High-Level Forum on the Health MDGs

MDG-ORIENTATED SECTOR AND POVERTY REDUCTION STRATEGIES: LESSONS FROM EXPERIENCE IN HEALTH

Abuja December 2004

Introduction

This paper summarises a forthcoming study to examine how the Millennium Development Goals related to health are being taken forward at country level, based on a literature review plus 14 country case studies of varying depth[1]. The country cases were chosen to include all countries with completed PRSPs that were being supported with both an IMF PRGF and a World Bank PRSC. The paper is organised in eight sections, each with brief 'Summary Points' at the end to highlight the main conclusions and recommendations. The paper first discusses how the health MDGs are reflected in national goals (section 1 and 2), and the content (section3) and costs (section4) of the strategies designed to achieve the national health goals. The paper goes on to discuss the resources available for implementing the national strategy, with a focus on the macroeconomic constraints on increasing expenditure (5). Implementation issues are discussed in relation to the coordination of health plans with the national budget process (6), and a discussion of absorptive capacity problems and what might be done to manage them (7). The final section discusses how effectively development assistance is supporting progress towards the MDGs, and what more could be done.

MDGs and National Targets

All of our country cases make significant reference to the MDGs in setting their own national goals and targets, and many of them set national targets that are consistent with the MDGs. All of them have targets and indicators linked to the MDGs for child or infant mortality, maternal mortality, and improved access to safe drinking water (excepting Albania where near universal access exists and the target relates to household connections). The child and maternal mortality MDGs are clearly regarded as the most challenging, with 9 of our 14 countries setting a lower target for MMR (Ethiopia having revised down a previous more challenging target), and half of our sample countries setting lower child mortality targets. Conversely, all countries except Ethiopia (which starts from a very low base) have adopted more ambitious water targets, and those few with nutrition targets have also aimed beyond the MDG.

All address communicable diseases, though fewer PRSPs include disease specific targets, and there is a wider choice of targets with indicators reflecting local data availability and not necessarily in line with the MDGs. All except Nicaragua and Tajikistan address HIV/AIDS. Nutrition is universally mentioned, but few countries have specific targets, and the indicators used again depend on local data availability and in some cases differ from the MDGs.

The MDGs do not capture all of the goals to which countries are committed, and are not equally relevant everywhere, with some countries prioritising peace and stability or overall

[1] Albania, Benin, Burkina Faso, Cambodia, Ethiopía, Ghana, Guyana, Nepal, Nicaragua, Rwanda, Tajikistan, Tanzania, Uganda, Vietnam.

economic growth over an exclusive focus on poverty. The specific health related MDGs also need to be adapted to the circumstances of individual countries: -

- Countries may have already achieved one or more of the goals, and may wish to set a more challenging target, as with HIV/AIDS in Uganda or access to clean water in Albania;
- The target reductions from a 1990 baseline may be too challenging to be achievable, especially in circumstances where e.g. child and maternal mortality have stagnated or increased in the 1990s, requiring an even faster rate of reduction to reach the 2015 targets.
- The MDG targets may also be inappropriate as well as too challenging for middle-income countries like Albania where, for example, maternal mortality levels are already relatively low. The MDG target of a three-quarters reduction would imply achieving levels similar to far wealthier countries, and would involve prioritising the MDG over other health goals (e.g. reduce chronic illness) that may be more important nationally.
- The MDGs exclude some health issues that are important in specific countries. For example, smoking in Vietnam, cervical cancer in Nicaragua. A health policy exclusively focused on the MDGs would have significant gaps and inappropriate priorities.
- The MDGs may require disaggregation to address inequality by setting more challenging sub-targets for those population groups and regions with particularly poor health outcomes, as in Vietnam.

Summary Points

- **MDGs need to be adapted to national circumstances and priorities**

Should strategies be 'Needs Based', 'Resource Constrained' –or both?

Although there is no formal link with the MDGs, the PRSP has in practice become the main national planning instrument for articulating the strategy for achieving national goals related to the MDGs. The Millennium Project argues that national poverty reduction strategies should be 'needs based', setting out strategies that are consistent with reaching the MDGs, and challenging the donor community to fill the financing gap left after reasonable national efforts at resource mobilisation. Others stress that, if the PRSP is to be useful as a guide to action, it needs to be linked to the national budget process, setting out clear priorities that are used to guide the preparation of public expenditure plans and budgets based on a realistic assessment of the resources available.

By developing multiple scenarios, some countries (Rwanda, Senegal, Niger) have shown how the PRSP can be used both to guide the allocation of the resources they expect to have, and as a bid for additional support: - a 'high' scenario is used to attract additional finance by showing what could be achieved with it, while realistic or low case scenarios set out how

expenditure plans should be prioritised in the event that fewer resources are available[2]. The World Bank and IMF have supported those countries wishing to adopt this approach, but a strong case can be made for more active encouragement of all countries to do so.

Summary Points

- **Reconcile 'needs based' and 'resource based' approaches by developing more than one scenario for PRSPs**.

Framing health strategies to achieve the targets

Most PRSP health strategies are dominated by health services, and aim to deliver a package of essential interventions that is quite similar and which is derived from an international consensus on 'what works.' There is a focus on promotive and preventive interventions and on primary health care delivery. The strategies prioritise the areas most closely linked to the MDGs, with reproductive and child health and the control of the major communicable diseases given high priority. PRSPs include the costs of expanding education, roads, water and sanitation, and their contribution to achieving health targets is often recognised, but it is seldom quantified[3].

State funded health systems in many countries are grappling with similar problems: staff availability, pay and motivation, and the difficulty of managing a complex and geographically dispersed service with inadequate financial resources and institutional capacity relative to expectations of what can be delivered. Service coverage is presently low, especially in rural areas, and nearly all PRSPs envisage substantial provision for reducing geographical barriers to access, building new primary facilities, increasing operating budgets, and providing incentives for staff to work in previously underserved areas. However, trends in actual health expenditure are mixed, with no strong evidence as yet of the increases in spending that would be required in order to implement these plans (Table 1).

