation to the latter point, the World Bank and IMF 2005 Global Monitoring Report found that "…their [global funds'] cumulative impact is to undermine the capacity of ministries of health for coherent planning, financing, personnel deployment, and administration. A recent study of 14 low-income countries found that the multiplicity of global programs, on top of existing multilateral and bilateral channels, is exacerbating transaction costs and distorting sector priorities."[42] Part of the reason these problems arise is because the global funds are uncoordinated with government strategies but they have substantial resources and can employ significant numbers of health staff. For example, in Uganda, the activities of the (US) PEPFAR and the GFATM have raised the requirements for health workers sharply and these activities are crowding out other normal interventions in health units because of staff shortages. The implication is that the allocation of health sector staff is being skewed according to the priorities of donor projects but this allocation of resources may not be optimal. Increasingly NGOs funded by GFTAM, PEPFAR and other global initiatives are offering high salaries to attract health staff, which is undermining the public sector.
It may be that the IMF is turning a blind-eye to these funds because it considers aid delivered through them to be less problematic than other sources of aid because it is off-budget and therefore it generally goes through NGOs and thus requires no long-term government commitment which could strain the budget in the future. However, the governance problems these funds cause imply that the IMF should not condone them.

[41] For examples of good governance conditions which focus on improving budget management and limiting 'off-budget spending' see Wood, A., *Demystifying World Bank Governance Conditionality*, Trocaire, Dublin.
[42] World Bank and IMF, 2005, *Global Monitoring Report*, p97.

The answer to the problem of IMF wage ceilings is not to circumvent these. Instead the answer is to raise them. This implies a need to establish wage ceilings based on a careful assessment of needs and availability of appropriate resources. Health ministries need to facilitate this by establishing prioritised and realistic staffing plans. Donors need to provide on-budget, high quality aid. The IMF needs to constructively support both.

4. Conclusion and Recommendations

It is widely recognised that international health goals will not be reached with current levels of health service provision. To expand provision on the scale that is necessary will require a massive injection of resources to provide the staff, medical inputs and health centre facilities. In particular, employment of front line health professionals is vital given the positive relationship between the volume of medical personnel and health outcomes and impacts. At present the health sector is woefully under-staffed with staffing levels substantially below international minimum standards.

However, IMF policies which impose low ceilings on government budgets and in turn on wage and health sector budgets for macroeconomic stability are constraining significant increases in health spending. Whilst profligate government spending should be avoided, and governments should be encouraged to focus limited resources on key priorities, budget ceilings set without due regard for needs in the social sectors, particularly the health sector, are having devastating consequences and could be undermining long-term growth potential. Likewise, whilst short- and long-term budget sustainability should be considered and macroeconomic stability should be maintained the answer to uncertain and short-term aid flows is not to wait until commitments are certain enough to include them in the governments' budgets but to push donors to take the steps to improve aid that they have publicly committed to. The IMF has a responsibility to more actively pressure donors to do so.

4.1. Avoid ceilings as a mechanism to promote better spending

Relying on conditions on wage bill ceilings to provide incentives to governments to reorganise and improve the efficiency of their wage spending in order to generate resources for spending on priority poverty-reducing sectors is not working. Instead it leads to perverse outcomes, whereby employment of health professionals who are desperately needed to tackle poverty is seriously constrained. The fact that MOH bilateral and global funds find ways to circumvent these ceilings makes a mockery of them, and of donors' efforts to impose good governance discipline. Thus the use of such conditionality should cease.

Determining wage spending budgets according to an average wage spending figure for SSA is too simplistic. Average figures tell us nothing about actual needs and sustainability, whilst percentages of GDP tells us nothing about what the share of the wage bill is in relation to the total budget, which includes aid. Wage budgets should be assessed according to staffing needs. In some cases MOH staff are beginning to define staffing plans and identify staffing needs to facilitate this, and more effort is needed in this area. Resources are not

only needed to employ sufficient staff, they are also needed to train and retain staff by increasing salaries and providing incentives for staff to work in deprived areas.

4.2. Weigh economic and social policy targets

Rather than setting macroeconomic targets in isolation of other social and human rights goals the trade-offs between social and economic policy goals need to be carefully weighed. Underlying such considerations should be the assumption that where necessary and with due caution macroeconomic targets can be loosened to allow greater domestic financing of the social sectors and/or greater use of aid resources, which are slowly being made available. The IMF should be required to present alternative policy scenarios to facilitate informed debate about the trade-offs.

Also, to facilitate a better weighing of policy and budgetary choices and their potential outcome and impacts the processes of determining spending needs and setting budgets ceilings need to be carried out in a joint and collaborative process, which involves all key stakeholders. This implies a need for wider involvement of key sector ministries in IMF programme negotiations too. More participation in setting budget ceilings implies the need to develop greater capacity within the MOH and civil society to negotiate for more resources, which in turn requires greater planning and budgeting capacity.

4.3. Find solutions to unreliable aid flows

The IMF has put forward several reasons why governments should be cautious about using aid to increase spending, particularly when this can be expected to lead to a long-term increase in recurrent expenditure. Whilst the IMF's cautions are valid, they reflect the uncertainty of aid flows, and that aid is often provided in a mode and over a time-frame that is not conducive to allowing a government to increase its recurrent expenditure.

However, rather than take these uncertainties as given and force LIC governments to adjust to these, the IMF could do much more to push donors to improve the quality of aid. The IMF should do more to proactively encourage donors to provide extra money by presenting alternative macroeconomic scenarios and their potential impacts.

Colophon

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