Table 1 Trends in Public Expenditures on Health

Albania	Increased health spend as share of budget and GDP since 2001, narrowing gap with Europe with rapid growth performance.
Benin	Committed to increase health budget, but failure to disburse budgeted funds led to a reduced budget share more in line with absorptive capacity. The 2003 & 2004 budgets of roughly 2% of GDP represent 90% of the amounts envisaged in PRSP, but actual disbursement in 2003 was only 1.5% of GDP- about two thirds of plan.
Burkina	**PRSP**: Envisaged increasing the health budget share from 9.8% 2000 to 11.5%

[2] WHO 2004,PRSP Synthesis Report; IMF April 2003. The 'high case' scenarios have not been directly related to achieving the MDGs, but the principle is the same.
[3] Case Study material; WHO 2004, op cit.

Faso	2003, raising p.c. health spend from $7.7 to $9.5. The **MTEF** envisaged a health sector share of 7.5% in 2004, increased to 8.5% in the budget due to HIPC funds. **Actual spending** was just $5.90 in 2003, 6.3% of budget, due to low HIPC spending. Far from increasing as envisaged, health spending has fallen as share of budget, GDP, and in real p.c. terms.
Cambodia	Government health expenditure doubled from 0.57 percent of GDP in 1999 to 1.20 percent of GDP in 2003. Public health spending per capita increased by more than 40% between 2001 and 2003, albeit from a very low base (around $3/head). However, domestic public expenditures represent an estimated 9% of total health sector expenditures
Ethiopia	Spending fluctuating at low 5% of Govt spending since 1992/93, short of the 8.2% targeted in PRSP for 2004/5. Spending of $1.50 p.c. possibly the lowest in world. Regional subsidies forecast to be flat, limiting scope for increase.
Ghana	30% real increase in public health spending (Govt and donors) since 2001, Govt exceeding 11% target share of recurrent budget- but increase dominated by salaries and investment while non-salary recurrent budget (& productivity indicators) have fallen
Nicaragua	2001-2003, GDP share increased from 2.2% to 2.95%, p.c. spend from $17 to $22. Current GDP share is sufficient to meet NDP cost estimates to achieve the goals.
Tajikistan	2001-2003, spending fell from 1.17% of GDP to 1.01%, & from 6.3% to just 5.3% of Govt spending- both v low levels.
Tanzania	Health spending increased 75% in real terms in 3 years to FY04, budget share 9.7% is below Abuja 15% target, spending including donors only $7.26, and budget share dropped in 2003 & 2004 budget. Some increase in share of primary & preventive.
Uganda	Health share of non-interest budget increased from 2.5% in 1987/88 to 9% in 1998/8 and 12.2% in 2002/3, with improved targeting as the share of the MHCP has been increased. 15% target share in 2007/8. Current p.c. spend $8-9, will reach $11 in 2015 with15% share. Implementation rate has been over 95%, but fell to 90% in FY2003 due to recruitment problems.
Vietnam	Limited and partial data, trend unclear though substantial increase in funding of services for the poor seems to have occurred.

Decentralisation is a nearly universal theme. It encompasses institutional approaches ranging from ceding responsibility for health services to a lower tier of Government, through contractual arrangements with public and/or private entities to provide agreed levels of service, through to more limited changes to increase the responsibility of lower level units under health ministry authority. This often takes the form of increased authority to manage their own budgets, while holding them more accountable for results, often as part of a wider

move to introduce 'performance based budgeting' (e.g. Benin, Ghana, Tanzania). The desire to hold those delivering services accountable has not always been accompanied by equal willingness of finance ministries, health ministries, or donors to relinquish control over expenditure decisions, staffing, and procurement. Reasons of lack of capacity and problems of accountability are cited, but the effect is that good managers may be frustrated in their efforts to achieve improved results (Box 1).

Box 1: Is there a need to delegate more authority to those responsible for achieving results?

Benin: 1995 policy envisaged decentralisation to health facilities and districts, public-private partnerships and performance contracts. Over-centralised budget management has frustrated the policy and prevented planned increases in health expenditure, but is now being addressed with PRSC support.

Burkina Faso: Complex multi-level planning, but over-centralised and complex procedures contribute to low budget execution (below 80% including HIPC) and very late release of funds, especially at the periphery. Key MDG priorities are heavily dependent on HIPC funds and donor projects, funds for both of which experience large shortfalls. PRSC is supporting limited introduction of more decentralised access to funds at district level.

Ethiopia: Health sector support inconsistent with block-grant funding of regions. Health SWAP is mainly project financed, but donor projects achieve lower and more variable disbursement than Government funds[4], Govt pressing for more budget support.

Ghana: MOH performance contract with GHS, but MOH has retained responsibilities for procurement, staffing, training. There are 23 administrative steps for districts to access GOG funds.

Nepal: Reviews in late 90s concluded vertical projects were inefficient and unsustainable, called for decentralisation and enhanced community role[5]. Detailed budget programming and late donor confirmation of support results in late releases. But decentralisation is proceeding:- Sub-health posts being handed to communities, limited powers at present (no control over hiring staff), but there are plans for local bodies to have powers to vary compensation, plans to devolve drug and medical supply purchase to districts, public-private partnerships being expanded.

Tanzania: District health plans require formal approval by basket funding committee. This delayed fund release in FY 03..

Source: Country Case Studies, WB reports.

Where decentralisation has been to local Government bodies (Uganda, Tanzania, potentially Nepal), it has in practice been accompanied by earmarking of funds to ensure that national priorities are respected, often accompanied by higher level review of plans and budgets, with

[4] World Bank, Ethiopia, First Poverty reduction Support Operation, Program Document, 23 January 2004.
[5] World Bank Nepal, PAD, Health Sector program, August 4th 2004

incentives and sanctions linked to aspects of performance. Imposition of sanctions is problematic given that the worst performers are commonly the poorest districts where it is hardest to obtain staff, and hence performance budgeting needs careful design to avoid either reinforcing existing inequalities, or lacking credibility because funds can not be denied when performance is poor.

Efforts to help communities hold service providers accountable are increasingly common, including community management of primary health facilities (Benin, Burkina Faso, Rwanda, Nepal). An increased community voice is often linked to community financing schemes. Pre-payment schemes increase utilisation by those who are covered, but inability to pay usually excludes the poor from participation (Rwanda coverage ranges from 10-50% of population, Ghana similar). Protecting the poor's access to services by exempting them from payment has proved difficult to implement[6]. Several case study countries are piloting approaches to reducing or eliminating cost barriers to the poor.

Re-allocating budgets, both within and between sectors, is difficult to achieve. Based on the material in our case studies, PRSPs say remarkably little about how non-priority expenditures can be reduced in order to fund expanded services for the poor, with Nicaragua one of the few making explicit reference to increased reliance on the private sector to fund services for the better off. Stated priorities risk being squeezed by growth of other expenditures (e.g. Ghana district services and non-salary recurrent spending have been squeezed by big increases in spending on salaries, on investment, and on central spending; primary health share of total health budget has fallen in Burkina Faso, whereas policy is to increase it).

Summary Points

- **Stronger inter-departmental coordination is needed to move from 'health services strategy' to 'health strategy.'**
- **Plans for expanding support to high priority interventions (on which there is broad agreement) need to be balanced by plans for how funding can be withdrawn from lower priority services.**
- **In most countries, achieving national targets requires institutional reforms to strengthen performance incentives, but with accountability for results matched to more reliable access to the necessary resources**.

[6] See Dr. Guy Hutton, User Fees and other determinants of health service utilisation in Africa: A review of formal and informal health sectors.

Estimating the costs of achieving the targets

Health is just one among many sectors competing for scarce funds in order to achieve faster progress towards national goals and the global MDGs. It is important to be explicit about the assumptions linking public expenditure costs to expected health outcomes because the argument for additional resources may otherwise be lost by default, both with the Ministry of Finance, and with the donors. Estimates of the expected costs and impact on outcomes of specific expenditure programmes are also helpful for prioritisation of the budget in the light of available resources, and provide a quantified framework for subsequent monitoring and evaluation and for setting realistic targets for managing performance.

Although some countries have set targets that are less ambitious than the MDGs, all of them have set targets that imply an acceleration of progress relative to the historic trend. Achieving those targets will require increased budgets to fund more challenging expenditure programmes. However, more than half of the case-study countries are spending less than $10 per head on health, with Ethiopia spending only $1.50, Cambodia just $3. The health sector budget share is in all cases below the 15% target agreed by African countries at Abuja, and in many of them the share is both low and not increasing (Ethiopia, Benin, Burkina Faso, Tajikistan, and Tanzania in the most recent budget). The resources that are available are in most cases far short of the resources required to achieve the Government goals in the health sector. This risks undermining faith in Government and the motivation of health workers who cannot achieve what is asked of them. Although it does not require sophisticated costing exercises to demonstrate that there is a shortfall, costing the targets can help to make the case for what could be achieved with increased funding. In Mauritania, for example, the 40% increase in the health budget in 2002 was reportedly influenced by analysis suggesting that a targeted increase could achieve within five years a 30% reduction in child mortality and a 40% reduction in maternal mortality[7].

Although the shortfall in resources has been highlighted in global estimates, it is often obscured at national level by relatively weak analysis. Most poverty reduction strategies do not attempt to estimate the public expenditure cost of achieving their targets[8]. Although most of the health strategies we looked at have been costed, few of them articulate clearly (and provide evidence for) the assumed chain of causality linking the resources required to the activities to be undertaken, the outputs to be produced, and the expected impact on outcomes. Many countries still produce their health budgets on an incremental basis not linked to objectives or even activities (e.g. Tajikistan). Others have moved towards activity-based budgeting in which objectives are stated, but have produced detailed programme

[7] World Bank, Mauritania Case Study (mimeo), quoting Ould Ahmed N and others, Mauritania HNP Country Status Report; and Ould Didi and others, MTEF Mauritania.. Knippenberg et al (2003) report that application of the marginal budgeting for bottlenecks approach for preparing health MTEFs in Mali and Mauritania resulted in doubling of health budgets.

[8] IEO IMF, July 2004

budgets in which it is difficult to link the many activities to overall strategic priorities (Ghana, Tanzania). In most cases, the goals are determined with reference to the MDGs and to the expectations of the donors, the plans reflect national constraints and priorities and available resources, but the links between the two are not specified.

A number of different approaches to costing have been developed and are in use for different purposes. There are well established methodologies (supported by good international evidence) for estimating the cost-effectiveness of different health interventions. These provide a sound basis for prioritising the health sector interventions that will be included in essential services packages. Global estimates of the costs of achieving the MDGs have mostly been based on estimates of the cost of scaling up the coverage of cost-effective interventions of known efficacy.

For costing national strategies and relating them to outputs, however, an approach is needed that can handle the costs and impact of actions that have wider effects than individual interventions or groups of interventions. In particular, it is necessary to consider the cost and impact of measures to address institutional and incentives problems, and to prepare cost estimates that can be 'mapped' to the way that budgets are actually allocated. One approach that is being piloted aims to do this by packaging interventions in terms of how they are delivered (facility based, outreach, community-based), and focuses on bottlenecks constraining coverage and effectiveness (physical accessibility, human resources, logistics and supply, cost and other barriers to demand and utilisation, gaps in technical and organisational quality, and steering and management costs)[9]. The approach aims to identify those areas where there is most scope for significant impact on health outcomes at modest cost. In Ethiopia, for example, it suggested that a 42% reduction in under 5 mortality could be achieved for less than half of the cost required to meet the target reduction of 66%. Although useful as a conceptual approach, the realism of the analysis has yet to be assessed in terms of actual results.

Summary Points

- **Strategies should include explicit analysis of expected linkages between costs-outputs-outcomes.**
- **Cost estimates should address institutional constraints and be prepared in a form that can be mapped to budgets and support resource bids**
- **Priorities should be identified to permit adjustments in the light of resource availability**

[9] Soucat et al, 2002.

Are macro-economic frameworks too restrictive?

The level of public expenditure that is consistent with reasonable macroeconomic stability has been an area of some controversy, and will be discussed in some detail because it is central to the prospects for achieving the MDGs.

A macro-economic framework should contain assumptions on the future growth path of the economy and some justification for the assumed growth rate, informed by past experience and the expected impact of future changes in the economic and policy environment. It should contain a discussion of the future desired level of public expenditure in relation to GDP, and of how it can be financed. The public expenditure projections might start from a 'needs' basis, presenting the costs of achieving the MDGs or national targets, but may need to modify the level of spending and the national targets in the light of the resources expected to be available and the implications for private sector growth and for macro-economic management. The consideration of resources should include discussion of taxation policy and the expected future share of domestic revenue in GDP. It should consider the past and expected future level of external grants and loans available to the economy, the terms on which that finance is likely to be available, and the implications for Government debt service. Finally, it should consider the scope for net domestic financing of Government expenditure and develop Government expenditure and financing assumptions that are consistent with a growth of total domestic demand that allows for healthy private sector growth, moderate inflation, sustainable debt burden, and prudent build up of foreign exchange reserves.

The macro-economic framework may require ceilings to be placed on total Government spending, even if proposed increases in spending are financed by external grants. The problem arises when aid is used to pay for local costs, rather than financing additional foreign exchange costs. In the health sector, local costs are typically 70-75% of total spending[10]. An intuitive way of thinking about the problem is that if donor aid is converted to local currency and used to buy locally produced goods and services, it does nothing in the short term to increase the supply of those goods and services. If there is no spare capacity, the aid-financed increase in Government demand for local staff, construction materials, housing etc will push up their price and squeeze out private sector demand[11]. This need not matter if the additional outputs produced by the public sector are more socially valuable than the private sector outputs they displace. That may well be the case with cost-effective health expenditures, especially when the positive impact of improved health on productivity is taken into account alongside the social benefits. However, if we assume that the public sector expenditures with the highest benefit: cost ratios are undertaken first, while the least profitable private sector activities are displaced first, there will come a point at which diminishing

[10] Millennium Project, MDG Needs Assessment.

[11] Some of the private sector demand may be diverted to purchase imports, which would reduce the foreign exchange reserves and ease (but not eliminate) the excess demand problem. This complication is ignored for ease of exposition.

marginal benefits of additional public expenditure fall below the rising marginal costs of displacing private sector activity. This argument does not depend on assuming that increased donor flows are inflating the real exchange rate and causing loss of competitiveness of traded goods producers ('Dutch disease.') Irrespective of Dutch disease, in any economy, there will come a point beyond which additional public expenditure on local costs should not be undertaken, even if financed with grants. The argument is not on whether such limits are needed, but concerns the judgement on where they should be set.

Other concerns may also lead countries (and the IMF) to take a cautious line on the extent of dependence on aid. The main requirement for additional spending is to finance incremental salaries and other operating costs of a recurrent nature. Aid is a volatile source of finance, and aid commitments are conditional and short-term whereas the spending obligations are long term and difficult to exit from quickly without provoking political problems. For poor countries such as Tanzania and Ethiopia, simple analysis can demonstrate that sustaining per capita expenditure increases financed by a doubling of aid flows would require the higher level of aid to be maintained for 20 years or more, representing a substantial risk to the Government[12].

These issues are not discussed in most PRSPs. The IEO evaluation of PRSPs and the PRGF found that only 4 countries from a sample of 10 presented a realistic macro-economic framework, two of them by explicitly adopting the pre-existing IMF PRGF framework, while events conspired to make 4 of the macro frameworks unrealistic by the time of Board discussion[13]. Part of the reason for not developing a robust macro framework within the PRSP may be the recognition that in practice, the macro-economic framework that is actually implemented has to be negotiated with the IMF, since the existence of an on-track IMF programme remains a pre-requisite for accessing significant external aid or HIPC debt relief.

The key criticism frequently levelled against the IMF is that fiscal and macro frameworks have been too pessimistic regarding the resources potentially available, resulting in countries implementing unnecessarily modest public expenditure plans that do not permit rapid enough progress towards the MDGs. At first sight, the empirical evidence appears to suggest that the bias is in the other direction, with IMF programmes over-estimating foreign aid, over estimating GDP growth, and consequently over-estimating both domestic and foreign resources available to finance public expenditure.[14] IMF policy statements are also supportive of increased aid, stating that additional aid inflows should be accommodated by appropriate

[12] See Foster, Mick, The Case for Aid.
[13] IEO IMF, 2004
[14] IMF and IDA September 2003. This over-estimation of the available resources is just as serious as under-estimation, since unplanned shortfalls in resources may necessitate damaging short-term cuts in public spending, often focused on easy to cut non-salary recurrent budgets, resulting in disproportionate negative impacts on outputs by denying staff the resources to do an effective job.

adjustments of the program's fiscal and financing targets, 'if they can be effectively absorbed and utilised without endangering macro stability.[15],

Despite the evidence of over-optimism on aid disbursements, it could still be argued that the IMF may unintentionally restrain future aid commitments by producing fiscal frameworks that assume only modest growth in aid levels. Countries may not push for additional aid flows, nor will donors offer such aid, if the macroeconomic projections on which the expenditure programme is based do not show a clear need for additional aid. Table 2 shows the assumptions for our sample countries, and does appear to suggest a conservative bias in the projections, all but one of which converge towards a level where public expenditure as a percentage of GDP is around 25%. Only two countries assume more than a 2% of GDP increase in the share of public expenditure within the projection period, both of them being countries starting from a low base of public expenditure less than 20% of GDP. With per capita economic growth typically forecast at 3-4% per annum, the projections imply per capita public expenditure increasing by about 50% by 2015. This may sound a lot, but might imply raising Government health expenditure from $8p.c. to $12- still far short of estimates of the cost of delivering the essential health package to all, and for Ethiopia would leave health spending at little more than $2 per capita. In a 3-7 year projection period, less than half of our sample countries project any increase in net external financing as a share of GDP. Even relatively well performing and low income countries are projecting aid increases for themselves that are well below the commitments made at Monterrey.

Table 2: IMF Macro-economic frameworks in case study countries

Country	GDP Growth p.a. (geom. average)		Domestic Revenue%GDP		Net External Finance (including grants) of Public Expenditure, %GDP		Public Expenditure, % GDP	
	Historical (years)	Projected (years)	Base (Year)	Proj. (Year)	Base (Year)	Proj. (Year)	Base (Year)	Proj (Year)
Albania	6.39% (1999-2003)	6.05% (2003-2007)	22% (2003)	22.4% (2007)	1.7% (2003)	1.9% (2007)	26.5% (2003)	26.6% (2007)
Benin	5.55% (1999-2003)	6.6% (2003-2006)	16.8 (2003)	17.0% (2006)	4.8% (2003)	3.5% (2006)	21% (2003)	22% (2006)
Burkina Faso	6.59% (1999-2003)	5.4% (2003-	12.4% (2003)	14.6% (2006)	8.7% (2003)	5.7% (2006)	21.6% (2003)	23.4% (2006)

[15] IMF (2)

Country	GDP Growth p.a. (geom. average)		Domestic Revenue%GDP		Net External Finance (including grants) of Public Expenditure, %GDP		Public Expenditure, % GDP	
		2006)						
Cambodia	5.83% (1999-2003)	4.65% (2003-2009)	10.4% (2003)	14% (2009)	6.0% (2003)	23.4% (2005) 21.1% (2009)	17.4% (2003)	18.4% (2009)
Ethiopia	3.72% (1999-2003)	6.83% (2003-2006)	19.6% (2003)	20.4% (2006)	14.8% (2003)	8.6% (2006)	29.1% [16](2001)	29.5% (2006)
Ghana	4.66% (1999-2003)	5.03% (2003-2008)	20.8% (2003)	22.4% (2008)	8.0% (2003)	5.1% (2008)	29% (2003)	24.3% (2008)[17]
Nepal	2.18% (2000-2003)	4.5% (2003-2006)	12.3% (2003)	13.45 (2006)	2.9% (2003)	4.2% (2006)	16.3% (2003)	18.2% (2006)
Nicaragua	2.58% (1999-2003)	4.2% (2003-2008)	21.9% [18] (2003)	22.1% (2008)	10.45 (2003)	8.7% [19](2004)	30.3% (2003)	28.7% (2004) 26.8% (2008)[20]
Rwanda	5.61% (2000-2003)	5.33% (2003-2006)	13.5% (2003)	13.6% (2006)	10.5% (2003)	17.1% (2004) 13.9% (2006)	24.1% (2003)	28.3% (2004) 25.1% (2006)
Tajikistan	9.47% (1999-2003)	5.85% (2003-2010)	16.8% (2003)	19.1% (2010)	2.8%[21] (2003)	1.2% (2010)	19.0% (2003)	22.1% (2010)
Tanzania	7.58% (1999-2003)	6.06% (2003-2006)	11.4% (2003)	14.0% (2007)	7.7% (2003)	10.7% (2007)	18.6% (2003)	25.4% (2007)
Uganda	5.63% (2000-2003)	5.84% (2003-	12.3% (2003)	13.4% (2005)	11.5% (2003)	8.5% (2005)	23.7% (2003)	22.9% (2005)

[16] Includes special programs such as demobilization and reconstruction, which accounts for around 0.7% of GDP

[17] Interest payment as % of GDP decreases from 6.2% in 2003 to 1.7% in 2008.

[18] These numbers are reported as total current revenue as % of GDP, capital revenue is recorded under the capital expenditure (net of capital revenue)

[19] Due to missing data for some of the financing projections, projection target year is different (2004) for net external financing. IMF Executive Board Completes Fifth and Sixth Reviews Under Nicaragua's PRGF Arrangement recently (sep. 2004).

[20] Interest payment as % of GDP decreases from 5.1% in 2003 to 2% in 2008.

[21] These are data for net foreign borrowing. Grants are excluded due to missing projections for the program years (2005-2010)

Country	GDP Growth p.a. (geom. average)		Domestic Revenue%GDP		Net External Finance (including grants) of Public Expenditure, %GDP		Public Expenditure, % GDP	
		2008)						
Vietnam	5.43% (1999-2002)	6.8% (2002-2007)	22.5% (2002)	22.2% (2007)	1.4% (2002)	1.6% (2004) [22]	24.8% (2002)	25.1% (2007)

Source: Calculated from data reported in IMF PRGF documents
Nepal, Rwanda and Vietnam numbers are based on 2003 PRGF program. The other countries are based on latest 2004 reported programs.

It is difficult to assess the fiscal frameworks in IMF programmes, because the Fund provide no clear justification for their assumptions on the level and financing of public expenditure- something the IEO have criticised them for[23]. The convergence of spending to roughly 25% of GDP is not a result of any IMF policy. It may be coincidence, or it may reflect a tendency for IMF country staff to encourage countries to move towards a level of expenditure that Board and senior management have found acceptable in other cases. Whatever the explanation, the lack of variation between countries in the public expenditure assumptions is surprising. Countries differ in their public expenditure needs: low income countries with poor infrastructure and low education and health levels could make a strong case for a higher public expenditure share in order to create the conditions for faster economic growth and poverty reduction[24]. Countries differ in their ability to finance expenditure, both their ability to attract external aid, and the scope for mobilising domestic resources without damaging growth and stability. It would also be reasonable to expect that, other things being equal, public expenditure levels would be higher in countries like Uganda and Burkina Faso, where almost all aid flows are recorded in the IMF public expenditure tables, than in countries like Benin, where more than half of aid is not included[25]. The lack of explicit rationale for the assumptions, together with the absence of the expected degree of difference in projected spending between countries, add up to a strong case for a more open debate on the macro framework. Although some aspects of IMF discussions are commercially sensitive (e.g. relating to future exchange rates and interest rates), there need be no objection to a more open discussion regarding the appropriate fiscal stance, though such discussion is only likely to be fruitful if supported by high quality technical analysis. Uganda and Tanzania both provide striking examples where the Government were able to persuade the IMF to

[22] Program target year is different due to the same reason described in footnote 68.
[23] IEO IMF, 2003.
[24] See for example, Millennium project, 2004.
[25] Foster, Mick, forthcoming.

accommodate higher expenditure by procuring independent macroeconomic analysis that commanded the respect of IMF staff.

A more fundamental problem is that aid commitments are short-term and unreliable, whereas the additional public expenditure that is needed is mainly for recurring costs that will need to be sustained and to grow into the indefinite future. Even with a rapid increase in domestic revenues, the low-income aid dependent countries that are furthest from the MDGs could only sustain the significant increases in per capita public expenditure required to help them get there if aid donors were able to maintain increased spending levels for 20 years or more. Countries face significant risks if they establish health systems that cannot be maintained if donor preferences change. A range of alternative approaches could be taken to managing this problem: - the International Financing Facility as a way to ensure growing aid at least at global level; increased reliance on multilateral channels less subject to political pressures; longer term commitments to specific expenditure programmes, with guarantees that they will continue so long as the programme-specific conditions are met; further debt relief as a form of irrevocable long-term commitment; increased use of aid for reserve build-up to help in managing aid fluctuations. Each of these requires political will on the part of the donors to commit their money longer term in ways that are less at risk of interruption in the face of events outside the objectives of the programme itself.

The plans set out in the PRSP can only be implemented if they are consistent with the macro framework negotiated with the IMF. The PRSP discussions may therefore provide an appropriate forum for the wider debate on the level and financing of public expenditure. Both Ministry of Finance and IMF views need to be reflected in the PRSP. Good practice in this regard includes: -

- Ensuring that the relevant staff of the Ministry responsible for preparing the macro-economic framework for the budget are fully involved from the earliest stages in developing the PRSP until the finalisation of the fiscal ‘envelope’ set out in the approved version;
- The IMF should also be continuously involved through the resident representative, given the requirement for PRGF countries to agree the macro-budget framework with the IMF;
- PRSP priorities and proposed expenditure ceilings should influence and feed in to the preparation of the budget and of any MTEF or medium term expenditure plan;
- The PRSP needs to be a ‘living document’ that is elaborated as necessary and adapted in the light of events. The institutional details vary, but a number of countries have established systems in which the poverty reduction strategy is annually reviewed, and the results of that review feed in to adjustments to the targets, the macro-economic framework, and the expenditure priorities and budget ceilings.

Summary Points

- **Involve MOF/IMF in preparing PRSP macro-fiscal frameworks to ensure consistency with the budget, but with explicit rationale and more open debate**
- **Coordinate annual PRSP progress review with budget cycle including revision of macro-fiscal framework and budget ceilings and priorities**
- **Reduce risks of aid dependence by longer term commitments less prone to interruption, more reliable timing of disbursements**

Coordinating health plans with the MTEF and the Budget

The expenditure implications of the national goals and strategies of the PRSP need to be implemented via the national budget. Good practice approaches include: -

- The sectoral priorities of the PRSP and the allocations eventually agreed in the budget are the outcome of an iterative process in which proposals for sector plans and allocations are prepared by line ministries, scrutinised by the centre, and adjusted in the light of national priorities.
- The PRSP sets out clear priorities and criteria, and those priorities are reflected in the guidelines and ceilings sent to line ministries to guide budget preparation.
- The MTEF that is approved is the same as the annual budget for the first year, and the chart of accounts is structured in such a way that spending priorities of particular importance for achieving the goals can be identified.
- There is an annual process for reviewing sector-level progress, and the domestic and foreign finance requirements for the coming period, timed to feed in to the Government budget preparation cycle.
- There is a central 'challenge' function as part of the budget process, providing credible incentives for line ministries to review their performance, construct well-designed budgets that shift resources towards national goals, and to present them in ways that make the strategic shifts transparent.
- The Ministry of Finance and Cabinet establish and maintain the credibility of the process by ensuring that carefully prepared budgets that are in line with nationally important goals receive favourable treatment in the budget that is finally approved, and in the timely and full release of funds.
- Ministry of Finance provides credible medium-term assurances of sectoral budget levels or shares, to encourage line ministries to re-allocate resources from lower priority areas without fearing that their budget will suffer as a result. Credibility can be built via a medium-term track record in which it is shown by example that the MTEF guides resources, with year one of each year's budget preparation taking year 2 of the previous MTEF as the starting baseline. Agreements with external partners on the

share of spending to be devoted to health are also sometimes used, and can be helpful in reinforcing the confidence of line ministries in their likely future budget share.

- Donor support needs to be fully taken into account in setting expenditure priorities. This requires donor commitments early enough in the budget preparation process, and committed to activities that are drawn from the national strategy. To minimise transactions costs, aid should increasingly be provided using Government channels to plan, disburse, and account for it.

Many of these good-practice features are present in Albania, Benin, Rwanda, Tanzania and Uganda, though the identification of priority expenditure programmes is in some cases limited to the aggregate level (e.g. sector or sub-sector shares, such as primary health), and only Uganda has a strong central budget 'challenge' function. In countries with decentralised budget responsibility, such as Vietnam and Ethiopia, it may be impossible for Government to establish centrally a medium term framework to determine public expenditure shares. The goal of achieving similar shifts in priority is being addressed through increased resources for targeted national programmes, such as the province-level poverty health funds in Vietnam.

Not all MTEFs have focused sufficiently on achieving a strategic shift in expenditures towards national priorities. The MTEFs in Cambodia and Ghana, and to some extent in Tanzania, are based on detailed bottom-up activity costing, resulting in bulky documents where it is difficult or impossible to see how the changes in the budget allocations relate to higher-level goals and targets.

Where budget preparation and public expenditure management is particularly weak, there may be no effective means to ensure that health strategies are implemented. The effort devoted to preparing a health strategy and a sector MTEF is largely wasted if the annual budget is not in practice implemented and the medium-term priorities are not respected. Several of the countries in our sample still lack any credible mechanism for linking policy priorities to expenditure allocations, with budgets still prepared on an incremental basis, via fragmented parallel processes, and with actual budget execution not reflecting the approved budgets. In Tajikistan, for example, the budget is prepared incrementally on a line item basis; actual expenditure bears little relationship to approved budgets, making it impossible to relate health outputs to budgets either for planning or reporting purposes. Cambodia is an extreme example, with health centres receiving less than 10% of their budgets, but several other countries need to establish credibility.

Improvements in public expenditure management require action by central economic ministries, though implementation may also require reform and capacity building at sector and local Government level. External support to the health sector may need to be complemented by, or preceded by, support to cross-cutting reforms. Improved public expenditure

management is always a central concern of the policy dialogue associated with general budget support. In all cases, the PRSC policy matrix addresses issues of public expenditure management, and provides a vehicle for monitoring progress. In Benin, for example, the PRSC is supporting measures to overcome problems of low rates of budget execution that have prevented planned increases in health budgets.

Summary Points

- **Minimum standards of public expenditure management need to be attained before any health strategy can be effective.**
- **In good practice cases, PRSP identifies spending priorities in consultation with sectors, MTEF/budget process shifts resources towards them, review and adjust each year in light of performance.**

Absorptive capacity

It is sometimes argued that the speed of any increase in donor flows needs to be constrained to the absorptive capacity of the countries. Very large increases in funding over a very short period of time, as envisaged in some estimates of the cost of reaching the MDGs, might well lead to difficulties in making good use of the money. However, the situation in most of the case study countries appears to be one of grossly inadequate funding that is increasing at a speed that could be easily absorbed and effectively used, provided that it is appropriately prioritised and managed without excessive bureaucracy. For many countries, existing capacity is underused because low operating budgets mean that drugs and other consumables are unavailable or have to be paid for, while staff lack the travel budget to expand outreach activities. Increased aid for non-salary recurrent costs and for financing free basic health services would enable that existing capacity to be used: reducing user fees will increase utilisation of services, but only if quality does not decline, which requires the lost revenue from fees to be replaced by increased budget funding[26]. Increased funding would also help to overcome the more fundamental capacity problems caused by staff vacancies, and by low output from underpaid staff who need to devote time to alternative occupations or private practice. These problems are capable of being relieved with additional funding for new recruitment and for salary increases, though the increase would need to be sustainable and should preferably be sequenced as part of an approach to performance management that links increased pay to improved performance. Given time, contractual arrangements with non-Government agents could be put in place to expand services and/or support capacity development. A balanced increase in funding that addresses the critical constraints in a logical sequence could be well used in most of the countries considered. However, very large disease-specific programmes (such as proposed HIV/AIDS treatment programmes in Guyana

[26] Hutton, op cit.

and Tanzania that envisage spending sums equal to half of the existing health budget) may well experience and cause capacity problems by drawing disproportionately on available staffing and other resources.

Concerns about absorptive capacity frequently reflect concerns about Governance and accountability rather than technical limits on spending, and the disbursement problems are the consequence of procedural requirements intended to address those concerns. There are cases where Governance and expenditure management constraints are so pervasive that major reforms need to precede or accompany increased funding (Tajikistan, Cambodia). In other cases, Government procedures are over-centralised and bureaucratic and need to be reformed to permit available funding to be spent (Benin, Burkina Faso). Action to address public expenditure management or civil service reforms requires action by central authorities as well as the health ministry, requiring coordinated action by Government that is mirrored by coordination between donor agency support to macro-level and sector level reforms. Donor project or pooled funding procedures are usually part of the problem (Box 1). Donor procedures not only cause low disbursement, they also divert capacity away from service delivery towards servicing the donor demand for meetings, field trips, reports, accounts, audits etc. By absorbing the capacity of financial management staff, they also get in the way of effective Government action to address the systemic weaknesses that make parallel procedures necessary.

Summary Points

- **On present trends, the binding constraint is lack of finance, not lack of capacity.**
- **Capacity problems can be managed if health strategies tackle bottlenecks in a logical sequence, and avoid large 'earmarked' commitments that distort health sector priorities.**
- **Where Government is committed to improving financial management, external partners should use Government systems while supporting coordinated action to strengthen them as necessary.**

Reforming development assistance

The ways in which development assistance is committed and disbursed are major constraints on implementing public expenditure strategies. Commitments are too short term to be the basis for long-term strategies, disbursements are often a long way short of commitments, are unpredictable and subject to interruption for reasons outside the programme itself, and the majority of development assistance continues to be committed through parallel arrangements that may be imperfectly coordinated with the Government strategy. There are problems with

the data, but Box 2 presents some rough estimates of the significance of aid to the budget. Budget support is increasing as a share of donor support, but even in the most highly aid dependent countries it represents little more than half of the support for public expenditure, and less than one third of total aid flows. On average, less than 20% of donor disbursement is provided as budget support. This is a major problem in aid dependent countries where substantially more than half of health spending is often donor funded, and where the numbers of donors involved continues to increase. The priorities for increased spending are dominated by recurrent costs, spent at local level via geographically scattered cost centres, and difficult for donors to support via projects without incurring very high costs. If the case for an increase in health spending to progress towards the MDGs is accepted, it seems inescapable that the bulk of the increase will need to be provided as budget support[27].

Box 2: Where does all the aid go?

On average, for every $1 disbursed by donors to our 14 case study countries, we estimate: -	
Direct donor spending (TA and direct payments) not recorded in balance of payments	$0.30
Recorded in Balance of Payments, but not reported as part of Government spending	$0.20
Aid earmarked to specific projects	$0.30
Provided as Budget Support	$0.20
Some of the budget support is itself earmarked to specific sectors or budget lines.	
Source: Foster, forthcoming, Tables 3.12-3.14	

Meanwhile, countries continue to face the problem of coordinating large numbers of donors providing their assistance via multiple routes. Good practice approaches from our sample countries include: -

- Joint Government-donor reviews of sector performance that are coordinated with the MTEF and national budget process and will feed in to a national PRS progress report or into a national public expenditure review process. There are a number of country examples where arrangements along these lines are in place, notably Uganda and Tanzania, where external partners work closely with Government in sector working groups, and where the sector dialogue is coordinated around the annual budget cycle.
- Indications of future donor funding should be made early enough in the year to be taken into account in setting ceilings for budget preparation, and should be confirmed as the budget is being finalised.
- Donor policy dialogue at different levels needs to be coordinated. The PRSC and general budget support groups are the appropriate vehicles for addressing issues that are crosscutting or are the concern of the central economic ministries. Of direct relevance to health, this includes the overall macro-economic framework, budget allocation, public finance management, civil service reform, and decentralisation.

[27] Several Millennium Project documents have made the same point.

Where there is an established sector dialogue, the health content of the PRSC should rely upon the sector reviews to set and assess the achievement of sector level actions, as is the case in Uganda, avoiding overloading the budget support policy matrix with sector level detail.

Several of the country case studies suggest that large commitments from the global funds are distorting priorities in a number of countries: - committing an unsustainable share of the budget to HAART for AIDS sufferers, sucking staff and resources into vertical programmes with costs that are neither replicable nor sustainable without longer-term commitments than the donors have yet provided (Tanzania, Guyana, Ethiopia). GFATM has in some countries set up separate coordination arrangements specific to the funds it is providing[28]. Several countries are uncomfortable with the approach of some of these new actors. In August 2004, Ministry of Finance in Uganda was reported as having decided to cap new project aid commitments that are outside the national health strategy[29]. There is a strong case for all external partners in the health sector working entirely within existing health sector coordination arrangements, and providing their assistance in support of the PRSP strategy, focusing first on filling the financing gaps for implementing the PRSP.

Summary Points

- **Progress towards the MDGs requires a further shift towards budget support as the main aid modality in aid dependent countries.**
- **All donors should participate in sector coordination, and should ensure that information is provided to Government to enable their commitments and disbursements to be fully captured in the macro-economic framework and reflected in public expenditure plans.**
- **Where Government has a sound sector strategy, the first call on donor funds should be to ensure that it is fully funded.**
- **Donors should try to commit early enough to inform the budget preparation.**
- **Where a strong sector level policy dialogue is in place, the PRSC should rely on sector reviews to agree sector level actions and to assess their achievement.**

[28] Barbara Bruns, informal note of June 28th 2004 workshop on the role of the IMF in relation to HIV programmes.
[29] New Vision, Uganda, August 20th 2004.

References

Conway, Tim, Karin Christiansen and Dan Lui, what are the implications of the MDGs for the welfare of the poorest, ODI report for DFID's 'reaching the very poorest' policy team, 12 March 2004.

Daima Associates and Overseas Development Institute September 2004, Joint Evaluation of General Budget Support to Tanzania, 1995-2004, Phase 2 Report.

Forum on Alignment Challenges in Programme- Based Approaches, Enhancing implementation effectiveness of Programme-Based Approaches through programme and stakeholder alignment, 17 to 19 November 2003, Berlin

Foster, Mick, How are the health-related MDGs being taken forward at country level? A review of some country experiences. Main report (forthcoming).

Foster, Mick Patrick Chaussepied and J Shivakumar, 2004, Evaluation of the Public Expenditure and Financial Accountability programme, June.

Foster Mick, The Case for Increased Aid, Final Report to the Department for International development, December 2003.

Makiko Harrison, Jenny Klugman and Eric Swanson (2004), Are PRS's undercutting the MDGs? An empirical review, April.

Hutton, Dr Guy (2002), User fees and other determinants of health sector utilisation in Africa: A review of formal and informal health sectors. Swiss Development Cooperation and Swiss Tropical Institute. August.

IMF, September 2004, External grants and IMF Policies.

IMF survey, June 28 2004, IMF book forum, are IMF-prescribed fiscal targets too tight?

IMF Public Information Note, March 11 2004, follow up on the recommendations s of the Independent Evaluation office report on fiscal adjustment in IMF supported programmes, report of Executive Board discussion.

IMF, Feb 9 2004, follow up on the recommendations of the independent evaluation office report on fiscal adjustment in IMF-supported programmes, policy development and review and fiscal affairs departments.

IMF, Aligning the PRGF and the PRSP Approach: Issues and Options, April 25 2003.

IMF & IDA, PRSPs- Progress in Implementation, September 12 2003.

Independent Evaluation office, IMF (2004), Evaluation report on PRSPs and the PRGF, July 7

Independent Evaluation office, IMF (2003), fiscal adjustment in IMF supported programmes, 2003.

Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS. How many child deaths can we prevent this year? Lancet 2003; 362(9377): 65-1

Knippenberg R, A Soucat, W Vanlerberghe, 2003, Marginal Budgeting for Bottlenecks: A tool for performance-based planning of health and nutrition services for achieving the MDGs. Millennium project, (2004), Summary of a global plan to achieve the MDGs. Draft report for discussion at the OECD-DAC high level consultation on the UN Millennium Project, 8-9 July 2004.

Millennium project, MDG country case studies: methodology and very preliminary results, October 2003

Millennium Project (undated), MDG Needs Assessment

Mills, Anne (2004), Achieving the Health MDGs, Presentation to DFID economist's retreat, July.

New Vision, Uganda, 20th August 2004

Nkusu, Mwanza (2004), IMF Africa Dept Working paper, Aid and the Dutch disease in low-income countries, informed diagnoses for prudent prognoses. March.

Operations Evaluation Department, World Bank, OED Review of the Poverty reduction Strategy process

Sachs, Jeffrey D, Mobilisation of Domestic and Donor resources for health: a viewpoint, increasing investments in health outcomes for the poor, second consultation on macroeconomics and health, October 2003.

Agnes Soucat, Wim Van Leberghe, Francois Diop, Son nam Nguyen, Rudolf Knippenberg, marginal budgeting for bottlenecks: a new costing and resource allocation practice to buy health results. Draft version November 2002, not for quotation.

Adam Wagstaff and Mariam Claesson, The millennium development goals for health, rising to the challenges, 2004.

World Bank, Development Data Group, Targets and Indicators for MDGs and PRSPs: What Countries Have Chosen to Monitor

World Bank (2004), World Development Report, Health chapter

World Bank, Chief Economist's Office, Africa Region (2004), The PRSP Process, NEPAD and the Millennium Development Goals, April

World Bank, Sept 12 2003, supporting sound policies with adequate and appropriate financing, implementing the Monterrey consensus at the country level

World Bank (undated), Interim Guidelines for PRSCs

WHO, PRSPs, their significance for health, second synthesis report, 2004.

WHO, Macroeconomics and Health, An update, Increasing investments in health outcomes for the poor, second consultation on macroeconomics and health, October 2003